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**Epidemics and the civilizing process in the UK: Fear and
morality from Cholera to Covid-19**

**Dissertation Submitted in Partial Fulfillment of the Requirements for
Master's Degree in Literature and Civilization**

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Dedication

I dedicate this work first and foremost to Allah, the Almighty, for His infinite grace, strength, and guidance. Without His blessings and the doors, He opened for me, this academic journey and the completion of this dissertation would not have been possible.

To my beloved mother: you are the light that continues to guide my path. Your love, prayers, and the values you instilled in me are woven into every page of this work. I hope I have made you proud.

To my beloved Husband : thank you for being my unwavering support system. Your patience, encouragement, and belief in my abilities provided the peace of mind I needed to persevere through the most challenging stages of this research.

To my grandfather and grandmother: for your enduring love and the legacy you carry in my heart.

Finally, I dedicate this achievement to myself. I am deeply proud of the discipline, resilience, and passion I have shown in reaching this milestone. This dissertation is a testament to my hard work and the fulfillment of a significant dream.

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Abstract

This study investigates the construction of epidemics through language, examining the intersection of discourse, fear, and morality in the United Kingdom from the nineteenth-century cholera outbreaks to the contemporary COVID-19 pandemic. Rather than treating disease as a purely biological occurrence, this research explores how linguistic practices shape public perception, interpret risk, and facilitate social management. By analysing crisis narratives, the study demonstrates how epidemic discourse generates a sense of urgency that regulates both individual and collective behaviour, transforming medical events into moments of profound social reorganisation. The analysis pays particular attention to the role of metaphors and spatial representations, which map disease onto specific environments and social groups, thereby embedding moral judgements and the allocation of responsibility within public health messaging. Furthermore, the research connects these discursive processes to the civilising process, illustrating how the internalisation of norms such as hygiene, self-control, and discipline serves as a form of governance. By comparing historical and modern contexts, the study reveals significant continuities in how language is used to justify state intervention and encourage self-regulation. Ultimately, this work contributes to an understanding of how the relationship between disease, public messaging, and social control has evolved, highlighting the enduring power of discourse to structure the moral and social reality of epidemic experiences.

Keywords: civilising process, discourse, epidemics, morality, social control.

List of Abbreviations and Acronyms

Abbreviation	Word/Phrase
BBC	British Broadcasting Corporation
CDC	Centers for Disease Control and Prevention
NAO	National Audit Office
NHS	National Health Service
ONS	Office for National Statistics
SAGE	Scientific Advisory Group for Emergencies
UK	United Kingdom
WHO	World Health Organization

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– General Introduction

Background of Study

Epidemics are disease outbreaks that affect a large number of people in a community, while pandemics are epidemics that spread across a wide geographic area. Both have serious effects on economies and societies. How well a society handles these crises depends on social cohesion, which is the way different groups work together to survive and recover. Poverty and inequality can make these situations worse, as they affect how people interact and support each other during and after a disaster.

In the past, many believed that population growth in pre-industrial England was controlled by high death rates. But research by Wrigley and Schofield shows that between 1541 and 1871, population growth was actually driven more by rising fertility than by falling mortality. For example, England's population doubled from about 5 million in the late 1600s to over 11 million in the early 1800s, mostly because more people were having children. This happened as people married earlier and fewer remained single. These findings change how we view the past: instead of being helpless against disease and famine, people made active choices about family size based on their economic situation. This also suggests that agriculture became more productive, allowing more people to work outside farming—in towns and as artisans—without causing food shortages or rising prices (Kearns, 1988).

Today, health means more than just not being sick. It includes a person's overall well-being, their ability to take part in society, and having access to good health throughout their life. Some health issues, like obesity, are easy to measure. But others, like how connected someone feels to their community or neighborhood, are harder to define. For example, some experts believe that living above the fifth floor in a high-rise building can make people feel

disconnected from the street, but it's difficult to measure this kind of connection (Zheng et al., 2021).

Public emergencies—like the COVID-19 pandemic—are sudden events that threaten national security, public order, and people's lives. They often cause fear and sadness, which can affect how people make decisions. During the pandemic, many people experienced strong negative emotions, and research shows that these emotions can influence moral judgments. In moral dilemmas, such as the classic "trolley problem," people often choose between saving many at the cost of a few (utilitarian thinking) or following moral rules (deontological thinking). This study looks at how negative emotions during public emergencies affect such moral choices (Zheng et al., 2021).

In London, there are programs working to reduce stigma related to HIV, mental health, and substance misuse. These programs involve people with lived experience and focus on issues such as racism, transphobia, and migration status.

Key efforts include:

- HIV support and prevention programs for Black communities.
- Training for healthcare organizations to reduce stigma.
- Mental health projects such as Thrive LDN and online tools like Good Thinking.
- Support for people dealing with addiction and homelessness.

These programs are built on teamwork, personal storytelling, and targeted support for underserved groups (Parker & Aggleton, 2003; Herek, 2002).

In the mid-1800s, cholera outbreaks in London caused widespread fear and death. This forced the government to act. At the time, the city was dirty and overcrowded. The crisis

led to the first Public Health Act in 1848 and the creation of a modern sewage system. It marked a turning point in how the city managed public health (Halliday, 2001; Rosenberg, 1962).

The COVID-19 pandemic tested how well smart cities—like London—could respond to a crisis. It showed that technology alone isn't enough. Cities had to focus more on people's needs, using technology to support residents rather than just monitor them. This shift toward "value-sensitive design" helped make cities more resilient and human-centered (Yigit, 2022).

Even though there are huge differences between the 19th-century cholera outbreaks and the COVID-19 pandemic, people's reactions to fear have stayed the same. In both cases, fear led to panic, blame, and social division. During cholera, the working class accused the rich of poisoning them. During COVID-19, people blamed certain groups or countries for the virus (Bakugou et al., 2021).

These responses show that, no matter the time period, fear can reduce rational thinking and lead to stigma and scapegoating.

Understanding how cities grew and faced challenges in the past helps us understand today's urban life. The ethical and social struggles of earlier times—like during cholera outbreaks—still matter today. By studying history, we can better prepare for the future of cities in the UK and beyond (Koçak et al., 2021).

Statement of the Problem

This study looks at how British society has changed over time by comparing two major health crises: cholera in the 1800s and COVID-19 in the 2000s. It explores how fear, morality, and what is called the "civilizing process" helped people in Britain cope with and recover from these disasters. The study will examine government speeches, medical reports,

and public health messages to understand how health strategies were created, how the idea of a "civilized citizen" was shaped, and how these ideas changed over time. It also looks at the hidden beliefs behind these messages and how fear and morality were used to guide and control people's behavior.

Research Questions

This study aims to answer the following questions:

- 1) How does epidemic discourse construct fear and regulate behavior from cholera to COVID-19 in the UK?**
- 2) How does language shape moral judgments of responsibility and risk in epidemic discourse?**
- 3) How do epidemic discourses reflect the civilizing process through norms of hygiene, self-control, and discipline?**

Aims of the Study

This study aims to investigate how epidemics are constructed through language, with a focus on the relationship between discourse, fear, and morality in the UK, from cholera to COVID-19. Rather than viewing disease as a purely medical phenomenon, it investigates how linguistic practices influence how epidemics are perceived, interpreted, and socially managed.

The primary goal is to investigate how epidemic discourse creates fear and urgency, and how these elements influence and regulate both individual and collective behaviour.

Language is examined in terms of how it assigns meaning to risk, constructs crisis narratives, and encourages specific types of response. In this context, the study also aims to investigate how moral judgements are embedded in discourse, particularly in the allocation of responsibility and the positioning of social groups.

The study seeks to explore the role of metaphors, representations, and descriptive patterns in making disease visible and meaningful. These linguistic strategies are not neutral; they shape understanding and guide interpretation, contributing to the overall structure of social reality.

Finally, the study intends to show how these discursive processes relate to the civilising process, specifically through the internalisation of norms like hygiene, self-control, and discipline. By examining both cholera and COVID-19, the study highlights historical continuities, demonstrating how language contributes to the regulation of behaviour and the moral structuring of epidemic experiences.

Research Significance

This study helps to understand how fear, morality, and the civilising process have shaped the way Britain handles epidemics. It shows how language influences public behavior and social structures during health crises. The findings may add to current discussions about public health ethics, social inequality, and the role of the government in the UK. By comparing the 19th and 21st centuries, this study offers a unique view of how the relationship between disease, public messages, and social control has both stayed the same and changed over time.

Research Methodology

This qualitative study examines the discourse and moral psychology of epidemics in the United Kingdom, spanning from 19th-century cholera outbreaks to the COVID-19 pandemic, to demonstrate how fear and moral regulation have shaped the British civilising process.

6.1. Corpus of Study

The corpus of this study consists of a collection of texts about Cholera, and another collection of text and videos about COVID-19 from the United Kingdom (UK). Table 1, Table 2, and Table 3 provide all details needed for clarity and ease of reference.

No.	Title / Work	Author(s)	Date
1	<i>Cholera treatment and preventive measures</i> (pp. 39–44)	Unkown	19th century
2	<i>Cholera morbus: Advertisement for an improved domestic instrument</i>	Brothers & Williams	n.d.
3	<i>Cholera</i> (1832 archival materials)	Oxfordshire Health Archives	1832
4	<i>Cholera epidemics in Victorian London</i>	The London Gazette	n.d.
5	<i>The date-book of remarkable and memorable events connected with Nottingham and its neighbourhood</i> (pp. 407–408)	Henry Field	1884
6	<i>Spread of the cholera from Sunderland</i>	The Guardian (archival article)	1831 (republished 2011)
7	<i>Communication of cholera by Thames water</i>	Medical Times and Gazette	1854
8	<i>‘Checking the evil’: Ways to halt the advance of a cholera pandemic – archive, 1866</i>	Rebekah Nelsson	2020
9	<i>Fear and humour in the art of cholera</i>	Mark P. Park & Robin H. R. Park	2010
10	<i>On the mode of communication of cholera</i> (2nd ed.)	John Snow	1855
11	<i>‘This pestilential stream’: Exploring the Great Stink of 1858</i>	Rachael Staveley-Wadham	2021
12	<i>The best prescription for cholera – archive, 1854</i>	The Guardian	2009
13	<i>The public health</i>	The Times (London)	October 7, 1848

Table 1. Cholera Written Documents

No.	Title / Work	Date	Publisher / Source
1	'New hope': Queen reassures nation in first Easter message	2020	The Guardian
2	Queen tells UK to 'focus on the common goal' in coronavirus message	2020	The Guardian
3	Covid left me 'exhausted', Queen tells bereaved couple	2021	The Guardian
4	Queen cancels pre-Christmas family lunch as Covid cases soar	2021	The Guardian
5	'I feel fear and guilt': An NHS junior doctor on the effect of getting Covid-19	2020	The Guardian
6	There are so many Covid patients, younger this time. But my hospital is full	2021	The Guardian
7	UK to begin using Oxford Covid vaccine as PM strikes hopeful tone	2020	The Guardian

Table 2. Covid-19 Written Documents

No.	Author(s)	Topic / Title	Date
1	Queen Elizabeth II	We will meet again' – The Queen's Coronavirus broadcast (2020)	05/04/2020
2	Boris Johnson	Coronavirus: PM Boris Johnson's lockdown statement (2020)	23/03/2020
3	Boris Johnson	Coronavirus in the UK: The first 100 days (2020)	09/05/2020
4	Boris Johnson	Boris Johnson announces third national lockdown (2021)	04/01/2021
5	Queen Elizabeth II	The Queen addresses the UK on coronavirus (2020)	05/04/2020
6	Queen Elizabeth II	Delivers hopeful Christmas message amid COVID-19 pandemic (2020)	25/12/2020
7	Queen Elizabeth II	The Queen's Christmas Broadcast 2020 (2020)	25/12/2020
8	Boris Johnson	Lockdown: What you can do from Monday - Boris Johnson Covid briefing (2021)	10/05/2021
9	Dr. Jenny Harries	Coronavirus: All parts of UK 'on emergency footing' - minister (2020)	29/03/2020
10	Boris Johnson	UK's Johnson delivers new guidance in COVID-19 speech (2020)	10/05/2020
11	Boris Johnson	Coronavirus UK: Boris Johnson urges British public to stay home to stop Covid-19 spread (2020)	23/03/2020
12	Boris Johnson	In full: Boris Johnson orders three-week lockdown of UK to tackle coronavirus spread (2020)	23/03/2020
13	Boris Johnson	Coronavirus: PM announces second national lockdown	31/10/2020

Table 3. Covid-19 Speeches

6.2. Data Collection

This study uses a qualitative data analysis approach to look at the evolution of moral discipline and state regulation in the United Kingdom through the lens of public health crises. The data come from both historical and contemporary primary sources, such as parliamentary reports, sanitary board records, public health legislation, and official government addresses. The analysis focuses on specific shifts in discourse and social control over time, contrasting 19th-century cholera outbreaks with the 21st-century COVID-19 pandemic to show how fear and morality shape the civilising process.

Historical documents from the Victorian era, particularly those concerning the "Blue Death" and the rise of the sanitary movement, shed light on the early stages of state expansion. Contemporary data sources, such as newspapers articles, British government briefings, and digital public health campaigns, provide insights into modern social transformations. This study analyses these diverse sources to identify similarities and differences in how the state manages epidemics, tracing a shift from moralisation of the "unwashed masses" in the 1800s to war metaphors and "superspreader" stigmas in the 2020s.

6.3. Data Analysis

The study uses an analytical framework based on Foucauldian discourse analysis and moral psychology. Discourse analysis is the study of how language, knowledge, and power interact to shape our understanding of social reality (Foucault, 1972). In this study, discourse analysis will be used to investigate how epidemic narratives are created and shared in the United Kingdom. For example, the analysis could examine how diseases are framed using specific metaphors, such as referring to a virus as an "invisible enemy" or a "plague", to determine which voices—such as scientists or politicians—are given the most authority. (Haugaard, 2022).

Moral psychology is the study of moral identity development, or how people integrate moral ideals into the formation of their own personalities (Ethics Unwrapped, 2017).

When combined with discourse analysis, this method can reveal how emotions such as fear and compassion are embedded in public language. The integrated framework will be used to examine British public health discourses ranging from cholera outbreaks to the COVID-19 pandemic.

The study investigates how infected people are morally evaluated, such as whether they are viewed as "victims" to be helped or as "criminals" to be punished. It also examines how these narratives frequently switch between different modes of speech to justify government actions. For example, public health policies may employ compassionate language to foster solidarity while employing punitive language to justify surveillance or quarantine (Discourse Analyser, 2024). By analysing these shifts, the study reveals how the UK government uses verbal structures to achieve broader goals of moral discipline and social order.

Structure of the Study

This dissertation contains one theoretical and two empirical chapters. The theoretical chapter begins by outlining the conceptual framework of epidemics and the historical process of urbanisation in the United Kingdom. The theoretical framework is then presented through an examination of Norbert Elias' concept of the "civilising process" and the evolution of epidemiology as an interpretive tool. Finally, this chapter examines the historical context of the Industrial Revolution, emphasising how inadequate infrastructure and rapid urban expansion in the nineteenth century aided the spread of cholera and spawned the sanitary movement.

