

Trading Blame: Drawing Boundaries around the Righteous, Deserving and Vulnerable in Times of Crisis

Sociology

2023, Vol. 57(5) 1040–1059

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DOI: 10.1177/00380385221137181

journals.sagepub.com/home/soc



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Abstract

Symbolic boundaries shape how we see and understand both ourselves and those around us. Amid periods of crisis, these boundaries can appear more salient, sharpening distinctions between ‘us’ and ‘them’ and reinforcing inequalities in the social landscape. Based on 50 in-depth interviews about pandemic experiences among Canadians with disabilities and chronic health conditions, we examine how this community distinguishes between the ‘deserving’ and ‘undeserving’, and how emotions related to blame and resentment inform the boundaries they draw. We find that people with disabilities and chronic health conditions drew boundaries based on unequal health statuses and vulnerabilities and between those who are and are not legitimately entitled to government aid. Underlying these dimensions are a familiar set of moral

*The order of authors listed reflects the scope and scale of the contributions made to this work.

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tropes that respondents use to assert their own superiority and to inveigh their frustrations. Together, they play an important role in solidifying boundaries between groups, complicating public perceptions of policy responses to crisis.

Keywords

boundaries, COVID-19, crisis, disability, health, inequality

Introduction

Symbolic boundaries refer to the conceptual and classificatory dimensions through which we distinguish individuals and groups (Bourdieu, 1984; Lamont, 1992; Lamont and Molnár, 2002). Boundaries invoke feelings of similarity and difference, expressed in statements like ‘we are like them’ and ‘they are different from us’ (Harkness, 2012; Wimmer, 2008). Boundaries also contribute to one’s sense of self where, ‘by generating distinctions, we also signal our identity and develop a sense of security, dignity, and honour’ (Lamont, 1992: 11). Security, dignity, and honour are often in short supply among people with disabilities and chronic health conditions and can be easily threatened in times of crisis. This raises important questions about how marginalized groups draw boundaries in the face of risk. Namely, how do people with disabilities and chronic health conditions use symbolic boundaries to make sense of social and economic crises? And, what are the implications of symbolic boundaries for inequality more generally?

Disability is an important axis of inequality. People with disabilities and chronic health conditions are often stigmatized and experience significant obstacles to participation in social life (Brown, 2015; Gill, 2009). They are, for example, excluded from labour and credit markets (Maroto and Pettinicchio, 2014a, 2020; Maroto et al., 2021). When they are included, they are often separated or isolated from the mainstream (Maroto and Pettinicchio, 2014b). They confront additional boundaries with respect to accessing health and mental health care, childcare and affordable housing (Clarke and Latham, 2014; Smith et al., 2004).

The nature of these boundaries is conditioned, at least in part, by existing social policy contexts and welfare regimes, which govern the kinds of protections and supports available to citizens. Canada exemplifies a ‘liberal’ social welfare state characterized by programmes and policies with relatively low levels of support, especially compared with European welfare states (Esping-Andersen, 1990). Canada’s more limited approach to social welfare understands well-being largely as a matter of individual responsibility and something to be obtained through employment, limiting opportunities for people with disabilities and chronic health conditions to secure resources (Prince, 2015).

Boundaries surrounding the disability community and their access to social, political and economic resources highlight the relationship between symbolic processes of distinction and the production and maintenance of structural inequality – what Lamont et al. (2014: 574) call the ‘cultural processes’ connecting ‘shared categories’ to enduring patterns of social stratification. Throughout the COVID-19 pandemic, these symbolic processes and the inequalities that underscore them became more salient for people with

disabilities and chronic health conditions. Although this community was identified as an at-risk and vulnerable group during the pandemic, it was largely ignored by policymakers and absent from discussions regarding COVID-19 countermeasures (Shakeri, 2020).

Economic and social resources for people with disabilities were particularly limited in Canada throughout the COVID-19 pandemic (Maroto et al., 2021). Chief policies included the Canadian Emergency Response Benefit (CERB) and the Canada Recovery Sickness Benefit (CRSB) (Maroto et al., 2021; Pettinicchio et al., 2021). Because this CAN\$2000 taxable monthly income was only available to individuals who lost work as a direct result of COVID-19, those unemployed, looking for work or out of the labour market – which includes many people with disabilities – were ineligible. Most relied on largely stagnant provincial benefits and supports. Not only does this showcase an extant system exercising jurisdictional control over the allocation of supports for marginalized groups, but it also alludes to acceptable exclusion from relief programmes. It is imbued in a moral logic of ‘deservedness’ (Bambra and Smith, 2010; Beck, 1967; Bloemraad et al., 2019; Skocpol, 1992; Slothuus, 2007; Steensland, 2006) based on productivity and means-tested dependence that has long informed the relationship between people with disabilities, society and the state. Indeed, the knot that binds welfare, work and perceptions of deservedness together has become tighter with time (Lamont, 2019), and the significance of this was further heightened throughout the COVID-19 pandemic as the distribution of resources took centre stage.

By the spring of 2020, many were becoming disillusioned with their fellow citizens – neighbours, close friends and even family members. They saw their failure to comply with pandemic countermeasures as contributing to the burden on a healthcare system already stretched thin (Crawley, 2021). The term ‘Covidiot’ began to trend on social media to distinguish some individuals and groups (Lilley, 2020). Later, the virtuous were cast against lazy and irresponsible vaccine resisters (Olive, 2021). Canadians also drew boundaries around the many ‘morally corrupt’ and ‘undeserving’ citizens who allegedly took advantage of the almost CAN\$44 billion in COVID-19 related economic aid like CERB (e.g. Cullen and Everson, 2020), questioning whether certain individuals and groups were entitled to those benefits.

As the pandemic continues to unfold, individuals are trying to make sense of and categorize others in accordance with perceived culpability and blameworthiness (Aassve et al., 2021; Atlani-Duault et al., 2020), inflecting their criticisms with moral and emotional judgements. Emotions like blame and resentment have been particularly pronounced during the COVID-19 pandemic, colouring how individuals and groups find fault and discharge frustration in times of crisis. Boundaries drawn around health and economic vulnerabilities as well as access to resources invoke a similar set of emotions and moral judgements, calling forth claims of identity and appeals to superiority. And yet, we know very little about how people with disabilities and chronic health conditions – a broad and heterogeneous group – view themselves and others during moments of social upheaval.

Based on 50 in-depth interviews about pandemic experiences among people with disabilities and chronic health conditions, we find that people with disabilities and chronic health conditions drew boundaries along two interrelated dimensions: unequal health statuses and vulnerabilities, and around financial supports. Underlying both dimensions

is a moral and emotional reasoning that invokes resentment, deservedness, righteousness and blameworthiness.

Extending existing work on cultural boundaries and the reproduction of inequality (Bloemraad et al., 2019; Bourdieu, 1984; Davis and Love, 2017; Harkness, 2012; Lamont, 1992; Lamont and Molnar, 2002; Lamont et al., 2014), we sketch potential ‘processes and causal pathways’ that reproduce and maintain inequality (Lamont et al., 2014) through the everyday and taken-for-granted mechanisms used to evaluate, justify and augment existing distinctions between individuals and groups. Specifically, we show how members of marginalized groups understand precarity and vulnerability vis-a-vis others, and how these distinctions are couched in blameworthiness and deservingness as a basis for boundary making. These boundaries provide important symbolic *and* material resources to marginalized people, fostering a sense of superiority while securing access to benefits – however limited – in a moment of crisis.

The Moral and Emotional Underpinnings of Symbolic Boundary Making

Symbolic boundaries are intimately connected to processes of inclusion and exclusion (Durkheim, 1955 [1915]; Lamont, 1992), as individuals guard group membership and vie for resources. While traditional definitions of symbolic boundaries are often rooted in class (Bourdieu, 1984; Weber, 2010), boundaries are also drawn along cultural and moral lines (Lamont, 1992). These boundaries may overlap, taking material form in and through routine processes that (re)produce inequality (Lamont et al., 2014). When this is the case, groups are partitioned in social space, creating stable and seemingly objective differences in their access to and monopolization of resources (Weber, 2010). These boundaries are often used to legitimize power relations between groups. As Bourdieu (1984: 479) explained, boundaries are a ‘means of power, harnessed to social functions and overtly or covertly aimed at satisfying the interests of a group’. Boundaries between racial, ethnic and gendered groups (Krzyzowski and Nowicka, 2021; Ng and Zhang, 2020), for instance, shape how group members interact with one another and the degree to which they are afforded certain social, political and economic resources (Lamont et al., 2014; Patler, 2018).

This is no less true for members of the disability community and for people with chronic health conditions, who have long contested their access to material and symbolic resources including employment and social and economic supports (Prince, 2002, 2020). On the one hand, people with disabilities and health conditions are among one of few groups who historically have been regarded as deserving public support and government benefits (Pettinicchio, 2019). Even in the most residual welfare states, like the United States, means-tested social benefits have been awarded to elderly and disabled people as broader social assistance programmes were stifled or retrenched (Barnartt and Scotch, 2001; Pierson, 1994; Skocpol, 1992). This is not surprising, as social benefits ordinarily flow most freely towards those who can ‘demonstrate they warrant care’ (Fang and Huber, 2020: 543) and those who are seen as unable to work because of their health status (Jensen and Petersen, 2017). On the other hand, people with disabilities and chronic

health conditions continue to navigate a terrain in which benefits are limited and support, narrowly conceived (Geiger, 2021; Pettinicchio, 2019). In Canada, strict definitions circle around disability, with stringent means-tests governing over the receipt of both federal and provincial supports. These means-tested supports are imbued by a logic of deservedness and reveal a set of moral and emotional boundaries colouring some, but not all, worthy and blameless.