The empirical chapters delve into practical applications, examining the discourse and moral psychology surrounding health crises ranging from Cholera to COVID-19. It compares disease narrative framing, contrasting the 19th-century emphasis on "miasma" and

"moral contamination" with 21st-century metaphors like the "invisible enemy" and war terminology. The chapters also look at how state authority and moral judgements categorise people, contrasting the Victorian distinction between the "clean" and "unwashed" masses with modern divisions between "compliant" citizens and "conspiracy theorists." Through these comparisons, they demonstrate how the UK uses public health discourse to reshape lifestyles and maintain social power.

CHAPTER ONE

Epidemics in the Context of Historical Urbanization in the United Kingdom

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Introduction

Epidemics have long presented significant challenges to human societies, and they are closely linked to changes in living patterns, particularly during rapid urbanisation. Cities become fertile ground for the emergence and spread of infectious diseases due to population density, poor infrastructure, and changing daily habits. The United Kingdom provides a rich model, having transitioned from overcrowded, cholera-ravaged cities in the nineteenth century to modern cities dealing with COVID-19, allowing for historical comparison and revealing both persistent and transformed problems. This chapter presents a theoretical framework for understanding the complex relationship between epidemics, urbanisation, and the reshaping of living patterns, progressing from concepts to historical and comparative applications. It defines the conceptual framework of epidemics and the immunisation process, and then examines the nineteenth-century British cholera epidemic as a classical model, followed by a comparison with COVID-19.

1. Epidemics in the Context of Historical Urbanization in the United Kingdom

Before examining specific epidemic outbreaks, it is important to consider the rapid urbanization that transformed the United Kingdom during the nineteenth century. The growth of industrial cities created crowded living conditions and poor sanitation, which facilitated the spread of infectious diseases and shaped public responses to health crises.

1.1 The conceptual framework of epidemics and the process of urbanization

6.3.1. Definition of an epidemic

The Centers for Disease Control and Prevention (CDC) describes an epidemic as an unexpected increase in the number of disease cases in a specific geographical area, with yellow fever, smallpox, measles, and polio being prime examples; however, an epidemic

disease does not necessarily have to be contagious, as West Nile fever and the rapid increase in obesity rates are also considered epidemics, and the term can refer to a disease or other health-related behavior (e.g., smoking) with rates clearly above the expected occurrence in a community or region (Centers for Disease Control and Prevention [CDC], 2012). In contrast, the World Health Organization (WHO) declares a pandemic when a disease's growth is exponential—meaning the growth rate skyrockets and each day cases grow more than the day prior—and this declaration has nothing to do with virology, population immunity, or disease severity; rather, it means the virus covers a wide area, affecting several countries and populations (World Health Organization [WHO], 2020a).

6.3.2. The Differences between Pandemics and Epidemics

The WHO defines pandemics, epidemics, and endemic diseases based on a disease's rate of spread, meaning the difference between an epidemic and a pandemic lies not in the severity of the disease but in the degree to which it has spread (WHO, 2020a). Specifically, a pandemic cuts across international boundaries as opposed to regional epidemics, and this wide geographical reach is what makes pandemics lead to large-scale social disruption, economic loss, and general hardship (Morens et al., 2009). It is important to note that a once-declared epidemic can progress into pandemic status, because while an epidemic is large, it is also generally contained or expected in its spread, whereas a pandemic is international and out of control (Porta, 2014).

1.1.3. The spread of an epidemic

Infectious diseases are present to some extent all the time in any community; but sometimes a disease spreads more actively, affecting many more people than usual at the same time and causing more sickness and sometimes more deaths than the community is able to cope with. This is an epidemic (Heymann, 2015).

Many different diseases can cause epidemics. At this stage, the focus is placed on understanding how germs that are transmitted from one person to another or from animals to humans spread and can become an epidemic (CDC, 2012). The accompanying illustration serves to demonstrate how an infection originating from a single individual can be transmitted to others, thereby facilitating its progressive spread within a community.



Figure 1.1 The Spread of Infection (Columbia University Mailman School of Public Health, 2021)

Because one ill person or a vector can infect many people, an epidemic can start when one or a few people fall sick. Those who are infected then spread the infection even more widely to more people (Anderson & May, 1991).

It is important to remember that not any person who is infected by a germ falls sick. Some people can resist an infection. These people have immunity or have a very mild infection that goes unnoticed. If they are carriers ; however, they can still pass the germs to other people. In addition, some individuals are more vulnerable to disease because they are not well nourished or have other diseases that reduce their resistance or immunity to disease. This means that their bodies are unable to produce enough antibodies to fight bacteria and viruses, and as a result they fall ill more frequently (Heymann, 2015).

An epidemic occurs when the number of sick people in a community increases. More people become infected than in normal situations, exceeding the community's ability to cope. It occurs for one of several reasons:

- The germs are more active than usual (for instance, they are a new kind of germ).
- The germs have been introduced into a community for the first time, so the population has no immunity to them.
- A vector that carries the germs has arrived in a community for the first time.
- The number of vectors has increased (for example, mosquitoes have multiplied during the rainy season).
- People are less able to resist the germs, because they suffer from malnutrition and because few people have immunity.
- Germs have multiplied because the surrounding environment has deteriorated or has not been properly maintained (for example, there is insufficient water or water sources have been polluted).
- People have more contact with one another (for example, because they are living in refugee camps) or with animals (for example, following deforestation).
- Few (or fewer) people are vaccinated (World Health Organization, 2018).

To control epidemics effectively, it is important to think of the factors that cause an epidemic to spread. This can be done by understanding the infection that is causing the epidemic and the environment in which it is spreading (Heymann, 2015).

6.4. Epidemiology as an Interpretive Framework

6.4.1. Definition of epidemiology

Epidemiology is the foundation of public health and is defined as the study of the "distribution and determinants" of diseases or disorders within groups of people, and the

development of knowledge on how to prevent and control them (Last, 2001, p. 7; Gordis, 2014, p. 3). Epidemiological research helps us understand not only who has a disorder or disease, but also why and how it affects particular individuals or regions (Friis & Sellers, 2021, p. 12).



Figure1.2 What is Epidemiology? (Columbia University Mailman School of Public Health. Accessed: April 15, 2026)

One of the earliest instances of modern epidemiology can be found during an 1854 cholera outbreak in London. Doctors believed the widespread illness must have been airborne, but Dr. John Snow, widely considered to be the father of epidemiology, employed a different kind of thinking (Snow, 1855; Rosen, 1993). By carefully mapping the outbreak and analyzing those who were infected, Snow was able to link every cholera case to a single water pump at the intersection of Broad and Cambridge Streets (now Lexington Street) in London’s Soho neighborhood (Johnson, 2006). The removal of the pump stopped the disease in its tracks—laying the basis of today’s epidemiological practices (Porter, 1999). Today, epidemiologists use the insights gathered in their research to determine how illness within a population affects our society and systems on a larger scale, and in turn, provide recommendations for interventions, such as removing a fatal water pump (Gordis, 2014).

As the novel coronavirus became widespread, epidemiologists around the world worked to control the spread. Our research spans work to better understand the virus and how it is transmitted; to project its spread and identify vulnerable communities; to develop diagnostic tests and therapies; and, to assess the U.S. and global health systems’ preparedness (World Health Organization [WHO], 2020b; Fauci et al., 2020).

6.5. The Concept of the Civilising Process

6.5.1. Definition of the Civilizing Process

The Civilising Process is a sociological theory developed by German sociologist Norbert Elias (1897-1990) in the 1930s, first published in 1939 in his work "The Civilizing Process: Sociogenetic and Psychogenetic Investigations" (Über den Prozeß der Zivilisation). The theory aims to describe and explain long-term transformations in human behaviour and social structures in Western societies over approximately five centuries (Kilminster, 2007).

According to Stephen Mennell, a "civilised" person can be defined as someone who is polite, well-mannered, considerate towards others, clean and decent in personal habits, humane, gentle, kind, restrained, self-controlled, even-tempered, and reluctant to use violence against others except in exceptional circumstances (Mennell, 1990). Above all, to be civilised is to live with others in an orderly, well-organised, just, predictable, and calculable society (Elias, 2000).

6.5.2. The Emergence of the Concept and Its Historical Development

6.5.2.1. Historical Roots of the Concept

6.5.2.2. Development of the Concept in Germany

Elias provides a sociogenetic analysis of concepts, showing how the opposition between "*Kultur*" and "*Zivilisation*" developed in German usage (Elias, 2000, p. 45). In Germany, "*Kultur*" carried positive connotations associated with spiritual depth, art, and inner creativity, while "*Zivilisation*" was associated with superficial values, pragmatism, and external organisation that particularly characterised French society (Williams, 1983, p. 56).

6.5.2.3. Nineteenth-Century Developments

During the 19th century, the concept of civilisation defined European self-images that revolved around feelings of cultural superiority in two interwoven respects (Bowden, 2004):

- Confidence in intellectual and material progress beyond earlier eras such as the "barbaric" medieval period.
- Collective pride in the presumed cultural and technological superiority of European peoples over outlying societies (Said, 1978).

This context led to the emergence of the so-called "civilising mission," which European colonial powers claimed the right to undertake to bring progress to humanity as a whole, profoundly affecting the formation of the global order at the height of Western imperialism (Conklin, 1997).

6.5.2.4. Rediscovery of the Theory in the Twentieth Century

Due to World War II, Elias's work was largely ignored. It was rediscovered and gained popularity after its republication in 1969 and its English translation between 1978 and 1982 (Kilminster, 2007). In 1998, the International Sociological Association listed *The Civilizing Process* as the seventh most important sociological book of the twentieth century (Mennell, 1998).

6.6. Historical and Social Context in Britain during the 19th Century

6.6.1. The Impact of the Industrial Revolution on the Environment and Public Health

The Industrial Revolution, which began in Britain in the late 18th century and lasted until the mid-19th century, brought about tremendous changes in the country's economy, society, and urban conditions (Briggs, 1963; Ashton, 1997). As the country shifted from an

agricultural to an industrial economy, people moved from the countryside to the cities in search of work, leading to a rapid process of urbanisation. However, the growth of the cities was not without its problems, and the living conditions for many people in urban areas were often dire (Hobsbawm, 1962).

6.6.1.1. Filth and Overcrowding

One of the primary issues associated with urbanisation was overcrowding. As people flooded into the cities, there was a shortage of housing, and many people ended up living in cramped, unsanitary conditions (Engels, 1845/2009). Often, several families would be forced to live in a single room, and diseases spread quickly in these crowded spaces (Porter, 1999).

Between 1801 and 1851, the population of London in particular doubled from 1 million to 2.3 million (Wohl, 1983). Sadly, infant mortality rates in urban areas were exceedingly high; in the 1840s, in some industrial cities, as many as 60% of children died before reaching the age of five (Szreter & Mooney, 1998). Sanitation was also a significant problem in urban areas. Many houses lacked indoor plumbing, and waste was disposed of in cesspools, which were often very poorly built and prone to overflowing (Halliday, 2001). This led to a build-up of human waste in the streets, creating an unpleasant smell and an environment ripe for the spread of disease (Hamlin, 1998). The consequences of these poor living conditions were dire. Diseases like typhoid and cholera, which thrive in unsanitary environments, were rampant in many urban areas (Rosenberg, 1962).

6.6.1.2. Industrialisation

From 1750, there was a movement of people from rural to urban areas due to the *Industrial Revolution*. Goods were being made in factories powered by steam, instead of in peoples' homes (Ashton, 1997). People needed to move to where there was work, and this was in the new factories in urban areas (Briggs, 1963). This led to towns and cities growing quickly

in size. The table below shows the rapid increase in the size of some cities between 1801 and 1901.

City	Population in 1801	Population in 1901	City
London	1,090,078	5,567,591	London
Greater Manchester	334,013	2,125,441	Greater Manchester
Birmingham	60,882	245,216	Birmingham
Glasgow	46,779	571,615	Glasgow

Table 1.1 “Industrial Revolution – Urbanisation and population growth (1801–1901)”(BBC Bitesize,, 2026)

6.6.1.3. Housing and sanitation

Factory owners often built cheap houses for their workers. *Back-to-back* terraced housing was common, with families living in a single room (Engels, 1845/2009). There was a lack of clean running water, proper sanitation and *sewage systems*. Toilets were normally shared between several houses (Wohl, 1983).

Water came from pumps in the street with water supplied from a river that was often heavily polluted. Cracked pipes could also lead to contamination of the water with human waste from cesspits (Halliday, 2001). If there was an outbreak of a disease, it would spread rapidly due to overcrowding and poor sanitation (Snow, 1855).

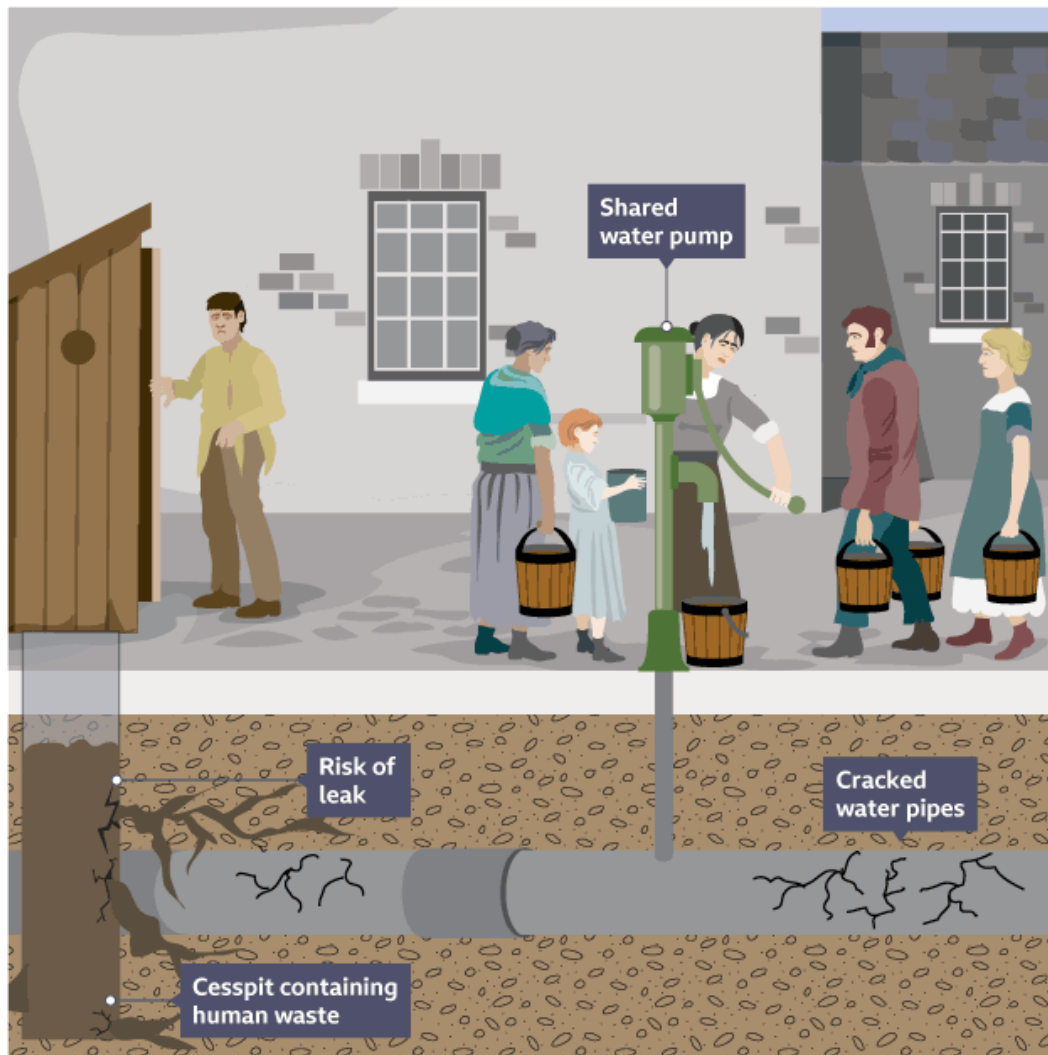


Figure 1.3. “*The Industrial Revolution and Its Impact on Society and the Environment*” (BBC Bitesize, 2026)

6.6.1.4. Air pollution

Huge amounts of coal were being burned to power new factories and mills in towns and cities. Air pollution caused significant damage to health, as a thick *smog* hung over towns and cities where people had moved to in order to live and work (Mosley, 2001). It caused breathing difficulties and led to many deaths as it damaged people’s lungs (Brimblecombe, 1987).