Symbolic boundaries can be drawn in combination with moral and emotional criteria (Davis and Love, 2017; Hughes, 2007; Lamont, 1992; Sherman, 2005). This occurs when, for example, individuals or groups express envy or resentment against others they feel are to blame for broader social issues, or against those they feel are not legitimately entitled to economic benefits on account of their moral character (Bloemraad et al., 2019; Foster, 2021; Hughes, 2007). As Sayer (2005: 953) explains,

social groups often distinguish themselves from others in terms of moral differences, claiming for themselves certain virtues that others are held to lack: we are down-to-earth, they are pretentious; we are cosmopolitan, they are parochial; we are hard-working, they are lazy, and so on.

In doing so, they buttress their self-presentation, elevate their sense of worth and save face (Lamont, 2019; Sherman, 2005).

Scholarship surrounding boundary work has only begun to investigate these moral distinctions, the emotions that underscore them and their relationship to inequality and exclusion (e.g. Foster, 2021: 643; Pugh, 2011; Rafferty, 2011). Emotions, as Ahmed (2004: 119, emphasis in original) observes, '*do things*'. They connect individuals and groups, but they can also distinguish and differentiate groups, reinforcing boundaries between them (Foster, 2021). Blame is a particularly powerful emotion shaping boundary making (Davis and Love, 2017; Hughes, 2007) around understandings of deservedness and people's willingness to offer support in times of need (Zagefka, 2020). Blame allows individuals and groups to assert a sense of control, to locate fault and responsibility, and to discharge their hurt and frustration. Blame also plays a role in colouring public trust in government, driving expectations around policymaking and performance (Canales et al., 2019: 2594). Over time, taken-for-granted emotions like blame can reinforce boundaries separating 'us' from 'them', ultimately reproducing extant distinctions between groups and the material and structural consequences that follow.

In moments of crisis, where the distribution of state resources is highly visible and often contentious, boundaries between the 'deserving' and 'undeserving', as well as their moral underpinnings, are more forcefully drawn. For example, in the aftermath of the 2008 financial crisis, intense public debate surrounding the distribution of public benefits gave way to a wide range of austerity measures in Europe and the United States (see Clark, 2016; Limberg, 2020), fuelling rigid distinctions around those who needed aid such as low-income workers and disability insurance claimants (Maestas et al., 2021). Research from the UK likewise suggests that periods of crisis promote greater suspicion of welfare recipients and harsher distinctions between the deserving and underserving poor (Bloemraad et al., 2019). Even in the world's most generous welfare states, perceived crises can negatively affect public support for welfare spending (Eger, 2010),

suggesting that these periods tend to unsettle public support and reinforce distinctions around deservedness across contexts and regime types.

During these periods of crisis, behaviour is known to be especially ‘malleable’ or subject to change ‘on a scale and at a speed that would be inconceivable in normal circumstances’ (Elcheroth and Drury, 2020: 705; see also Ravenelle et al., 2021). This has important implications for boundary work. As Gorman and Seguin (2018: 706) explain, periods of crisis – whether real or constructed – ‘motivate people to emphasize the most powerful identity that they can legitimately claim’, pulling closer to the social collective and drawing more particularistic distinctions when it is advantageous to do so. In a crisis, these distinctions tend to draw from and map onto broader public perceptions of ‘what other people do or value’ (Elcheroth and Drury, 2020: 705), reinforcing affinities for those who are like us.

Distinctions between groups then, can appear more salient during pandemics as when, for example, health crises solidify boundaries between those who are and are not meaningfully assisting others (e.g. healthcare workers) (Atlani-Duault et al., 2020; see also Aassve et al., 2021; Zagefka, 2020), when this is the case, existing social distinctions adapted to distinguish groups, secure resources and protect interests. Of course, this need not always be so. Periods of crisis can also render some boundaries less salient than others, resulting in ‘boundary blurring’, repositioning or expansion (Wimmer, 2008). Boundaries may expand, for example, when individuals and groups require ‘allies to ensure security in the face of threat’ (Gorman and Seguin, 2018: 712). Or when out-group members marshal culturally lauded values to signal belonging and reorder ‘the cluster of conditions used to govern’ distinctions between us and them (Harkness, 2012: 296).