6.6.1.5. Disease

Overcrowding and the lack of an effective public health system led to the outbreak and spread of several diseases. These included the following (Porter, 1999):

- **Cholera** first arrived in England in 1831 and caused an outbreak that killed around 50,000 people. It was spread by contaminated water or food. It caused diarrhoea and vomiting, which often led to severe dehydration and death. There were further cholera epidemics in 1848, 1854 and 1866.
- **Typhoid** was also spread by contaminated food or water. It caused a high temperature and fatigue, and could also be fatal.

6.6.2. Weak Health Infrastructure and the Spread of Diseases

During the nineteenth century, the rapid growth of industrial cities in Britain exposed the severe weaknesses of the existing public health infrastructure (Wohl, 1983). Urbanisation occurred at an unprecedented pace due to the Industrial Revolution, but it was not matched by adequate planning or investment in essential services (Hamlin, 1998). As a result, many towns and cities expanded without proper drainage systems, sewage networks, or access to clean and safe drinking water. This lack of basic infrastructure created ideal conditions for the spread of infectious diseases, particularly cholera, typhoid, and other waterborne illnesses (Porter, 1999).

In many urban areas, human waste was often disposed of in streets, shallow pits, or poorly constructed cesspits located close to living spaces. These cesspits frequently overflowed or leaked, allowing contaminated waste to seep into nearby water sources. Rivers and streams, which were commonly used as sources of drinking water, became heavily polluted with sewage and industrial waste. Consequently, the population was continuously exposed to disease-causing pathogens without understanding the true cause of infection (Hamlin, 1998) .

The weakness of the health system was also evident in the lack of coordinated medical response and public health regulation. Before major reforms in the mid-nineteenth

century, there was no centralized authority responsible for managing sanitation or controlling epidemics. Local authorities often lacked the resources, knowledge, or political will to implement effective health measures (Rosen, 1993). Medical understanding of disease transmission was also limited, with many doctors still supporting outdated theories such as miasma—the belief that diseases were caused by “bad air” rather than contaminated water or germs (Porter, 1999, p. 42) .

Overcrowded housing further intensified the problem. Rapid urban migration led to the development of densely packed working-class districts where families lived in small, poorly ventilated rooms with minimal hygiene facilities. These conditions allowed diseases to spread quickly from one household to another, especially during outbreaks. Once an infection entered such communities, it often spread uncontrollably due to close living conditions and the absence of effective isolation measures (Wohl, 1983) .

The consequences of weak health infrastructure were devastating. Epidemics spread rapidly through urban populations, causing high mortality rates and recurring public health crises throughout the nineteenth century (Halliday, 2001) . These repeated outbreaks eventually highlighted the urgent need for reform, leading to the development of modern sanitation systems, public health legislation, and improved urban planning. In this way, the failures of early industrial cities played a crucial role in shaping the foundations of contemporary public health systems (Rosen, 1993).

6.7. The Spread of the COVID-19 Pandemic in the British Urban Context

6.7.1. The Evolution of COVID-19 Response and Spread in the United Kingdom, with London as the Epicentre

United Kingdom's (UK) first COVID-19 case was reported on 31st Jan 2020 (Lillie et al., 2020; Moss et al., 2020). Succeeding the advice from the Department of Health, the UK government requested all individuals to undergo self-isolation or home-quarantine (14–20 days) provided they visited the infected countries/regions namely, Hubei province (mainland China), Thailand, Japan, Republic of Korea, Hong Kong, Taiwan, Singapore, Malaysia, and Macau (Sohrabi et al., 2020). To further prevent transmission, the UK government requested quarantined individuals not to go to GP surgeries, community dispensaries, or infirmaries (symptoms observed: unceasing cough, body temperature ≥ 37.8 °C, or flu-like complaint) but to call NHS 111 if the situation becomes worse. Unnecessary travel to Mainland China and particularly to the Hubei Province were also advised not to perform (Sohrabi et al., 2020). In the beginning, the UK's approach was more towards social distancing and suggested people over 70 to stay at home (self-isolation) (Mahase, 2020; Pollock, Roderick, Cheng, & Pankhania, 2020). This attitude changed when researcher from MRC Centre for Global Infectious Disease Analysis at Imperial College London lead by Neil Ferguson indicated using a theoretical study that home isolation and the social distance still can result in a death count of ~260,000 (Ferguson et al., 2020).

As per the report, on March 10, the number of deaths related to the coronavirus was 6. On 5th May death toll in the UK from COVID-19 was 32,313 (including suspect) which was highest in Europe as it exceeded the death toll of 29,029 (excluding suspect) in Italy (The Guardian, 2020). This number drastically increased as 95,000 people entered the UK from overseas on 13th May, since coronavirus lockdown was imposed, (Guardian, 2020). Prime

minister addressed the nation advising to maintain social distance and work from home (since 16th March) and steps to be taken while under lockdown (23rd march) (Khan & Cheng, 2020). Additionally, experts also advised maintaining 2 m (or 6Ft.) distance from another person under any circumstances. As of now a reduction in socializing proved to be the most appropriate method to diminish the transmission of COVID-19 (Zhang et al., 2020).

In England, from 13th of May, people were allowed to exercise more than once a day in outdoor spaces (parks), and interact with others by maintaining social distance. From 1st of June, schools for reception, year one and year six pupils were reopened while non essential retailers had permission to open their store from 5th of June in England (UK Cabinet Office, 2020). From 23rd June, 2 m restriction was lifted and changed to 1 m plus to enable people to meet their family and friends, help businesses get back on their feet and get people back in their jobs. From Saturday 4th of July, pubs, restaurants and hairdressers were allowed to reopen, providing they adhere to COVID-19 secure guidelines (UK Cabinet Office, 2020). The UK government has also devoted £20,000,000 as assistance to develop a COVID-19 vaccine (BBC News, 2020). London was reported to be the epicentre of the COVID-19 pandemic in the UK (London Loves Business, 2020).

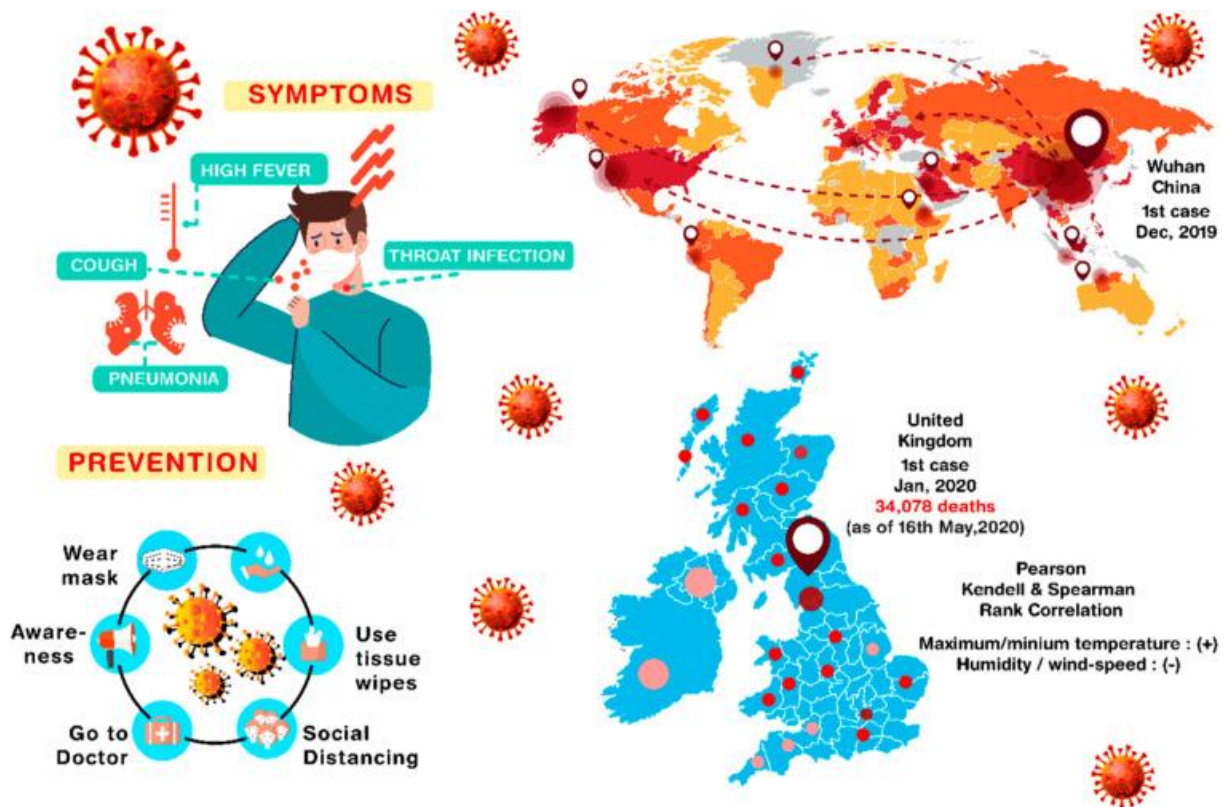


Figure 1.4 World-wide distribution of COVID-19 with symptoms and precautions to be taken against coronavirus infection and temperature, humidity, and wind speed correlation with COVID-19 epidemic in the UK.” (Ghosh et.al., 2020)

6.7.2. The relationship between population density and Covid-19 cases is mostly driven by London

Looking at cases up until lockdown – which should reduce the importance of density – shows no clear relationship between density and the spread of the virus. The graphs below show that, when looking at cases at the urban local authority (LA) level, the link – quite strong at first sight (figure 1.5) – is rather weak when London boroughs are removed (Figure 1.6).

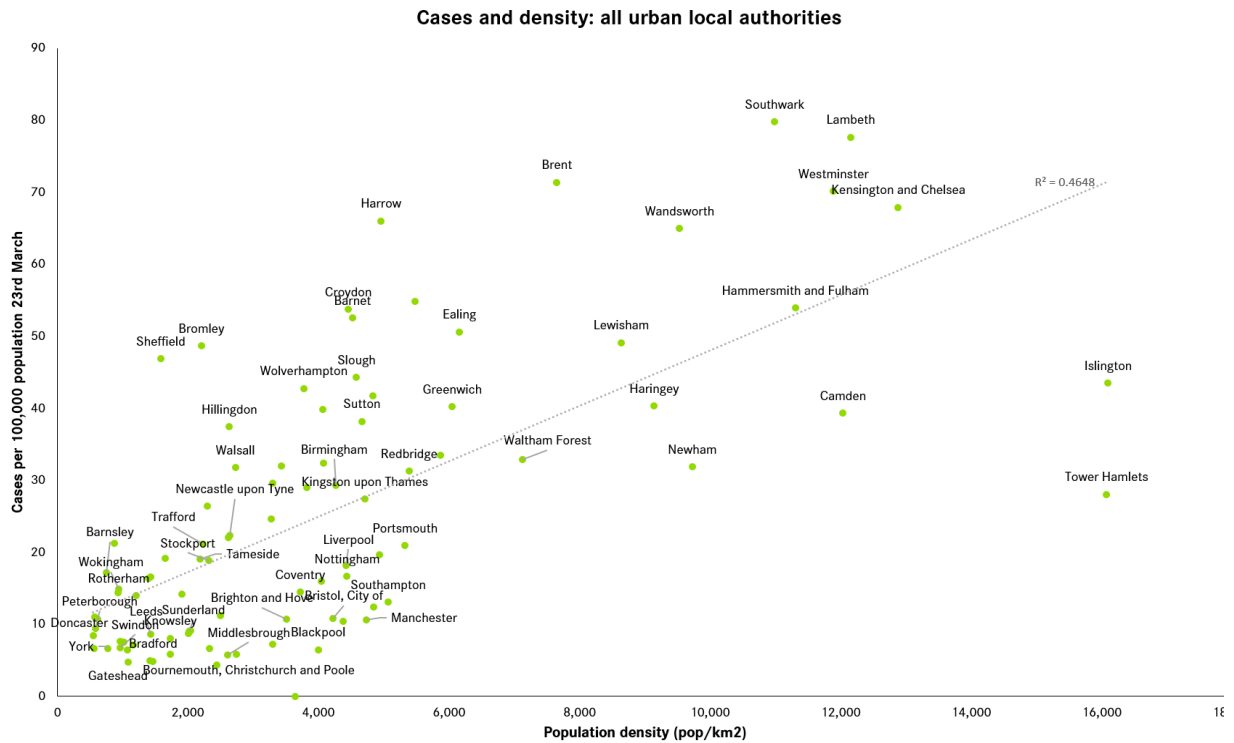


Figure 1.5 Cases and density: all urban local authorities (Ghosh et al., 2020)

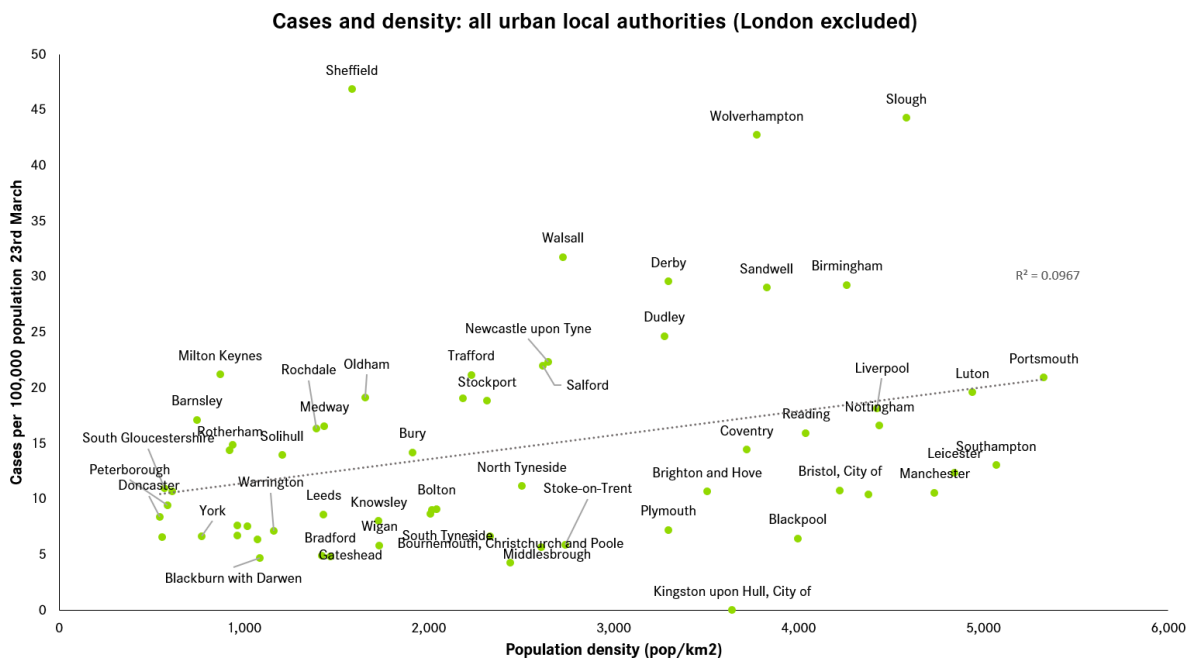


Figure 1.6 Cases and density: all urban local authorities (London excluded) (Ghosh et al., 2020)

This suggests that density is not as important a factor as is often assumed. This was confirmed by further analysis that showed that even when density was in play, it was not significant once the model accounts for London's unique character.

In London, density could have played a role but it can also be explained by other factors, for example its position as an international hub, with large flows of visitors, or a high proportion of its population using public transport. This is supported by data on the spread of the virus in other cities. On 23 March dense places like Hull, Plymouth, Derby or Coventry, which all have similar levels of population density to London's had a much lower proportion of their population tested positive. Meanwhile Sheffield ranked second behind London on the number of cases per head, despite having much smaller density than the capital (Public Health England, 2020). Evidence from other countries also cast doubt on the role of density. Extremely dense urban areas such as Hong Kong, Seoul or Singapore rapidly flattened the curve. Meanwhile, in the US, the second densest city, San Francisco, is far less affected than New York City (Hamidi et al., 2020).

6.8. British State Policies in Confronting the Pandemic

6.8.1. Foundational Legal Legislation: The Coronavirus Act 2020

The Coronavirus Act 2020 represents the cornerstone of the British legal response to the pandemic. Enacted in March 2020, it granted the government unprecedented exceptional powers in peacetime. These powers included the authority to detain anyone "potentially infectious," including children, and transport them to quarantine facilities for unspecified periods. The Act also empowered authorities to restrict or prohibit public gatherings, close schools, care homes, and restaurants, and postpone local elections for up to a full year (United Kingdom Parliament, 2020). The Act was accused of representing "the most dangerous changes to state power in a generation" due to the breadth of these powers and the possibility of their

indefinite continuation without sufficient parliamentary review (Liberty, 2020). Data revealed that all prosecutions carried out under Schedule 21 of the Act (141 cases up to that date) were subsequently found to be unlawful upon review by the Crown Prosecution Service, reflecting the grave risks associated with granting wide-ranging powers without adequate training and guidance for police and officials (Crown Prosecution Service, 2020).

6.8.2. Public Health Strategy: Delayed Lockdown and Adoption of "Mitigation" over "Suppression"

The British government adopted an approach radically different from most European countries at the start of the pandemic. Instead of adopting a "Suppression" strategy aimed at total virus elimination through immediate, comprehensive lockdown and meticulous contact tracing, Britain chose a "Mitigation" strategy derived from seasonal flu preparedness plans (Scally et al., 2020). The first national lockdown was delayed until March 23, 2020, more than two weeks after the WHO declared a public health emergency of international concern and when Italy and Spain were already in full lockdown (WHO, 2020c). Later analyses revealed that the Scientific Advisory Group for Emergencies (SAGE) initially rejected the idea of a lockdown, arguing that the population would not tolerate it (House of Commons Science and Technology Committee, 2021). More controversially, the government's Chief Scientific Adviser, Patrick Vallance, publicly floated the idea of building "herd immunity" as part of the strategy, based on a miscalculation that most infections would be mild. Experts estimated that a lockdown just two weeks earlier could have saved at least 20,000 of the lives lost during the first wave (Flaxman et al., 2020).

6.8.3. The "Test and Trace" System: An Expensive Failure

The government launched the NHS Test and Trace system in May 2020 at a colossal cost of approximately £37 billion, making it one of the most expensive public health programs in British history. The system suffered from deep structural and implementation

problems from the outset. Private companies like Serco, which had no prior public health experience, were contracted to manage testing centers and tracing operations (National Audit Office [NAO], 2021). A National Audit Office (NAO) report revealed that the system lost track of nearly 600 million home tests (lateral flow tests) that were distributed, with only 14% recorded as having been used. Serco made enormous profits exceeding £225 million from its government contracts, sparking widespread criticism that taxpayers' money was being used to "reward failure." The system was excessively centralized, and repeated calls to delegate tracing operations to local public health teams who knew their communities were ignored (Sally et al., 2020).

6.8.4. Financial Support for Quarantine: Financial Barriers Undermined Compliance

The government recognized that the ability to self-isolate depended heavily on an individual's financial situation. A payment system was established for those losing income due to quarantine, worth £500 for eligible individuals (Department of Health and Social Care, 2020). However, Professor Richard Machin, a social policy expert at Nottingham Trent University, provided a detailed report to the official inquiry outlining major gaps in this system. The payment was insufficient and irregular, application procedures were complex and slow, and many workers (especially in the informal economy) were not eligible for support at all (Machin, 2021). The report demonstrated that financial hardship was a significant barrier to quarantine compliance, particularly among marginalized groups such as workers in precarious jobs, women, young people, and ethnic minority groups. The report recommended a fundamental reform of the Sick Pay system, removing thresholds and delays, linking it to the real living wage, and adopting an alternative income model similar to the Coronavirus Job Retention Scheme (furlough) (Machin, 2021).

Conclusion

This study falls within the body of research aimed at understanding the structural relationship between epidemics, urbanization, and the reshaping of living patterns, drawing on the British experience as both a historical and a contemporary model. To this end, the chapter seeks to construct theoretical framework that firmly connects its various levels of analysis, proceeding from a central hypothesis: that epidemics are not isolated exceptional events, but rather the natural outcome of a complex interplay of social, urban, and behavioral factors.

CHAPTER TWO

Discourse Analysis and Moral Psychology of Cholera Texts

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Introduction

This chapter examines how cholera was constructed and communicated through language in a corpus of nineteenth-century texts. Rather than treating these texts as neutral records of a biological event, the analysis approaches them as discursive artifacts that actively shaped how the disease was understood, feared, and governed. Drawing on discourse analysis and moral psychology, the chapter investigates four interconnected dimensions: the construction of crisis and urgency, the framing of movement and social interaction as sources of risk, the spatialization of disease in relation to social inequality, and the moral and governance implications that emerge from these patterns. Through this analysis, the chapter argues that cholera discourse was not simply descriptive but functioned as a mechanism of social organization — one in which language produced fear, distributed responsibility, and prepared the conditions for institutional intervention. In doing so, it reveals how epidemic language transforms a medical phenomenon into a moral and political reality.

1. Discourse Analysis and Moral Psychology of Cholera Texts

Cholera, as represented in the corpus, is not only a medical condition but a phenomenon shaped through language. The texts do more than report symptoms or describe outbreaks; they construct meaning by selecting specific words, images, and narrative patterns that frame how the disease is understood. Through expressions such as “dreadful scourge” and “pestilential stream,” cholera is presented as dangerous, pervasive, and socially significant, demonstrating how linguistic choices transform a biological reality into a structured representation (Foucault, 1972).

From a discourse-analytic perspective, language does not passively reflect the world; it actively organizes it by shaping perception and guiding interpretation (Foucault,

1972). In the case of cholera, this is evident in the ways the disease is framed as a crisis, associated with particular environments, and described through metaphors of contamination and decay. These linguistic patterns influence how the epidemic is perceived, making it visible, intelligible, and meaningful within a specific social context.

1.1. Narrative Framing: Cholera as Crisis, Threat, and Social Disorder

1.1.1. Crisis Construction and Urgency

Across the corpus, cholera is consistently framed as an extraordinary and disruptive crisis rather than a routine illness, and this framing is achieved through a carefully structured linguistic pattern that foregrounds urgency, danger, and instability. The disease is not presented as gradual or manageable; instead, it appears sudden, overwhelming, and difficult to contain, as reflected in expressions such as “*dreadful scourge*” and “*threatening a fatal descent*” . These phrases are not interchangeable descriptors; they perform distinct discursive functions. The term “*scourge*” carries strong moral and historical connotations, often associated with divine punishment or collective suffering, thereby elevating cholera from a medical condition to a socially significant catastrophe. In contrast, “*fatal descent*” introduces a spatial and directional metaphor, suggesting movement from above to below, which constructs the disease as an invading force descending upon society. Together, these expressions do more than intensify meaning—they layer the crisis with moral, spatial, and existential dimensions, reinforcing the perception that cholera is both external and unavoidable.

This sense of urgency is further intensified through narrative accounts of abrupt mortality, particularly in the example where individuals are described as being “*in perfect health... but soon after... both died*” . What is striking here is not only the content but the structure of the statement. The juxtaposition of “perfect health” with immediate death collapses temporal continuity, eliminating any sense of progression between illness and outcome. There

is no transition, no gradual decline—only rupture. This narrative technique transforms cholera into a disruptive force that breaks the expected logic of the body, thereby amplifying fear and uncertainty. It also performs a generalizing function: while the example is specific, its structure implies universality, suggesting that anyone—regardless of prior health—may be equally vulnerable. In this way, individual cases are mobilized to construct a broader sense of collective risk, aligning with Rosenberg’s (1992) observation that epidemic narratives often rely on exemplary cases to translate uncertainty into recognizable crisis patterns.

The emphasis on rapid escalation operates in a similar way, particularly in accounts describing how outbreaks intensify within a short period . These descriptions do not merely report an increase in cases; they structure time itself as compressed and unstable. The movement from “a few cases” to widespread fatalities is presented as swift and almost inevitable, creating a temporal logic in which delay becomes dangerous. This compression of time has important discursive consequences. It reduces the perceived possibility of intervention at the individual level, while simultaneously justifying immediate and large-scale responses at the institutional level. In other words, urgency is not only communicated, but also constructed to support the need for rapid action (Wallis & Nerlich, 2005).

Equally revealing is the example of cholera traveling along “*lines of human intercommunication*” , which illustrates how crisis framing extends into the redefinition of social relations. At first glance, the phrase appears descriptive, referring to patterns of movement and contact. However, its implications are far more significant. By linking disease transmission to communication networks, the discourse transforms interaction itself into a source of risk. Social connection is no longer neutral; it becomes potentially dangerous. This shift has profound implications for how individuals interpret their environment and behavior, as everyday practices—movement, contact, exchange—are recontextualized within a

framework of threat. As Michel Foucault (1972) suggests, such discursive redefinitions are central to the production of social reality, as they determine not only what is known but also how individuals are expected to act.

The cumulative effect of these examples is a highly structured narrative in which crisis is constructed through multiple, overlapping strategies: lexical intensification, temporal compression, narrative dramatization, and the redefinition of social interaction. Each example contributes a different dimension to the overall framing, yet they all converge toward the same outcome—the normalization of urgency. Fear is not incidental; it is systematically produced. Uncertainty is not destabilizing; it is organized into a coherent perception of threat. From a moral psychology perspective, these strategies activate fear and vigilance, encouraging individuals to adopt precautionary behaviors and align themselves with the expectations embedded in the discourse (Van Bavel et al., 2020). At the same time, the framing introduces an implicit moral dimension, where responsiveness to urgency becomes a marker of responsibility, and failure to act appears increasingly unjustifiable.

Ultimately, the analysis of these examples demonstrates that crisis framing in the cholera corpus is not simply a matter of description but a discursive mechanism of governance, through which language shapes perception, organizes experience, and directs behavior. By constructing cholera as sudden, severe, and rapidly spreading, the discourse creates a reality in which intervention is not only necessary but inevitable, reinforcing the Foucauldian insight that power operates through the production of knowledge and the structuring of what is perceived as true (Foucault, 1978).

1.1.2 Movement, Spread, and the Transformation of Social Interaction

This sense of urgency is further intensified through the narrative emphasis on movement and rapid spread, where cholera is repeatedly described as traveling along “*lines of human intercommunication*” . The analytical weight of this phrase lies in how it fuses two domains that are normally separate: communication and contagion. Rather than simply indicating routes of transmission, The text presents communication networks as an important factor in the spread of cholera. Trade routes, movement between cities, and everyday interactions helped transmit the disease from one place to another. The use of the words “lines” and “intercommunication” emphasizes the connections between people and regions, showing how increased mobility contributed to the expansion of the epidemic. When these are combined, the result is a representation in which disease does not disrupt social systems from the outside but moves through them from within, making everyday interaction inseparable from risk. This is a clear example of what Michel Foucault (1972) identifies as the discursive reorganization of reality: the meaning of social practices is transformed, not by banning them, but by redefining their consequences.

This redefinition becomes more explicit in warnings such as “*the danger... by engaging in... communication with persons coming from the Continent*” . Here, the example does more than caution against travel; it constructs contact itself as morally and epidemiologically risky, particularly when associated with external or foreign sources. The phrase “engaging in communication” is especially revealing because it shifts the focus from passive exposure to active participation. Risk is no longer something that happens; it becomes something one contributes to through action. In this sense, the discourse subtly introduces agency and responsibility into the act of interaction, transforming what would normally be neutral behavior into a potentially blameworthy decision. Moreover, the reference to “persons coming from the Continent” introduces a spatial and social boundary, where external others are implicitly positioned as carriers of danger. This is not a direct accusation, but the implication is

clear: proximity to certain groups increases risk. As Briggs and Mantini-Briggs (2003) argue, such framing is central to epidemic discourse, as it redistributes responsibility by linking transmission to social relations rather than solely to biological processes.

The perception of acceleration reinforces this logic, particularly in reports that describe how outbreaks expand rapidly within a locality, with deaths increasing sharply over a short period . The analytical significance of these examples lies in how they structure time. Rather than presenting a gradual progression, the discourse emphasizes sudden escalation, creating a temporal rupture between normality and crisis. This rupture is further intensified when such accounts are read alongside narratives of abrupt mortality—individuals moving from apparent health to death within hours . Together, these examples produce a synchronized effect: the disease spreads quickly across space and progresses rapidly within the body. This dual acceleration collapses the distinction between transmission and outcome, reinforcing the perception that movement leads almost immediately to death. The implication is powerful. If spread is rapid and consequences are immediate, then delay in response becomes not just imprudent but dangerous. As Wallis and Nerlich (2005) suggest, such temporal compression is a key strategy in constructing urgency, as it reduces the perceived window for intervention and increases the pressure for immediate behavioral change.

At a deeper level, these examples collectively construct mobility as a site of moral evaluation, even when explicit moral language is absent. The repeated association between movement and contamination—whether through communication lines, travel warnings, or rapid local spread—creates a pattern in which interaction is consistently linked to risk. This pattern does not need to be stated as a rule; it emerges through repetition. The reader is not told “do not travel,” but is shown, through example after example, that travel correlates with danger. The same applies to interpersonal contact. By framing communication as a pathway of disease,

the discourse implicitly encourages individuals to reconsider their relationships, their movements, and their participation in social life. As Norman Fairclough (1995) notes, such indirect forms of regulation are characteristic of discourse, where norms are embedded in representation rather than imposed through explicit instruction.