The COVID-19 pandemic provides a unique opportunity to delve more deeply into public understandings of exogenous shocks, state, social and cultural responses to moments of crisis, and the boundaries that reflect and contribute to evolving perceptions and attitudes around these. It is also an opportunity to examine how people with disabilities and chronic health conditions themselves make distinctions based on health and economic vulnerabilities about who is deserving and righteous and who is blameworthy and reckless. The boundaries surrounding disability itself are porous, ambiguous and often contested as they negotiate a broad range of experiences and conditions that are not always visible to others (Barnart, 2013). This works to limit political mobilization and leaves individuals with fewer resources when distinguishing themselves as a social group (Bourdieu, 1984; Weber, 2010).

In Canada, where COVID-19 relief was closely tied to employment, and where people with disabilities continue to experience economic barriers and increased health vulnerabilities (Maroto and Pettinicchio, 2020), we expect to find sharp distinctions drawn between those who are *really* deserving of financial support and those who are not. Although specific financial supports for people with disabilities were limited during the pandemic, public messaging focused on the increased risks associated with comorbidities, highlighting the need to protect those with disabilities and giving them priority in terms of vaccine and treatment distribution (Government of Canada, 2022a). Given their increased vulnerability to the virus, we also expect people with disabilities and chronic health conditions to draw clear boundaries between those who are willing and unwilling

to comply with public health countermeasures – that is, the unselfish who are aware of others' health and do *the right thing*.

Data and Methods

In-depth interviews are especially helpful in shedding light on how individuals and groups construct boundaries and how they map onto the specific dimensions upon which these boundaries get drawn (Lamont, 1992; Lamont and Swidler, 2014). In this project, the research team interviewed participants recruited from a larger online survey of 1027 respondents administered by Qualtrics, a survey research company, in June 2020. Among the 506 survey respondents who expressed interest in being contacted for a follow-up interview, 100 were randomly sampled before narrowing the sample to 50 people. These individuals reflected diversity in age, race, gender, disabilities and health conditions. All participants were 18 years of age or older at the time of the interview, resided in Canada and reported experiencing one of six indicated disabilities or nine chronic health conditions. Interviewees received a CAN\$30 gift card, consented to being audio recorded and were informed the study obtained university ethics review clearance (see online Appendix). To ensure confidentiality, we use pseudonyms to refer to respondents throughout the article.

Aligning with Canadian survey instruments on disability and in accordance with the World Health Organization and the Washington Group on Disability Statistics (2021; see also Pettinicchio and Maroto, 2021), we defined disability in terms of respondents' answers to six questions that allowed respondents to indicate the presence or absence of a vision, hearing, physical, cognitive, emotional or other disability and to indicate the severity of this condition. Nine health conditions including asthma, cancer, chronic kidney disease, chronic respiratory or lung disease, diabetes, heart disease, hypertension, being immunocompromised and obesity are recognized by the Canadian government as increasing vulnerability to COVID-19 infection or serious illness because of infection (Government of Canada, 2022b). Comorbidity in our sample was high. On average, respondents reported experiencing four disabilities or health conditions, with several reporting seven to nine.

Interviews were conducted between August and November 2020 and ranged from 12 to 60 minutes in length with a median length of 33.4 minutes. Interviews covered participants' finances and personal health, their efforts to adapt socially and emotionally to social distancing measures and public health protocols, as well as respondents' thoughts on government responses to the pandemic and the distribution of public aid. Respondents were also asked to report on their previous voting behaviour and on their employment situations. Together, these topics produced a comprehensive picture of participants' lives throughout the pandemic. While theoretical saturation began to emerge in the first 35 interviews, these interviews continued to capture subtle distinctions between our interviewees and their relative positions throughout the pandemic.

Interviews were transcribed verbatim using an online audio-to-text transcription service and coded by the research team using Dedoose, resulting in 699 single-spaced pages of interview transcripts. We used an open-and-iterative process that incorporated both a deductive approach based on the larger accompanying quantitative survey's questions

and an inductive approach to identify emergent themes that participants introduced and discussed (Deterding and Waters, 2021). We first looked for discursive claims – people’s ordinary language revealing what they think is important about, and how they make sense of, broader societal issues (Babbie and Benaquisto, 2010; Jorgensen and Phillips, 2002; Lamont and Swidler, 2014). By analysing these claims we were able to comment on how individuals construct symbolic boundaries in moments of crisis. We performed analytic coding identifying common themes and patterns across interviews and differences between them (Auerbach and Silverstein, 2003; Morse and Richards, 2002). Once a preliminary set of themes was established, the research team coded interviews independently, meeting weekly to refine our procedure and establish inter-coder reliability. As our findings show, the codes revealed several patterns related to how respondents thought about and understood economic aid and the deservingness of others, vulnerability and risk, and emotions like blame and resentment.