From a moral psychology perspective, these examples operate by activating anticipatory fear and precautionary reasoning, rather than overt coercion. The warning about contact with travelers, for instance, does not command avoidance, yet it establishes a clear association between interaction and harm . This encourages individuals to internalize the risk and adjust their behavior accordingly, aligning with findings that perceived pathways of transmission increase self-regulation (Van Bavel et al., 2020). At the same time, the framing introduces an implicit evaluative dimension: if interaction leads to spread, then unnecessary interaction becomes ethically questionable. Responsibility is thus subtly redistributed, not through blame, but through the anticipation of consequences.

Ultimately, the closer analysis of these examples reveals that movement and spread are not merely descriptive elements within the cholera corpus; they are discursive mechanisms that reshape the meaning of social life itself. By linking communication, mobility, and contact to contagion, the discourse transforms ordinary practices into potential risks, embedding regulation within the interpretation of everyday behavior. Movement becomes charged with significance. Interaction becomes conditional. And through this transformation, the epidemic is not only described—it is socially organized, with language guiding both perception and conduct.

1.1.3 Spatialization of Disease and Social Inequality

At the same time, the narrative framing of cholera is deeply spatialized, linking the disease to specific environments and social conditions in ways that extend beyond simple description. References to “*narrow courts and alleys*” and “*imperfectly drained and ill-ventilated localities*” do not merely identify where cholera occurs; they actively construct a geography of risk in which danger is embedded within particular spaces. The analytical significance of these expressions lies in their specificity. “Narrow courts” suggests confinement and overcrowding; “ill-ventilated localities” evokes stagnation and lack of circulation. Together, they produce a spatial image of environments that are closed, dense, and contaminated, implicitly contrasting them with open, ordered, and healthier spaces that remain unnamed but clearly implied. In this way, spatial description becomes evaluative: certain environments are not only different—they are discursively marked as dangerous.

This process is reinforced through environmental imagery such as the depiction of the Thames as a “*pestilential stream*”, an example that is particularly revealing in how it attributes agency to the environment itself. The river is not described as polluted in a neutral sense; it is characterized as actively harmful, almost as if it participates in the spread of disease. The adjective “pestilential” transforms water into a carrier of corruption, collapsing the distinction between environment and pathogen. As a result, the physical setting is no longer a passive context but becomes an active source of threat, reinforcing the idea that certain spaces generate disease rather than simply host it. This aligns with Wald’s (2008) argument that epidemic narratives often rely on environmental metaphors to make disease visible and morally intelligible, while also connecting illness to broader concerns about disorder and decay.

At a deeper level, these examples reveal how spatialization operates as a mechanism for organizing social inequality. The environments described—crowded alleys, poorly

ventilated areas, polluted rivers—are not randomly distributed; they are associated with marginalized populations. Although the discourse does not always explicitly name these groups, the spatial markers function as proxies, linking disease to poverty, density, and urban neglect. This indirect association is significant because it allows inequality to be represented without being explicitly addressed. The environment appears as the cause, while the underlying social conditions remain backgrounded. As Norman Fairclough (1995) suggests, such representations can naturalize inequality by presenting it as an objective feature of reality rather than the outcome of structural arrangements. In this case, cholera becomes tied to space, and space becomes tied to social status, producing a layered mapping of risk that is both spatial and social.

Moreover, the repetition of these spatial descriptions across the corpus creates a pattern in which certain locations are consistently associated with disease, while others remain implicitly safe. This pattern is not neutral. It establishes a form of spatial categorization in which risk is unevenly distributed, even when the disease itself is framed as widespread. The result is a discursive landscape in which some areas—and by extension, some populations—are positioned as inherently vulnerable, while others are distanced from the immediate threat. This uneven distribution of risk aligns with findings by Ali, Keil, and Enns (2011), who show that epidemic discourse often reinforces existing socio-spatial inequalities by linking disease to marginalized environments.

1.1.4. Moral and Discursive Implications: Fear, Responsibility, and Governance

Moreover, the simultaneous emphasis on mobility and spatial concentration produces a complex and somewhat paradoxical representation of cholera, which is depicted as both widespread and localized. On the one hand, the disease is shown to move across regions and populations, suggesting a universal threat; on the other, it is anchored in particular environments, creating the impression that certain groups are more closely associated with its presence. This dual framing becomes particularly evident when examples of movement—such as cholera spreading along communication routes—are combined with warnings about contact with specific individuals or areas, such as “*persons coming from the Continent*”. The analytical significance of this combination lies in how it redistributes risk: while the disease is everywhere, its perceived origin and intensity are localized, often in relation to specific spaces or populations.

This duality has important moral implications. When cholera is linked to particular environments—such as overcrowded urban areas or polluted waterways—it becomes possible to interpret those environments not only as risky but as responsible for risk. At the same time, the emphasis on movement suggests that risk can spread beyond these spaces through interaction. As a result, responsibility is both localized and generalized: certain places are seen as sources of danger, while individuals are expected to manage their exposure to those places. This creates a layered system of accountability in which structural and individual factors are intertwined, but not equally emphasized.

From a moral psychology perspective, these strategies are highly effective because they activate fear and vigilance simultaneously. The representation of cholera as mobile and unpredictable encourages individuals to perceive the threat as immediate, while the spatial concentration of risk reinforces distinctions between safe and unsafe environments (Van Bavel

et al., 2020). At the same time, the association of disease with polluted or disordered spaces activates intuitions related to purity and contamination, encouraging avoidance and reinforcing social boundaries (Haidt, 2012). These moral responses are not imposed directly; they emerge through the repeated pairing of space, movement, and danger across the corpus.

Importantly, this framing also contributes to the normalization of governance, as the combination of fear and spatial differentiation creates the conditions under which intervention appears necessary. If certain areas are constructed as inherently dangerous, then measures such as sanitation reforms, inspections, or restrictions on movement can be justified as rational responses. Similarly, if interaction is framed as a pathway of transmission, then regulating behavior becomes a matter of collective protection. In Foucauldian terms, this reflects a form of governance in which power operates through the production of knowledge about risk and space (Foucault, 1978). Individuals are not only subject to external regulation; they are encouraged to internalize these spatial and behavioral distinctions, aligning their actions with the logic of the discourse.

The analysis of these examples demonstrates that spatialization and mobility are not separate elements but interdependent mechanisms within the cholera discourse. Together, they produce a structured understanding of the epidemic in which risk is distributed unevenly, responsibility is implicitly assigned, and behavior is guided through a combination of fear, moral evaluation, and discursive authority. Cholera, in this sense, becomes not only a medical condition but a socially organized phenomenon, where space, movement, and morality intersect to shape both perception and governance.

1.2. Metaphors and Representations: Contamination, Invasion, and Decay

The cholera discourse relies heavily on metaphors of contamination, decay, and environmental corruption, which function not only to make the disease visible but also to render it morally charged and socially meaningful. These metaphors do not simply describe conditions; they actively shape how the epidemic is understood by translating abstract and invisible processes into concrete and emotionally powerful imagery. A striking example appears in the description of the Thames as a “*pestilential stream*”, a formulation that transforms the river from a neutral natural feature into a dangerous, almost agentic entity. The accumulation of waste, filth, and decay is not presented as passive; rather, it becomes a source of contamination that threatens life itself. In this way, the environment is not merely a backdrop to disease but is discursively constructed as active, polluted, and morally degraded, reinforcing what Wald (2008) identifies as the tendency in epidemic narratives to link disease with broader anxieties about disorder and decline.

This association between cholera and invisible harmful substances further intensifies the metaphorical framework. The frequent references to “effluvia” or poisonous vapours reflect contemporary miasma theory, yet their significance extends beyond scientific explanation. These substances are not only physical but symbolic; they represent unseen danger, suggesting that contamination operates in ways that are difficult to detect yet impossible to ignore. Smell, dirt, and decay thus become key semiotic resources through which risk is communicated, transforming sensory experience into moral evaluation. As George Lakoff and Mark Johnson (1980) argue, metaphors structure understanding by mapping familiar domains onto complex phenomena, and in this case, contamination becomes a central organizing concept through which cholera is interpreted. The presence of filth signals more than environmental

neglect; it suggests disorder, irresponsibility, and social failure, thereby blurring the boundary between physical conditions and moral judgment (Douglas, 1966; Lupton, 2013).

In addition to contamination, the discourse frequently mobilizes representations of invasion and spread, even when explicit war metaphors are not fully articulated. Cholera is depicted as moving across regions, advancing through populations, and penetrating social boundaries, creating a narrative structure that closely resembles that of conflict. The language of movement—advance, spread, transmission—implicitly constructs the disease as an external force that must be contained or resisted. This is particularly evident in descriptions of its expansion along communication routes or through contact with affected individuals, where interaction itself becomes a channel of threat. Such framing aligns with research showing that epidemic discourse often adopts quasi-militarized structures to organize perception and response (Semino, 2021; Charteris-Black, 2004). Even without explicit references to “war,” the logic remains the same: cholera becomes an adversary, society becomes a site of defense, and intervention becomes a form of protection.

At the same time, representations of the human body reinforce and intensify this imagery by depicting disease as a process of visible deterioration and loss of vitality. Descriptions of victims—“*the eye sinks,*” “*the skin is deadly cold*”—present the body as progressively collapsing, stripped of energy and life. These details are not incidental; they function rhetorically to make the effects of cholera immediate and tangible, transforming abstract risk into a concrete and disturbing reality. The body becomes a site where the metaphor of decay is fully realized, linking internal processes to external conditions and reinforcing the association between disease and disintegration. As Sontag (1978) argues in her analysis of illness metaphors, such representations often carry moral weight, shaping how disease is perceived and how those affected by it are understood.

From a moral psychology perspective, these metaphorical structures play a crucial role in guiding emotional and behavioral responses, particularly through the activation of the purity/contamination foundation (Haidt, 2012). By framing cholera in terms of filth, decay, and invisible pollution, the discourse encourages avoidance of perceived sources of danger and reinforces sensitivity to environmental and bodily boundaries. Cleanliness becomes associated with safety and virtue, while dirt and disorder signal risk and potential moral failing. This process also contributes to the construction of social boundaries, distinguishing between what is acceptable and what is threatening, and often aligning these distinctions with existing social divisions. As Douglas (1966) notes, concepts of purity and pollution are deeply embedded in cultural systems, and in this corpus, they are mobilized to make sense of the epidemic while simultaneously shaping patterns of inclusion and exclusion.

Ultimately, the metaphors and representations used in cholera discourse do more than illustrate the disease; they organize it within a broader moral and social framework. Contamination makes the invisible visible, invasion provides a structure of conflict, and decay renders the consequences tangible. Together, these elements transform cholera into a phenomenon that is not only biological but also symbolic, where language plays a central role in shaping perception, guiding behavior, and reinforcing social order.

1.3. Authority and Knowledge: Competing Explanations and Legitimate Voices

Authority in the cholera corpus is neither fixed nor unified; rather, it is discursively constructed through the interaction—and often the competition—of multiple forms of knowledge, including medical expertise, public health institutions, and popular belief. Scientific authority, for instance, is frequently asserted through explicit appeals to professional legitimacy, as seen in recommendations that individuals should consult “*a respectable medical man*”, a phrase that does more than offer practical advice. It draws a boundary. It distinguishes

between valid and invalid knowledge. It positions professional expertise as reliable, while implicitly marginalizing alternative voices. This boundary-making is reinforced by the dismissal of widely circulated remedies, often described as “crude” or unreliable, which reflects an attempt to regulate not only medical practice but also the production and circulation of knowledge itself. In this sense, authority is not simply exercised; it is negotiated, contested, and stabilized through discourse, aligning with Michel Foucault’s (1972) concept of power/knowledge, where truth is inseparable from the institutions that produce and legitimize it.

Yet this authority remains unstable. It is challenged. It shifts. The coexistence of competing explanations—most notably the tension between miasma theory and waterborne transmission—reveals an ongoing discursive struggle over what counts as truth. On the one hand, cholera is attributed to “effluvia” or noxious vapours rising from decaying matter , reinforcing the idea that air and smell are central to disease transmission; on the other, emerging medical perspectives, such as those associated with John Snow, link the disease to contaminated water supplies . These explanations do not simply coexist; they compete for legitimacy, each supported by different forms of evidence, authority, and institutional backing. What is at stake is not only scientific accuracy but also the power to define reality, to determine which explanations guide intervention and which are dismissed. As Foucault (1972) suggests, regimes of truth are historically contingent, and this corpus illustrates precisely such a transition, where dominant knowledge shifts as new forms of evidence gain authority.

At the same time, governmental and public health institutions play a central role in consolidating authority by translating knowledge into policy and regulation. Measures such as quarantine, sanitation laws, and house inspections are repeatedly justified through appeals to expertise and necessity , and their presentation leaves little room for contestation. They are not

framed as optional or debatable; they appear rational, inevitable, and required by the circumstances. This discursive strategy is central to what Norman Fairclough (1995) describes as the legitimation of power through discourse, where actions are naturalized by being linked to objective knowledge and urgent need. The effect is cumulative: authority becomes embedded not only in institutions but also in the language through which those institutions speak, making compliance appear both logical and necessary.

However, authority in the cholera discourse is not confined to formal institutions; it also extends into the realm of moral and social regulation, where everyday behavior becomes subject to evaluation and guidance. Appeals to cleanliness, discipline, and proper conduct—often directed at specific populations—reflect broader cultural norms that operate alongside scientific reasoning. For example, advice concerning hygiene and environmental maintenance implicitly constructs a model of the “responsible” individual, one who adheres to standards of order and self-regulation. In this way, authority operates simultaneously at multiple levels: scientific, institutional, and moral. It does not merely instruct people what to do; it shapes how they understand themselves in relation to health, risk, and responsibility.

From a moral psychology perspective, this multi-layered authority activates several moral foundations at once. Appeals to expert knowledge engage respect for authority, while calls for cleanliness and discipline resonate with concerns about purity and contamination (Haidt, 2012). At the same time, the emphasis on protecting others reinforces the foundation of care, linking obedience to ethical responsibility. This combination enhances the effectiveness of the discourse, as individuals are not only informed but also morally guided. They comply not simply because they are instructed to do so, but because they come to see compliance as justified, appropriate, and necessary.

Ultimately, the cholera corpus reveals that authority is not a static attribute but a dynamic and contested process, shaped by competing explanations, institutional power, and cultural expectations. Knowledge is produced, challenged, and redefined, while authority is continually reinforced through discourse that links truth to expertise, necessity, and moral value. In this way, the management of cholera becomes inseparable from the management of knowledge itself, demonstrating how language functions as a central mechanism in the organization of both scientific understanding and social control.

1.4. Moral Psychology: Blame, Responsibility, and Ethical Positioning

The cholera discourse embeds strong moral evaluations, positioning individuals and social groups along a shifting spectrum of responsibility in ways that are neither neutral nor purely descriptive. While the disease is sometimes framed as an external and uncontrollable threat, this framing is frequently accompanied by representations that link susceptibility to individual conduct, particularly among marginalized populations. References to those described as *“poor, ill-fed, and unhealthy... addicted to irregular habits”* do more than identify vulnerability; they introduce a moral dimension in which exposure to disease is implicitly connected to behavior, lifestyle, and self-discipline. Such formulations create a subtle but powerful shift in interpretation. Cholera is not only something that happens to people—it becomes something that reflects, at least partially, what they are perceived to be. In this way, the discourse aligns with Crawford’s (1980) concept of the moralization of health, where illness is interpreted through a framework of personal responsibility, and where risk is tied to conduct rather than solely to structural conditions.

This moralization produces a notable tension. On the one hand, the poor are represented as victims of the epidemic, living in environments characterized by overcrowding, poor sanitation, and limited resources; on the other hand, they are simultaneously positioned as

contributors to the spread of disease through their supposed habits and behaviors. This dual positioning is not contradictory—it is constitutive. It allows the discourse to maintain a compassionate register while still assigning responsibility, thereby sustaining both empathy and control. As Briggs and Mantini-Briggs (2003) argue, epidemic narratives often operate through such ambivalence, where populations are constructed as both vulnerable and blameworthy, reinforcing existing social hierarchies even as they acknowledge suffering.

At the same time, moral psychology is evident in the emotional mechanisms through which behavior is shaped, particularly through the activation of fear and implicit guilt. Fear is mobilized through vivid descriptions of disease progression and environmental danger, encouraging individuals to perceive contamination as immediate and pervasive. This emotional response is not incidental; it is instrumental. By presenting cholera as both severe and easily transmissible—through contact, environment, or proximity—the discourse encourages avoidance and compliance. For example, warnings against interaction with potentially infected individuals or environments frame such contact as dangerous and irresponsible, thereby transforming everyday decisions into moral choices. Guilt, though rarely expressed directly, operates implicitly within this framework: to engage in risky behavior is not simply imprudent, but ethically questionable. As Lupton (2013) notes, public health discourse often works through such emotional cues, linking behavior to moral consequence in ways that encourage self-regulation.

Yet this emphasis on blame and regulation is counterbalanced by a persistent discourse of compassion and shared vulnerability, which foregrounds the human cost of the epidemic. Accounts of sudden illness and death, such as descriptions of individuals who were “in perfect health... but soon after... both died”, shift attention from responsibility to loss, emphasizing the fragility of life and the unpredictability of disease. These narratives invite

empathy. They humanize the epidemic. They remind the audience that cholera is not only a matter of behavior but also a matter of suffering. This duality—between control and care—reflects the coexistence of multiple moral frameworks, as identified by Jonathan Haidt (2012), particularly the foundations of care, authority, and purity. Care encourages empathy and protection; authority supports compliance with rules; purity reinforces avoidance of contamination. Together, they create a layered moral structure that shapes both perception and action.

Responsibility, therefore, is distributed across multiple levels, but not evenly. Individuals are expected to regulate their own behavior—to maintain cleanliness, avoid risk, and adhere to emerging norms—while authorities are positioned as responsible for managing the broader crisis through policy and intervention. However, the practical burden of prevention often falls disproportionately on individuals, particularly those already living in vulnerable conditions. This asymmetry is rarely made explicit; instead, it is embedded within the discourse itself, which emphasizes personal conduct while naturalizing structural inequalities. In this respect, the corpus reflects what Nikolas Rose (2007) describes as self-governance, where individuals internalize public norms and regulate themselves accordingly, aligning personal behavior with broader social expectations.

The moral psychology of cholera discourse reveals a complex and dynamic system of ethical positioning, in which individuals are simultaneously guided, evaluated, and held accountable through language that blends fear, compassion, and normative expectation. The epidemic becomes not only a biological event but also a moral field, where actions are interpreted in relation to risk, responsibility, and the collective good. Through this process, discourse does more than describe behavior—it shapes it, embedding moral judgment within everyday life and transforming health into a matter of ethical significance.

6.5. Epidemics and the Civilizing Process: Fear, Morality, and the Regulation of Social Behavior

The preceding analysis demonstrates that cholera discourse operates through a network of interrelated mechanisms—crisis framing, metaphorical representation, spatialization, authority, and moral evaluation—that collectively shape how the epidemic is understood and experienced. When these elements are considered together, a broader pattern emerges, one that extends beyond the immediate context of disease and points toward the regulation of social behavior through language. Fear, in this sense, is not merely expressed but carefully structured through narratives of urgency and unpredictability, while morality becomes embedded in the evaluation of everyday practices and decisions. Rather than functioning as neutral description, discourse actively organizes perception, directing how individuals interpret risk and respond to it. In this way, language does not simply reflect cholera; it participates in shaping conduct and guiding social response (Foucault, 1972; Fairclough, 1995).

Such a dynamic can be more fully understood through the lens of the civilizing process, as theorized by Norbert Elias (2000), which refers to the gradual transformation of social behavior through increasing self-restraint, discipline, and the internalization of norms. The cholera corpus reflects this process in multiple ways, particularly in how practices such as hygiene, avoidance of contact, and regulation of movement are framed. These behaviors are not presented solely as externally imposed obligations; instead, they are constructed as necessary, rational, and morally appropriate responses to the crisis. As a result, individuals are encouraged to regulate themselves, aligning personal conduct with broader expectations of social responsibility. What emerges is a shift from external constraint toward internalized discipline, where norms are no longer experienced as imposed but as self-evident and natural, a process closely linked to forms of self-governance described by Rose (2007).

Central to this process is the role of fear, which functions as a key mechanism for shaping perception and behavior. By emphasizing urgency, proximity, and unpredictability, the discourse activates vigilance, prompting individuals to reassess their environment and adjust their actions accordingly. Yet fear does not operate in isolation; it is intertwined with moral evaluation, particularly through distinctions such as safe versus unsafe, clean versus unclean, and responsible versus irresponsible. These distinctions are reinforced through metaphors of contamination and decay, which render abstract risks tangible while simultaneously embedding them within a moral framework. In doing so, they align individual behavior with broader norms of order and control (Douglas, 1966; Haidt, 2012). The outcome is not simply compliance but a form of self-regulation, where individuals internalize expectations and govern their own conduct in anticipation of risk (Van Bavel et al., 2020).

At the same time, the spatialization of disease and its association with particular environments reveals that the civilizing process operates unevenly, intersecting with existing social hierarchies. While norms of regulation are presented as universal, their application is often concentrated in specific spaces and among particular populations. Environments characterized by overcrowding or poor sanitation are repeatedly constructed as sites of danger, thereby linking risk to social and spatial marginality. This creates a tension within the discourse: it promotes general standards of behavior while simultaneously reinforcing patterns of inequality. Regulation, therefore, extends beyond health into the domain of social order, where expectations of cleanliness, discipline, and control are distributed in ways that reflect broader structural conditions (Wald, 2008; Briggs & Mantini-Briggs, 2003).

These patterns are not confined to the cholera context; rather, they reappear in contemporary epidemic discourse, suggesting a continuity in how disease is constructed and governed over time. In the case of COVID-19, similar emphases on hygiene, distancing, and

responsible behavior can be observed, alongside moral evaluations of compliance and non-compliance. Although the historical contexts differ, the underlying logic remains consistent, indicating that epidemic discourse functions within a longer trajectory of social regulation. This continuity supports the argument that epidemics are not isolated events but moments that intensify existing processes of behavioral and moral organization (Rosenberg, 1992; Wallis & Nerlich, 2005).

Taken together, these observations demonstrate that epidemics can be understood as sites where language, power, and morality converge to shape social behavior. Through the combined effects of fear, representation, and evaluation, discourse contributes to the formation of subjects who regulate themselves in accordance with socially constructed norms. Cholera, therefore, is not only a medical or historical phenomenon but also part of a broader civilizing process, in which the management of disease becomes inseparable from the management of conduct (Foucault, 1978).

Conclusion

The analysis of the cholera corpus shows that epidemic discourse was not merely a record of medical facts, but a system of meaning-making that made the disease socially and morally intelligible. Crisis framing portrayed cholera as sudden and overwhelming, intensifying urgency and shaping responses. The repeated link between movement, social interaction, and contagion turned everyday behavior into a potential risk, encouraging self-regulation. Spatial representations of the disease associated cholera with specific places and marginalized populations, naturalizing social inequality by presenting it as environmental rather than structural. The discourse also distributed responsibility unevenly between individuals and groups. From a moral psychology perspective, these patterns activated fear, contamination concerns, and precautionary behavior, promoting compliance. Overall, cholera discourse

functioned as a form of governance through language, organizing perception, behavior, and institutional authority.

CHAPTER THREE

Discourse Analysis and Moral Psychology of COVID- 19 Corpus

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Introduction

This chapter investigates the discursive construction of COVID-19 across political speeches and media articles through the combined perspectives of Discourse Analysis and Moral Psychology. Rather than treating the pandemic solely as a medical phenomenon, the chapter explores how language contributed to shaping public perceptions of risk, responsibility, authority, and collective action. By examining the speeches of Boris Johnson and Queen Elizabeth II alongside selected Guardian articles, the analysis highlights the ways in which crisis narratives, metaphors, moral evaluations, and appeals to expertise were employed to legitimize public health measures and influence social behaviour. Particular attention is given to how individuals were positioned as responsible citizens, how vulnerability and care were represented, and how compliance was framed as both a moral and civic obligation. Furthermore, the chapter considers the interaction between political, scientific, and symbolic forms of authority in constructing a coherent response to the pandemic. Building on these findings, it ultimately situates COVID-19 discourse within Norbert Elias's concept of the civilizing process, demonstrating how epidemic communication functions as a mechanism of social regulation through which norms of self-discipline, responsibility, and collective conduct are reinforced and internalized.

1. Discourse Analysis and Moral Psychology of COVID- 19 Corpus

This section examines the COVID-19 corpus through the perspectives of discourse analysis and moral psychology. It explores how language, values, and collective responsibilities were constructed and communicated during the pandemic.

1.1. Analysis of the Videos Using Discourse Analysis and Moral Psychology

The selected videos provide valuable insights into public narratives and moral responses to COVID-19. Their analysis reveals how communication strategies shaped attitudes, behaviours, and social obligations during the crisis.

1.2.1. Narrative Framing: Crisis, Duty, and National Survival

Narrative framing played a significant role in presenting the pandemic as a shared national challenge. Themes of duty, solidarity, and collective identity helped encourage public cooperation and resilience.

1.2.1.1 Crisis Framing: Constructing Urgency and Exceptionality

Across the speeches, COVID-19 is constructed not as a routine health issue but as an exceptional and escalating crisis that disrupts everyday life and demands immediate intervention. This framing is reinforced through repeated references to deterioration—such as the claim that “the situation is getting worse”—and through emphasis on rapid spread and pressure on healthcare systems. These linguistic choices actively produce a sense of urgency and instability, transforming the pandemic into an imminent and systemic threat. This construction becomes particularly explicit in Boris Johnson’s address on 23 March 2020: “*You must stay at home.*”

The abruptness and certainty of this directive eliminate ambiguity and present the situation as already critical, beyond ordinary management. Time itself becomes morally charged: delay is no longer neutral but dangerous. This aligns with research showing that crisis discourse amplifies severity to legitimize extraordinary measures (Boin et al., 2005; Rosenberg, 1992).

Moreover, the repeated use of necessity and inevitability frames restrictions as unavoidable rather than optional. As Norman Fairclough (1995) argues, such language naturalizes authority by presenting directives as rational and necessary. Consequently, everyday practices—movement, interaction, routine activities—are redefined as potential threats, marking a shift in which inaction becomes irresponsible and behavior becomes morally evaluated.

From a Foucauldian perspective, this illustrates how discourse reorganizes reality by determining what counts as legitimate action (Michel Foucault, 1972). Crisis framing therefore functions as a foundational mechanism: it creates urgency, legitimizes intervention, and prepares the ground for compliance. Simultaneously, it activates psychological responses such as fear and risk perception, encouraging individuals to internalize the sense of danger (Van Bavel et al., 2020). Over time, this repeated emphasis normalizes a state of vigilance, making restriction appear both necessary and expected (Lupton, 2013).

1.2.1.2 Duty Framing: Moralizing Individual Behaviour

Closely linked to crisis framing is the construction of duty, through which individual behavior is moralized and regulated. Instructions such as “stay home” are not presented as neutral guidance but as ethical obligations, transforming compliance into a moral act and non-compliance into a potential source of harm. This is reinforced through statements like:

“You must stay at home”

and the slogan:

“Stay home, protect the NHS, save lives.”

This formulation creates a direct link between individual action and moral consequence, positioning behavior as a contribution to collective well-being. As research suggests, public health discourse frequently relies on such moralization to shape behavior (Lupton, 2013; Crawford, 1980).

As a result, everyday activities—such as socializing or traveling—are redefined as potentially dangerous, while restraint and discipline are framed as moral virtues. This reflects what Norman Fairclough (1995) describes as the naturalization of norms, where expectations become self-evident. The emphasis on protecting “the most vulnerable” further reinforces this moral framework, constructing a binary in which compliance signifies care, while deviation implies risk or harm.

From a moral psychology perspective, this framing activates the foundations of care and authority (Jonathan Haidt, 2012). Individuals are encouraged to follow rules not only because they are imposed, but because they align with moral values. Consequently, citizens are positioned along a moral spectrum: those who comply are associated with responsibility and solidarity, while non-compliance is implicitly linked to danger (Petersen et al., 2020).

Importantly, this moralization is cumulative. Through repetition across speeches and media discourse, compliance becomes normalized and internalized. Individuals begin to regulate themselves according to these expectations, reflecting what Rose (2007) describes as governance through self-regulation. In Foucauldian terms, power operates not through coercion alone but through shaping conduct and subjectivity (Foucault, 1978).

Ultimately, duty framing transforms public health guidance into a moral order, where behavior is evaluated ethically and compliance becomes an expression of responsible citizenship.

1.2.1.3 National Survival Framing: From Individual Action to Collective Preservation

The narrative reaches its strongest form when individual behavior is linked directly to national survival, transforming personal conduct into a matter of collective destiny . The pandemic is constructed not only as a health crisis but as a threat to the continuity of the nation, particularly through references to protecting the National Health Service. The slogan “*Protect the NHS*” functions as more than a public health message; it establishes a direct connection between individual compliance and the preservation of a key national institution, thereby amplifying the moral significance of everyday actions.

As a result, behaviors such as staying at home or limiting contact are reframed as acts of collective preservation rather than mere precautions. Individual decisions are evaluated within a shared moral horizon, where personal sacrifice contributes to the survival of the whole. This framing is reinforced in the address by Elizabeth II (5 April 2020), where she stated:

“Together we are tackling this disease... we will succeed—and that success will belong to every one of us.”

The use of “we” constructs a unified national subject, dissolving distinctions between individuals and positioning society as a coordinated entity facing a shared threat. This collective identity is further strengthened by the phrase:

“We will meet again,”

which evokes historical memory and frames the crisis as a test of national endurance (Rosenberg, 1992; Edgerton, 2005).

This discourse reconfigures the relationship between individual and collective action. Personal sacrifice—through accepting restrictions and limiting personal freedom—is

elevated to the level of a national contribution. What might otherwise be perceived as a limitation becomes meaningful participation in the collective project. From a discourse-analytic perspective, this reflects a process of collectivization, in which individual identities are integrated into a shared national identity, thereby reinforcing social cohesion (Norman Fairclough, 1995).