Drawing Boundaries between the Deserving and the Rest

Following from our first research question, which asked how respondents used boundaries to help make sense of a crisis, we found that respondents drew boundaries in terms of unequal health statuses and vulnerability, explaining that some were more at risk of serious illness because of COVID-19. These boundaries were especially pronounced in relation to compliance with social distancing measures and public safety precautions. Linked to our second research question on the relationship between boundaries and inequality, we found that respondents drew boundaries related to the receipt of financial supports and government aid. This was evident in their discussion of eligibility and access to CERB. Underpinning both dimensions were moral and emotional appeals that cast some as selfish and blameworthy, and others as virtuous citizens deserving of support. These moral and emotional appeals helped respondents make sense of their own, often more precarious, situations in relation to others who received greater support or failed to comply with social distancing recommendations and, reinforced the boundaries they drew.

Vulnerability and Risk

In making sense of the COVID-19 crisis, respondents often referred to their disability or health status to highlight their susceptibility to the virus and the corresponding precautions they took to guard against infection, defining themselves and others with a disability as a distinct social group. Throughout, they drew comparisons with others who, in their view, were reckless or inconsiderate of the health and well-being of those around them. In doing so, respondents elevated themselves as necessarily more considerate and precautionous than most. Respondents asserted their moral superiority while making claims for the ‘legitimately’ vulnerable and ultimately, for the symbolic and material resources these claimants feel entitled to.

For example, Donald described himself as ‘more cautious than most’, keeping clear of large groups and gatherings to avoid risk of infection. He was concerned for himself and his elderly parents who were also at an increased risk of infection. He continued,

'some people are not in the same situation and I'm sure you've heard, younger people, may be a little bit more cavalier with their attitude' towards the pandemic or public health guidelines more broadly. In describing himself as more precautionary than most and in pointing towards the 'cavalier' attitude of others, Donald drew sharp boundaries around individuals and groups who must think twice about their well-being and others who have the luxury not to.

Kelsey, a woman in her 30s with diabetes, was similarly concerned for herself and for her family. Describing herself as more susceptible to serious infection, she expressed concerns about her ability to 'juggle' between social distancing and time spent outdoors exercising or seeing friends. In her own words, 'it is always this constant dance that's in my brain where I'm like, am I being too risky? Am I being too closed off?' Kelsey's concerns, though not uncommon, were influenced by her own experiences with chronic health issues. Even mundane decisions like visiting a grocery store became more complicated. In her own words, Kelsey had to be 'more conservative than the average' person when weighing risk.

Evan, who worked remotely during the pandemic, was also concerned for his physical health and well-being. His asthma put him at greater risk of infection, prompting a range of health-promoting behaviours and strict adherence to public safety guidelines. With his inhaler in hand, Evan wore gloves at the grocery store and sanitized everything he touched for fear that he might catch the virus. He said: 'Am I being overly cautious? Maybe, but I'd rather be overly cautious than overly carefree in this kind of environment.' Bailey, who was born with spina bifida shared similar thoughts. When asked about what safety precautions she had taken during the pandemic and how these compared with those around her, Bailey remarked:

I know of some friends that are not doing anything. They're just going about their lives going to work and this and that . . . if they want to be that way that's fine, but I'm not going to be *that way*.

Eve, a 66-year-old woman whose close family was 'just totally high risk' necessitated that she be 'extremely careful'. With these family members in mind, Eve shared that she had 'become really *judgmental*'. She said, 'If I am out in the mask and someone walks by and doesn't have one, it's like, you're giving them the death stare, you know?' For Eve, public precautions and her adherence to safety guidelines were a '*moral duty*' and so, those who failed to comply were wanting and morally suspect in comparison. Courtney, a 36-year-old customer-service representative with diabetes, was likewise concerned for herself and for others whom she perceived to be particularly vulnerable to infection and health decline. Children and the elderly, for example, warranted special concern, reminding Courtney how important it was to practise 'social distancing, wear a mask, sanitize and just stay home as much as possible'. Although Courtney described these safety practices as 'inconvenient', she was willing to comply to protect herself and her loved ones. The suggestion being that those who did not were somewhat more reckless and necessarily inconsiderate of those closest to them.

For others, compliance (or non-compliance) with public safety guidelines took on an intellectual tinge, suggesting that those who did not social distance, self-isolate or wear

masks, were ill-informed, obstreperous or stupid. Nicki, who was waiting for a kidney transplant at the time of the interview, went so far as to say that she was ‘the only one’ she knew that was ‘taking it [the pandemic] seriously’. Nicki had strict rules related to her own safety and was careful not to interact with others, but she felt like she was being undermined by the behaviours of others: ‘I try to tell *people like that*, so that I can have a life, I need everyone to wear a mask.’ For Nicki, those who did not comply with guidelines or downplayed COVID-19 jeopardized her safety and her own quality of life:

I mean, I’m not COVID sick, but because I have immune deficiency . . . I feel that a lot of anti-maskers, that’s their philosophy, ‘If you’re the one who’s going to get sick then stay the hell home. *Why should I have to put on a mask to protect you?*

Others, like Robert, feel like they are sacrificing their quality of life while selfish people are making things worse:

If I feel like going down to the pub, having a burger and a beer for lunch, I won’t do that . . . I get totally infuriated with what I call – and other people have called them – the COVIDiots who refuse to wear masks.