From a Foucauldian perspective, this dynamic illustrates biopolitical governance, where populations are managed through appeals to life and survival rather than coercion (Michel Foucault, 1978). Individuals regulate their behavior not simply because they are instructed to, but because they perceive their actions as contributing to collective survival. Moral psychology further explains this effectiveness: linking behavior to national outcomes activates loyalty, care, and authority, encouraging identification with the collective (Jonathan Haidt, 2012).

Importantly, this framing also manages the tension between restriction and freedom. Limitations on movement and social life are reframed as necessary sacrifices, justified by the need to protect the collective. In this way, national survival provides meaning to crisis and duty, integrating them into a coherent framework in which the pandemic becomes a moral and national project.

1.2.2. Metaphors and Representations: Threat, Protection, and Collective Endurance

The speeches rely extensively on metaphors to structure understanding and shape emotional responses, functioning not merely as stylistic devices but as cognitive tools that organize reality. As George Lakoff and Mark Johnson (1980) argue, metaphors shape how abstract phenomena are conceptualized; in the context of COVID-19, they render the crisis more tangible and morally charged.

In the speeches of Boris Johnson, the dominant metaphorical framework is one of conflict and defense. The pandemic is constructed as a threat that must be fought, as illustrated in statements such as:

“We are in a fight against this virus.”

This framing transforms the crisis into a battle scenario, where the virus becomes an enemy, the government provides strategy, and citizens are expected to cooperate to secure victory. Even when not explicitly stated, this conflict structure persists, organizing the narrative into a sequence of threat, response, discipline, and success. While this simplifies complexity and enhances clarity, it also introduces a moral binary, where actions are categorized as either helpful or harmful, reinforcing responsibility in polarized terms (Charteris-Black, 2004; Semino, 2021).

Alongside conflict, the metaphor of protection plays a central role. The repeated call to *“protect the NHS”* functions both as instruction and as a moral representation, positioning citizens as defenders of a national institution. Protection thus becomes not only practical but ethical, linking individual behavior to collective survival.

In contrast, the speeches of Elizabeth II employ a different metaphorical register centered on endurance, continuity, and hope. In her address (5 April 2020), she states:

“Together we are tackling this disease... we will succeed.”

While “tackling” suggests effort, it lacks the aggressive tone of warfare, shifting emphasis from confrontation to perseverance. This approach is reinforced by the phrase:

“We will meet again,”

which functions as a metaphor of restoration and continuity, drawing on historical memory

and national resilience (Edgerton, 2005; Rosenberg, 1992). Similarly, the symbolic association of “light” with hope reframes the pandemic as a moral and emotional journey, moving from darkness toward recovery.

These contrasting metaphorical frameworks—conflict versus endurance—produce different representations of both the crisis and the public. In Johnson’s discourse, citizens are positioned as disciplined actors within a regulated system, responsible for following instructions and controlling the spread of the virus. In the Queen’s discourse, they are constructed as members of a moral community, united by shared experience and emotional strength.

From a discourse-analytic perspective, this reflects different modes of governance. Johnson’s framing aligns with regulatory discourse, where language directs behavior and enforces norms (Norman Fairclough, 1995), while the Queen’s discourse emphasizes symbolic and affective meaning. From a moral psychology perspective, these metaphors activate different moral foundations: conflict emphasizes authority and control, whereas endurance emphasizes care, loyalty, and solidarity (Jonathan Haidt, 2012).

Ultimately, metaphor choice shapes how responsibility is understood. In conflict discourse, responsibility is framed in terms of action and compliance, while in endurance discourse it is framed in terms of persistence and mutual support. As Semino (2021) suggests, these choices are not neutral; they significantly influence perception and behavior. Metaphors therefore play a central role in constructing the pandemic as a socially meaningful and morally organized crisis.

1.2.3. Authority and Knowledge: Political, Scientific, and Moral Voices

Authority functions as a central mechanism through which knowledge is produced, legitimized, and translated into action, shaping not only what is said but who is authorized to say it. The speeches construct authority discursively, defining what counts as valid knowledge and which actions are justified. In the speeches of Boris Johnson, authority is built through a combination of institutional power, scientific reference, and policy articulation. Statements such as:

“We will be guided by the science”

position decisions as grounded in objective expertise rather than political choice, while directives like *“You must stay at home”* are framed as necessary responses to epidemiological danger.

Such strategies align with Norman Fairclough (1995), who argues that discourse legitimizes power by presenting actions as rational and inevitable. By linking policy to scientific authority, the speeches reduce contestation and normalize compliance. From a Foucauldian perspective, this reflects the operation of power/knowledge, where authority is exercised through the production of truth (Michel Foucault, 1972). Knowledge becomes a tool of governance, shaping perception and directing behavior.

This form of authority is further reinforced through references to protecting the NHS and preventing deaths, which frame government action as morally necessary. As Van Leeuwen (2007) notes, such discourse legitimizes authority through appeals to expertise, necessity, and ethical purpose, creating a convergence between political authority, scientific knowledge, and moral reasoning.

In contrast, the authority constructed in the speeches of Elizabeth II is symbolic and moral rather than technical. Her address acknowledges “an increasingly challenging time” and emphasizes collective effort through statements such as:

“Together we are tackling this disease... we will succeed.”

The use of inclusive language (“we”) positions her alongside the public rather than above it, constructing authority through shared identity and emotional connection rather than instruction. This is reinforced by the phrase:

“We will meet again,”

which draws on historical memory and national resilience (Edgerton, 2005), grounding authority in continuity and cultural symbolism.

From a discourse-analytic perspective, these differences reflect distinct modes of governance. Johnson’s discourse operates through regulation and directive language, while the Queen’s discourse operates through moral reassurance and value formation (Fairclough, 1995). From a moral psychology perspective, these approaches activate different foundations: Johnson’s discourse emphasizes authority and order, while the Queen’s activates loyalty and care (Jonathan Haidt, 2012).

Importantly, these forms of authority are not contradictory but complementary. Political authority provides structure, scientific authority offers justification, and moral authority provides meaning. Together, they create a multi-layered system of governance that enhances trust and compliance (Van Bavel et al., 2020; Briggs & Mantini-Briggs, 2003). Ultimately, authority emerges as a discursive achievement—constructed, reinforced, and sustained through language in order to manage the crisis effectively.

1.2.4. Moral Evaluation: Responsible Citizens and Vulnerable Others

The speeches do not simply describe behavior; they evaluate it morally, constructing a system of positioning that distinguishes between responsible citizens and those who may pose a risk to others. Public health compliance is thus transformed from a practical requirement into an ethical obligation, where individuals are guided not only in what to do but in how to understand themselves and others within a moral framework.

In the speeches of Boris Johnson, this evaluation operates through implicit contrast. Citizens who follow restrictions are constructed as responsible and caring, while non-compliance is associated—often indirectly—with risk and harm. This is reinforced through messaging such as:

“Stay home, protect the NHS, save lives.”

The structure of this slogan creates a direct link between behavior and moral consequence: compliance saves lives, while failure to comply implies danger. As Lupton (2013) and Crawford (1980) argue, public health discourse often moralizes behavior by linking it to risk and responsibility, positioning individuals along a moral spectrum.

At the same time, the discourse foregrounds the figure of the vulnerable other, including “the elderly” and “those with underlying conditions,” thereby personalizing the consequences of the pandemic. This shift transforms compliance into an other-oriented moral obligation, where individual actions are evaluated in terms of their impact on others. As Briggs and Mantini-Briggs (2003) note, epidemic discourse often embeds such moral relationships by linking personal behavior to collective outcomes.

In contrast, the speeches of Elizabeth II frame moral evaluation through compassion rather than regulation. Her acknowledgment that the pandemic has brought “grief to some” and “enormous changes to the daily lives of us all” shifts the focus from judgment to empathy. This is reinforced by the phrase:

“We will meet again,”

which emphasizes shared experience and continuity rather than moral division.

From a moral psychology perspective, these approaches activate different foundations. Government discourse emphasizes care and authority, encouraging rule-following to prevent harm, while royal discourse emphasizes care and loyalty, fostering solidarity and collective identity (Jonathan Haidt, 2012). Importantly, moral evaluation operates implicitly: individuals are rarely blamed directly but are guided through contrast and association, encouraging self-regulation without overt coercion (Petersen et al., 2020).

Furthermore, the emphasis on protecting the vulnerable frames personal sacrifice—such as limiting contact or staying at home—as meaningful and ethically valuable. Restrictions are not presented as loss but as contribution, aligning with Rose’s (2007) notion of governance through self-regulation. At the same time, a tension emerges between self-interest and collective care, which is managed by reframing sacrifice as moral virtue.

Ultimately, moral evaluation functions as a key discursive mechanism, defining responsibility, assigning value to behavior, and constructing a moral order in which individuals are positioned in relation to their impact on others. The pandemic is thus transformed into a site of ethical judgment, where actions are continuously interpreted through their consequences for the collective.

1.2.5. Assignment of Responsibility: Individual Conduct and State Governance

Responsibility in the speeches is not attributed to a single actor but is distributed across both individuals and the state, forming a layered and hybrid model of governance . On the one hand, citizens are directly addressed and repeatedly instructed to regulate their behavior; on the other, the state presents itself as the central coordinating authority. This dual construction creates a system in which personal conduct and institutional intervention are closely intertwined.

At the individual level, responsibility is articulated through direct imperatives such as:

“You must stay at home.” (Boris Johnson, 23 March 2020)

Such directives transform everyday behavior into a site of governance, where actions like movement and social interaction become matters of public concern. As a result, individuals are positioned as active agents in managing the pandemic, responsible for monitoring and adjusting their conduct. This reflects broader patterns identified in public health discourse, where responsibility is individualized through “healthism” (Crawford, 1980) and internalized as part of everyday life (Lupton, 2013; Petersen et al., 2020).

At the same time, responsibility is also institutional. The speeches construct the state as responsible for decision-making, coordination, and intervention, particularly through lockdown announcements and policy measures. In these moments, the government asserts its authority to regulate movement and impose restrictions, presenting such actions as necessary responses to crisis conditions.

What is particularly significant is the interdependence between these two levels. The success of state policies is explicitly linked to individual compliance: restrictions are introduced, but their effectiveness depends on citizens’ behavior. This creates a system in which

responsibility is shared yet unevenly distributed, as individuals are expected to ensure the success of policies designed by the state.

From a discourse-analytic perspective, this reflects a strategic form of governance in which authority operates through both command and the mobilization of individual agency (Norman Fairclough, 1995). Compliance is framed not as passive obedience but as active participation, encouraging individuals to see themselves as contributors to collective outcomes.

This dual construction aligns with Nikolas Rose (2007), who describes contemporary governance as relying on self-regulation rather than coercion. Similarly, from a Foucauldian perspective, it reflects governmentality, where individuals govern themselves in accordance with broader norms (Michel Foucault, 1978). The speeches therefore cultivate a mindset in which responsibility is internalized, making compliance appear both rational and morally justified.

Moral psychology further explains this dynamic: by linking individual actions to outcomes such as saving lives and protecting the NHS, the discourse activates moral foundations of care and responsibility, encouraging compliance through ethical motivation (Jonathan Haidt, 2012; Van Bavel et al., 2020).

At the same time, this model introduces a subtle tension. While the state retains decision-making power, individuals bear much of the burden of implementation. This asymmetry is rarely made explicit; instead, it is managed through language emphasizing unity and shared effort, particularly through collective pronouns such as “we” and “together.” Ultimately, the speeches construct responsibility as both individualized and collective, making it a central mechanism through which the pandemic is governed and experienced.

1.2.6. Ethical Justification of Public Health Policies

The speeches construct public health measures—such as lockdowns, social distancing, and movement restrictions—as ethically justified interventions grounded in the protection of life and collective well-being. The dominant moral logic is broadly utilitarian, evaluating actions in terms of their consequences—reducing harm, saving lives, and preserving the healthcare system. Restrictions are therefore framed not as arbitrary impositions but as necessary responses to an urgent threat.

This logic is clearly expressed in government discourse. In the address by Boris Johnson (23 March 2020), the directive:

“You must stay at home”

is accompanied by the rationale of protecting the NHS and preventing loss of life. Similarly, the slogan:

“Stay home, protect the NHS, save lives”

encapsulates this ethical reasoning by linking restriction directly to outcome, presenting limitation as meaningful moral action rather than deprivation. This aligns with public health ethics, where policies are justified by maximizing collective benefit while minimizing harm (Beauchamp & Childress, 2019; Gostin et al., 2020).

At the same time, the speeches acknowledge the costs of these measures, including restrictions on movement, social life, and personal freedom. However, rather than denying these impacts, the discourse reframes them as temporary sacrifices for a greater moral good. Limitation becomes contribution; restriction becomes virtue. Staying at home is framed as protecting the vulnerable, and avoiding contact as preventing harm, thereby activating moral intuitions of care and fairness (Jonathan Haidt, 2012).

This ethical justification is also closely tied to trust and legitimacy. Repeated references to scientific guidance—such as “we will be guided by the science”—present decisions as evidence-based and necessary, reinforcing what Norman Fairclough (1995) describes as the discursive legitimation of authority. From a Foucauldian perspective, this reflects biopolitical governance, where intervention is justified through appeals to life, health, and collective survival rather than coercion (Michel Foucault, 1978).

Alongside this utilitarian logic, an alternative ethical framing appears in the discourse of Elizabeth II, which emphasizes endurance, compassion, and shared experience. Her statement:

“Together we are tackling this disease... we will succeed”

and the phrase:

“We will meet again”

shift the focus from restriction to collective resilience, situating policies within a broader narrative of solidarity and hope.

These complementary approaches—rational justification and emotional framing—enhance acceptance of restrictions. As Van Bavel et al. (2020) argue, emphasizing shared identity and collective goals increases compliance, while trust in institutions strengthens legitimacy (Petersen et al., 2020). However, a tension remains between liberty and protection, as restrictions limit autonomy and personal freedom. This tension is not resolved but managed discursively, with limitations framed as necessary for preserving life.

Ultimately, ethical justification operates through a combination of utilitarian reasoning, moral framing, and discursive legitimation, transforming public health policy into a moral project in which compliance is both necessary and ethically meaningful.

2.1. Analysis of the Articles Using Discourse Analysis and Moral Psychology

2.1.1. Media Discourse as Moral Construction

The selected Guardian articles construct COVID-19 not merely as a biomedical phenomenon, but as a complex moral, social, and emotional crisis that reshapes how reality is perceived and acted upon. Through the lens of discourse analysis and moral psychology, it becomes evident that these texts actively produce meaning by organizing narratives, legitimizing authority, and embedding moral evaluation within language. As Michel Foucault (1972) argues, discourse does not simply reflect reality but structures what can be known and acted upon, while Norman Fairclough (1995) emphasizes its role in legitimizing power and shaping social practice. Within this corpus, three dominant discursive domains emerge—royal discourse, medical discourse, and scientific-political discourse—each contributing differently to the construction of the pandemic. These domains intersect to produce a unified yet complex representation of COVID-19 as both a public health emergency and a moral test of collective responsibility, aligning with broader findings that pandemic communication intertwines risk, governance, and ethical judgment (Lupton, 2013; Van Bavel et al., 2020).