Like many respondents, Nicki insisted that those who failed to comply with public health guidelines and social distancing measures were all ‘anti-government or anti-science’ and will ‘believe crap before they’ll believe science and information’. Similarly, Margo set herself apart from others who defy safety measures: ‘I’m not *one of these anti-science people*.’ Both Nicki and Margo invoke a boundary between themselves and others. Specifically, between those with enough good sense to take precautions and those without. But Nicki does something more too. In dividing individuals and groups in this way, Nicki elevates her sense of self (Sherman, 2005), asserting that she is the ‘*only one*’ doing their part to ensure the safety and well-being of those around her. Others, to compare are, as our respondents make clear, ‘selfish’ or ‘stupid’ and so, undeserving of our sympathies and support.

Deserving Financial Supports

Distinctions of risk and vulnerability are closely tied to boundaries around the distribution of resources, which have implications for the maintenance and reproduction of inequality. Although these boundaries incorporated moral and emotional aspects, respondents made particularly strong distinctions related to others’ experiences accessing CERB, which many people with disabilities and chronic health conditions were not eligible for. Specifically, respondents questioned the deservingness of those who received financial aid, criticizing young people and others who ‘refused to work’ and ‘took advantage’ of ‘handouts’. Respondents then drew on established tropes and frames related to welfare and social policy (Fraser and Gordon, 1994; Misra et al., 2003; Skocpol, 1992), insisting that they were *different* from others.

Esther, for example, was ineligible for CERB. Struggling to make ends meet and unable to find part-time flexible work to accommodate her osteoarthritis, fibromyalgia

and depression, Esther was troubled by individuals she felt were taking advantage of CERB. In her own words,

I'm sorry to say it, some of the younger crowd is taking CERB in the place of working . . . and that's the sad part. These people, they're young enough to go out and make a living. Why don't they go out there? They don't have compromised health issues to worry about.

Esther drew important distinctions between people with disabilities and chronic health conditions and those who could more easily access employment opportunities and who are young, presumably, physically able, and so undeserving of aid. Esther's comments echo others made by respondents and highlight the centrality of employment in the public's understanding of deservedness (Fraser and Gordon, 1994; Misra et al., 2003).

Several respondents voiced concern that CERB had been used by Canadians who did not need it or were not deserving of financial aid. Allison expressed considerable scepticism about the distribution of CERB benefits. Although she recognized that people 'needed handouts', Allison was critical about *who* got them: 'you hear so many stories on the news about some people that applied for CERB and they weren't entitled to it but got it. Some people that got multiple CERB payments. People that had somebody apply for CERB using their Canada Revenue Agency log-in' and so on. Here, Allison drew a clear distinction between those who are legitimately 'entitled' to state benefits and financial support and others who misuse or take advantage of this aid. That Allison described CERB as a 'handout' is itself meaningful, invoking images of the lazy and underserving welfare recipient (e.g. Lubiano, 1992). Angelica, a 67-year-old woman with chronic kidney disease made a similar distinction sharing that:

I'm starting to get upset with the amount of money he's [Prime Minister Justin Trudeau] starting to throw out now. It's just getting way out of control . . . and everybody now is putting out their hands saying, '*what that one got I want*'.

Angelica's comments were couched in her assessment of widespread greed among the lazy uninterested in working.

Maryam, who believed that the distribution of CERB was 'very fair' still worried that 'people were taking advantage'. And though her own freelance work had all but stopped, she did not apply for CERB. As she explained, 'I can take care of myself.' Maryam draws an important distinction between herself and others whom she implies should not or cannot be counted on to manage their finances and well-being. This discursive strategy allows respondents to feel superior and to elevate themselves in relation to hierarchies of value and competence (Lamont, 1992; Sherman, 2005). Dora, a retired teacher with asthma, similarly alluded to superiority in her interview. When asked if she had ever accessed or made use of any provincial or federal benefits, Dora replied, 'I don't *need* them. I have my own savings.' Without prompt, Dora began to list her credentials and extensive background in education as if to reinforce the point that she had the wherewithal to study hard, work and save so that she might never need public supports. Taken together, Maryam's and Dora's remarks about not having to make use of government supports remind us that moral and class-based boundaries often overlap. While moral

boundaries have distinct qualities, respondents like Maryam and Dora illustrate links between class positioning, hard work and personal responsibility to save. This is consistent with a broader cultural and institutional narrative in liberal welfare states around deservedness and redistribution.

Respondents also relied on the perceived situations of others when discussing economic supports. Dillan, a 37-year-old elementary school teacher with psoriatic arthritis, believed that ‘there was a lot of fraud’ but still thought it wise for the government to prioritize the economic well-being of those in need. As he explained, ‘it was a good choice to kind of not worry about fraud and worry more about the people that actually really need it [financial aid]’. While for Natalie, who retired at the age of 65, background checks might have been useful for distinguishing between those who truly deserved CERB and those who did not. In her own words, the government ‘gave out quite a bit of money . . . but they didn’t really check backgrounds on a lot of people’.

Dillan’s and Natalie’s comments highlight a broader tension related to the distribution of economic supports. On the one hand, these supports were perceived as invaluable in Canada’s response to the COVID-19 pandemic. This is especially so for vulnerable groups, including people with disabilities and chronic health conditions who are more susceptible to the virus and to its economic impacts within a liberal welfare system that has not always served them. On the other hand, government benefits invite significant scepticism related to those who are not legitimately entitled to them and an alleged widespread defrauding of public money. This is true even during crises. As Bloemraad et al. (2019: 73) observe of redistributive policies more broadly, ‘harsher judgments or boundaries over who “deserves” public assistance’ rise in contexts and during periods when inclusivity and aid ought to be prioritized, in turn ‘corroding solidarity’.

Importantly, respondents’ insistence on the frequency in which everyday people had ‘scammed’ the government is not consistent with what is objectively known about COVID-19 economic supports. CERB disproportionately went to those already more vulnerable and negatively impacted by the pandemic including low-wage workers, racial minority workers and women (Olson et al., 2021). Canada’s revenue agency’s own investigation reported that of the CAN\$74 billion delivered in aid to Canadians, only 190,000 (about 2%) of the 8.9 million Canadians who applied for CERB were found to be ineligible and made to *repay* the taxable benefit they received (Harris, 2020).

Overall, respondents drew pointed distinctions informed by moral inflections related to deservedness and the challenges people with disabilities and chronic health conditions continue to face during the pandemic. Whether explicit or implied, people with disabilities and chronic health conditions asserted their own deservedness alongside concerns that others were taking advantage. Reporting on their experiences throughout the pandemic, respondents elevated themselves in appeals towards superiority. These appeals centre respondents’ competency and ability to manage during periods of financial crisis against those who are in ‘need’ of ‘handouts’.

Conclusion

Symbolic boundaries help establish ‘legitimate’ claims for the material and symbolic resources marginalized groups are so often barred from accessing. These boundaries map

onto broader beliefs about deservedness to inform who is entitled to what. Although people with disabilities and chronic health conditions are often treated as morally deserving or entitled to support, this group continues to be neglected in the policy-making process (Pettinicchio, 2019; Prince, 2009), and from participation within social, cultural and economic markets more broadly. When they are included, people with disabilities and chronic health conditions face structural and attitudinal boundaries related to access and opportunity. And still, they are rarely, if ever, asked to comment on these (Geiger, 2021). Thus, we know little about how members of the disability community or people with chronic health conditions draw boundaries around themselves and others close to them, nor under what conditions these boundaries might blur.

This study sought to better understand how an especially vulnerable community made sense of social and economic crisis brought on by a pandemic and the implications of this reasoning for inequality. Throughout, we highlight the significance of boundary work as it relates to symbolic and material resources that often lack for these groups. Amid the global coronavirus pandemic, people with disabilities and chronic health conditions drew boundaries between themselves and others, establishing and reinforcing the deservedness of some, while casting others as selfish, dependent and blameworthy. Boundaries were drawn around two key dimensions of health risk and economic support and informed by a complex moral terrain of emotional evaluations and appeals towards superiority that mark our respondents as distinct.

Specifically, respondents' claims around financial support render some as morally superior and others as dependent and undeserving, reinforcing negative stereotypes surrounding low-income people and others in need of aid. These claims helped respondents rationalize their own positioning as virtuous citizens who willingly complied with their government's protections and produced a sharp moral distinction with others considered less deserving. In appealing towards superiority and virtue, respondents produced alternative visions of their own social identities as people with disabilities or chronic health conditions, highlighting their value and worth in contrast to a loosely defined and morally corrupt other (e.g. Lamont, 2012; Lamont and Mizarchi, 2012; Wimmer, 2008). Throughout, they make claims for important symbolic and material resources, asserting that people with disabilities are *more* deserving.