2.1.2. Narrative Framing: Hope, Crisis, and Endurance

The narrative framing across the articles reveals a dynamic interplay between reassurance and crisis, where the pandemic is constructed simultaneously as a threat and as a moment of collective endurance. In the Queen-related articles, the crisis is consistently reframed through unity and moral continuity. For instance, in “*Queen tells UK to ‘focus on the common goal’*,” the situation is described as a time of “great concern and uncertainty,” yet immediately followed by the reminder that the nation has historically overcome challenges by “coming together to work as one” (The Guardian, 2020a). This juxtaposition stabilizes

uncertainty by embedding it within a familiar narrative of resilience, reflecting what Rosenberg (1992) identifies as the narrative structuring of epidemics and what Wodak (2015) describes as the strategic framing of crises to shape public interpretation.

Similarly, the Easter message article introduces the framing of hope through “new hope,” positioning the crisis within a temporal trajectory that moves from disruption toward recovery (The Guardian, 2020b). In contrast, NHS-centered articles construct the crisis from within institutional experience. In “*There are so many Covid patients... my hospital is full,*” the statement “*Truly, I never imagined it would be this bad*” and the claim that “we are full” transform the pandemic into an immediate, material reality (The Guardian, 2021a). The junior doctor’s testimony—“*I feel fear and guilt*”—adds a psychological and moral layer, illustrating how crises are internalized emotionally and ethically (Hughes, 2020). Such narratives align with research showing that frontline accounts intensify risk perception and moral urgency (Briggs & Mantini-Briggs, 2003; Lupton, 2013). Meanwhile, the vaccine article reorients the narrative toward recovery, emphasizing protection for “tens of millions,” thereby aligning with what Van Bavel et al. (2020) describe as forward-looking framing that promotes compliance and hope.

2.1.3. Metaphors and Representations: Light, Pressure, and Protection

Metaphors play a crucial role in shaping how the pandemic is conceptualized, with different articles drawing on distinct representational frameworks. In royal discourse, metaphors of light, continuity, and endurance dominate. The Queen’s statement “*We will meet again*” operates as a symbolic expression of resilience, linking present uncertainty to historical endurance (The Guardian, 2020c). Such metaphors function as cognitive tools that simplify complexity and provide emotional reassurance, consistent with George Lakoff and Mark

Johnson (1980), who argue that metaphor structures human understanding of abstract phenomena.

By contrast, medical discourse relies on metaphors of pressure and expansion. COVID-19 is described as “taking over ward after ward,” representing the virus as an invasive force that overwhelms institutional capacity (The Guardian, 2021a). This aligns with findings by Semino (2021), who shows that pandemic discourse frequently uses metaphors of invasion and spread to make the threat tangible. Across the corpus, the phrase “*protect the NHS*” functions as both metaphor and moral representation, transforming the healthcare system into a symbol of collective survival and reinforcing what Charteris-Black (2004) describes as the persuasive power of metaphor in political and crisis communication.

2.1.4. Authority and Knowledge: Symbolic, Medical, and Scientific Voices

Authority in the corpus is multi-layered, constructed through symbolic, experiential, and institutional voices. The Queen’s authority is symbolic and moral, grounded in continuity and reassurance rather than technical expertise. Her acknowledgment of “an increasingly challenging time” positions her within the collective experience, reinforcing trust through identification rather than command (The Guardian, 2020c). In contrast, medical authority emerges from lived experience. The junior doctor’s statement “*I worry about my colleagues*” reflects situated knowledge grounded in frontline reality (Hughes, 2020), aligning with Foucault’s (1972) concept of knowledge as embedded within specific contexts of practice.

Scientific authority is constructed in the vaccine article through references to institutions, regulatory approval, and large-scale rollout (The Guardian, 2021b). This reflects Fairclough’s (1995) argument that authority is legitimized through the presentation of knowledge as rational and expert-driven, as well as Van Leeuwen’s (2007) framework of

legitimation through expertise. Together, these voices produce a layered authority structure in which emotional, experiential, and scientific forms of knowledge coexist and reinforce one another.

2.1.5. Moral Evaluation: Victims, Care, and Ethical Responsibility

The articles consistently construct infected individuals as victims rather than culprits, emphasizing suffering, vulnerability, and care. In “*Covid left me ‘exhausted’*,” the description of patients as “very tired and exhausted” foregrounds the human impact of the virus (The Guardian, 2022). Similarly, the junior doctor’s expression “*I feel fear and guilt*” introduces moral complexity, reflecting internalized responsibility and emotional strain (Hughes, 2020). This aligns with Lupton’s (2013) argument that health discourse moralizes behavior by linking it to care and responsibility.

The vulnerable—particularly elderly and at-risk individuals—are consistently represented as deserving protection, reinforcing what Haidt (2012) identifies as the moral foundation of care. As Briggs and Mantini-Briggs (2003) note, epidemic discourse often constructs such moral relationships to shape public attitudes. Importantly, blame is largely absent; instead, the discourse operates through compassion and implicit evaluation, positioning care as the dominant moral response.

2.1.6. Assignment of Responsibility: Individual and Collective Dimensions

Responsibility is constructed as both individual and collective, reflecting a hybrid model of governance. Individuals are encouraged to change behavior “for the greater good” (The Guardian, 2020a), transforming everyday actions into ethically meaningful practices. This aligns with Crawford’s (1980) concept of healthism and Rose’s (2007) notion of self-governance, where individuals regulate themselves according to social norms.

At the same time, responsibility is distributed across institutions, particularly in the vaccine article, which emphasizes the role of the NHS and scientific bodies in protecting “tens of millions” (The Guardian, 2021b). The hospital articles further highlight systemic pressures, suggesting that responsibility extends beyond individual behavior to include institutional capacity and policy decisions. This multi-level distribution reflects contemporary models of risk governance (Petersen et al., 2020).

2.1.7. Ethical Justification: Protection, Sacrifice, and Collective Good

Public health measures are justified through a combination of utilitarian reasoning and moral framing. The Queen’s appeal to act “for the greater good” explicitly frames behavioral change as an ethical obligation (The Guardian, 2020a), aligning with Beauchamp and Childress’s (2019) principles of public health ethics. Similarly, the cancellation of her pre-Christmas lunch demonstrates how private life is subordinated to public responsibility (The Guardian, 2021c), reinforcing the moral value of sacrifice.

The vaccine article justifies intervention through its capacity to protect large populations, while hospital narratives justify restrictions by making suffering visible (The Guardian, 2021a; 2021b). As Gostin et al. (2020) argue, such framing is central to legitimizing restrictive policies during health emergencies. Ethical justification, therefore, operates through both rational argument and emotional appeal.

3. Epidemics and the Civilizing Process: Fear, Morality, and the Regulation of Social Behavior

The preceding analysis demonstrates that cholera discourse operates through a network of interrelated mechanisms—crisis framing, metaphorical representation, spatialization, authority, and moral evaluation—that collectively shape how the epidemic is

understood and experienced. When these elements are considered together, a broader pattern emerges, one that extends beyond the immediate context of disease and points toward the regulation of social behavior through language. Fear, in this sense, is not merely expressed but carefully structured through narratives of urgency and unpredictability, while morality becomes embedded in the evaluation of everyday practices and decisions. Rather than functioning as neutral description, discourse actively organizes perception, directing how individuals interpret risk and respond to it. In this way, language does not simply reflect cholera; it participates in shaping conduct and guiding social response (Foucault, 1972; Fairclough, 1995).

Such a dynamic can be more fully understood through the lens of the civilizing process, as theorized by Norbert Elias (2000), which refers to the gradual transformation of social behavior through increasing self-restraint, discipline, and the internalization of norms. The cholera corpus reflects this process in multiple ways, particularly in how practices such as hygiene, avoidance of contact, and regulation of movement are framed. These behaviors are not presented solely as externally imposed obligations; instead, they are constructed as necessary, rational, and morally appropriate responses to the crisis. As a result, individuals are encouraged to regulate themselves, aligning personal conduct with broader expectations of social responsibility. What emerges is a shift from external constraint toward internalized discipline, where norms are no longer experienced as imposed but as self-evident and natural, a process closely linked to forms of self-governance described by Rose (2007).

Central to this process is the role of fear, which functions as a key mechanism for shaping perception and behavior. By emphasizing urgency, proximity, and unpredictability, the discourse activates vigilance, prompting individuals to reassess their environment and adjust their actions accordingly. Yet fear does not operate in isolation; it is intertwined with moral evaluation, particularly through distinctions such as safe versus unsafe, clean versus unclean,

and responsible versus irresponsible. These distinctions are reinforced through metaphors of contamination and decay, which render abstract risks tangible while simultaneously embedding them within a moral framework. In doing so, they align individual behavior with broader norms of order and control (Douglas, 1966; Haidt, 2012). The outcome is not simply compliance but a form of self-regulation, where individuals internalize expectations and govern their own conduct in anticipation of risk (Van Bavel et al., 2020).

At the same time, the spatialization of disease and its association with particular environments reveals that the civilizing process operates unevenly, intersecting with existing social hierarchies. While norms of regulation are presented as universal, their application is often concentrated in specific spaces and among particular populations. Environments characterized by overcrowding or poor sanitation are repeatedly constructed as sites of danger, thereby linking risk to social and spatial marginality. This creates a tension within the discourse: it promotes general standards of behavior while simultaneously reinforcing patterns of inequality. Regulation, therefore, extends beyond health into the domain of social order, where expectations of cleanliness, discipline, and control are distributed in ways that reflect broader structural conditions (Wald, 2008; Briggs & Mantini-Briggs, 2003).

These patterns are not confined to the cholera context; rather, they reappear in contemporary epidemic discourse, suggesting a continuity in how disease is constructed and governed over time. In the case of COVID-19, similar emphases on hygiene, distancing, and responsible behavior can be observed, alongside moral evaluations of compliance and non-compliance. Although the historical contexts differ, the underlying logic remains consistent, indicating that epidemic discourse functions within a longer trajectory of social regulation. This continuity supports the argument that epidemics are not isolated events but moments that

intensify existing processes of behavioral and moral organization (Rosenberg, 1992; Wallis & Nerlich, 2005).

Taken together, these observations demonstrate that epidemics can be understood as sites where language, power, and morality converge to shape social behavior. Through the combined effects of fear, representation, and evaluation, discourse contributes to the formation of subjects who regulate themselves in accordance with socially constructed norms. Cholera, therefore, is not only a medical or historical phenomenon but also part of a broader civilizing process, in which the management of disease becomes inseparable from the management of conduct (Foucault, 1978).

Conclusion

The analysis of COVID-19 discourse in the speeches of Boris Johnson and Queen Elizabeth II shows that language functioned as a tool for shaping meaning, identity, and behavior rather than simply conveying public health information. Through crisis and duty framing, the pandemic was presented as an urgent national challenge, where compliance with restrictions became a moral responsibility and a form of collective sacrifice linked to national survival. Metaphors of conflict and endurance helped structure public understanding of the crisis, while authority—political, scientific, and symbolic—was constructed to foster trust and encourage compliance. Moral evaluation further guided individual behavior by implicitly defining responsible conduct. Overall, COVID-19 discourse operated as a form of governance through language, transforming restriction into ethical meaning and positioning civic obedience as an expression of solidarity and national belonging.

General Conclusion

This study has demonstrated that epidemics are far more than biological crises; they are powerful discursive events that reshape the social and moral fabric of the United Kingdom. By comparing the linguistic construction of cholera in the nineteenth century with COVID-19 in the twenty-first, the research reveals that language serves as the primary tool for translating medical uncertainty into social order. Through crisis framing, epidemic discourse creates a temporal urgency that justifies immediate state intervention and necessitates rapid behavioral shifts.

The analysis of metaphor and spatialization confirms that these are not merely rhetorical devices but mechanisms of governance. Whether through the Victorian imagery of "pestilential streams" or the modern "war" against a virus, language maps disease onto specific bodies and environments, effectively moralizing geography and class. These linguistic strategies link physical health to moral character, reinforcing the civilizing process by encouraging the internalization of hygiene, discipline, and self-restraint. Ultimately, epidemic discourse functions as a form of "governing through fear," where compliance is framed as a civic virtue and non-compliance as a moral failing.

Limitations and Future Research

Despite these insights, this study is subject to certain limitations. The reliance on official government speeches, medical reports, and mainstream media may prioritize dominant institutional narratives while overlooking the "counter-discourses" or lived experiences of marginalized communities who may have resisted these moralizing frameworks. Additionally, focusing specifically on the UK limits the generalizability of the findings to different cultural or political contexts where the "civilizing process" may follow a different historical trajectory.

Future research should expand this scope by incorporating digital discourse and social media interactions to understand how epidemic narratives are contested in real-time by the public. Comparative studies involving non-Western societies would also provide a more global perspective on whether the link between epidemic language and moral regulation is a universal phenomenon or a specific byproduct of Western liberal governance. Finally, investigating the long-term psychological impact of "moralized health messaging" could offer valuable insights into how these periods of crisis leave lasting imprints on social cohesion and public trust.

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المخلص

تبحث هذه الدراسة في كيفية بناء الأوبئة من خلال اللغة، حيث تسلط الضوء على تقاطع الخطاب، والخوف، والأخلاق في المملكة المتحدة منذ تفشي مرض الكوليرا في القرن التاسع عشر وصولاً إلى جائحة كوفيد-19 المعاصرة. وبدلاً من التعامل مع المرض كظاهرة بيولوجية بحتة، يستكشف هذا البحث كيف تشكل الممارسات اللغوية الوعي العام، وتفسر المخاطر، وتسهل الإدارة الاجتماعية. ومن خلال تحليل روايات الأزمات، توضح الدراسة كيف يولد خطاب الأوبئة شعوراً بالضرورة الملحة التي تنظم السلوك الفردي والجماعي على حد سواء، مما يحول الأحداث الطبية إلى محطات لإعادة تنظيم اجتماعي عميق. ويولي التحليل اهتماماً خاصاً لدور الاستعارات والتمثيلات المكانية، التي تسقط المرض على بيئات وفئات اجتماعية محددة، مما يدمج الأحكام الأخلاقية وتوزيع المسؤوليات ضمن الرسائل الموجهة للصحة العامة. علاوة على ذلك، يربط البحث هذه العمليات الخطابية بـ «العملية الحضارية»، موضحاً كيف يعمل استيعاب المعايير وتبنيها داخلياً – مثل النظافة، وضبط النفس، والانضباط – كأحد أشكال الحوكمة والسيطرة. ومن خلال المقارنة بين السياقات التاريخية والحديثة، تكشف الدراسة عن استمرارية وتوافق كبيرين في كيفية استخدام اللغة لتبرير تدخل الدولة وتشجيع التنظيم الذاتي. وفي نهاية المطاف، يساهم هذا العمل في تعزيز فهمنا لكيفية تطور العلاقة بين المرض، والرسائل العامة، والرقابة الاجتماعية، مع تسليط الضوء على القوة الراسخة والدائمة للخطاب في هيكلة الواقع الأخلاقي والاجتماعي للتجارب الوبائية.

الكلمات المفتاحية: العملية الحضارية، الخطاب، الأوبئة، الأخلاق، الرقابة الاجتماعية