Consistent with existing research suggesting that crises may shift attitudinal responses to public policy (Isaac and Elrick, 2021) or foster opportunities for boundary change (Elcheroth and Drury, 2020; Ravenelle et al., 2021), several respondents expressed favourable attitudes towards redistribution; some even recommended that CERB continue as a form of Universal Basic Income. By and large however, our findings show that crises reinforce extant distinctions between 'us' and 'them', particularly as these distinctions apply to the distribution of resources. These resources remain highly contentious with their receipt a subject of suspicion and public debate, which limits governments' abilities to use such programmes to help reduce inequality (Bloemraad et al., 2019).

Among the central findings reported here is the stubborn assertion that others took advantage of CERB and fraudulently sought income supports where none were needed. Although there is little concrete evidence to support this, respondents remain convinced suggesting that tensions related to welfare resources and their insidious distinctions may be growing. Respondents' reflections on the receipt of CERB highlight that even in a

period of crisis, entrenched discourse surrounding the deserving and underserving poor reflect a well-known cultural and political narrative (Fraser and Gordon, 1994). As Misra et al. (2003: 499) observed, ‘images of dependency often dominate media discourse’ and these images carry very real consequences for how we think about and understand the deservingness of others (see Gazso et al., 2019).

For years, this kind of rhetoric has maligned marginalized groups, casting those who receive government aid as necessarily dependent and to blame. People with disabilities and chronic health conditions are not immune from this discourse and, as we have shown, may leverage it to make sense of their own circumstances and draw boundaries during periods of crisis. Like others in the general population, people with disabilities and chronic health conditions were, for example, less sympathetic towards those who they felt did not warrant care, including young people who, they reasoned, ought to be able to work and those who were inconsiderate of others’ health and well-being. While these boundaries likely intersect with partisan affiliations and with news media discourse surrounding the pandemic more broadly (Pettinicchio et al., 2021), the distinctions they highlight, and the emotions they extract, carry very real consequences for redistributive social policies.

To the extent that these boundaries prevent policy intervention and raise distrust among and between individuals and groups, they function as a casual pathway through which existing inequalities and patterns of social stratification are reproduced or exacerbated (Lamont et al., 2014). For example, suspicion circling around the distribution of CERB may create obstacles for future political efforts to enact Universal Basic Income. Although our data cannot comment on the precise nature of respondents’ moral inclinations or sense-making strategies prior to the pandemic, their repeated appeals towards pandemic-specific interventions, including those related to stay-at-home orders and social distancing measures, can tell us a great deal about how boundaries adapt to and are made more salient by broad social changes and exogenous shocks. Here, respondents contrasted their own health status and relative vulnerability against others who lacked the sense to comply with government orders, sharpening existing distinctions between themselves and others. These individuals and groups were morally suspect and, for many respondents, plainly ‘stupid’.

Although the coronavirus pandemic is an extraordinary case, its lessons are not. The pandemic and the sense-making strategies around social interaction, culture and public policy shed a great deal of light on attitudinal and governmental responses during periods of social and economic crisis. More recently, heated debates emerged around the vaccination status of individuals and groups, and the government’s role in mandating vaccinations. ‘Freedom’ protesters who assembled in Canada’s capital, for example, pushed back on government mandates aside ‘a wide array of antigovernment grievances’ increasing frustration among many Canadians (Austin and Isai, 2022). Commenting on what are seemingly growing divisions among the public, former Supreme Court Justice Beverley McLachlin (2022) added that, ‘the unconstrained right to do what you want free of government limits, serves as a cloak for actions that harm women, men and children who are simply going about their business and trying to do the *right* thing’ (emphasis added). Together, they highlight the need for continued investigation into a contested moral territory etched by resentment and blame lobbied against and by policy makers and the broader public too.

Moving forward, future research should continue to explore how periods of crisis are seen and understood by the public and evaluate the obstacles and opportunities these understandings present. This research should, as we have done, pay careful attention to stigmatized and marginalized people – like people with disabilities and chronic health conditions – who are often side-stepped by the policy-making process and who remain among the heaviest hit by public health crises and economic shocks (Maroto and Pettinicchio, 2022; Maroto et al., 2021). The distinctions they draw between themselves and others can tell us a great deal about the production and maintenance of inequality and the relationship between symbolic boundaries, public attitudes and public policy more broadly. This is especially true now as restrictions lift, and people with disabilities and chronic health conditions are asked to bear the weight of the pandemic's aftermath in a return to 'normal'.

Funding

The authors disclosed receipt of the following financial support for the research, authorship and/or publication of this article: data collection for this project was funded in part by a Social Science and Humanities Research Council of Canada Insight Grant, Ottawa, Ontario, Canada (#435-2015-0382) as well as an Ontario Ministry of Research and Innovation Early Researcher Award Grant, Toronto, Ontario, Canada (#502347).

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Supplemental material

Supplemental material for this article is available online.

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Date submitted March 2022

Date accepted August 2022