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(Mis)communicating about COVID-19: Insights from Health and Crisis Communication

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ABSTRACT

The COVID-19 pandemic has posed unprecedented challenges for the United States and the world. In this article, we discuss several communication challenges that have arisen during the pandemic, with insights from the fields of health and crisis communication. We focus in particular on the lack of clarity in the US response in terms of both what behaviors we are trying to change and how we are communicating about behavior change. While the mixed messages and contradictions have hampered the US response thus far, it is our hope that we will do better going forward. This will require state and local health departments, public health organizations, and all of us to increasingly apply our field's best practices to help calm fears, change behavior, and ultimately reduce suffering and save lives.

On March 11, 2020, the World Health Organization formally declared the novel coronavirus crisis a pandemic. Despite early warnings from other countries and our own infectious disease experts, the U.S. failed to produce a comprehensive and lasting response commensurate with the level of the threat posed by this virus. As of this writing, the U.S. has surpassed 7.5 million coronavirus cases and 210,000 deaths from COVID-19.

While the pandemic poses unprecedented challenges for health and crisis communication, we have decades of research and on-the-ground experience to guide the way. In this article, we discuss several communication challenges that have arisen during this pandemic, with insights that can directly inform effective communication about COVID-19 going forward. It is our hope that our state and local health departments, public health organizations, and all of us will increasingly apply our field's best practices to help calm fears, change behavior, and ultimately reduce suffering and save lives.

Clarity of message: What are we asking the public to do?

Given that few treatments exist for COVID-19, and no vaccine is yet available, behavior change is crucial. And yet our messaging will be ineffective if we are not clear what behaviors we want to change in the first place. That is, effective communication demands clarity on *what* behaviors we are trying to change (Fishbein & Ajzen, 2010) coupled with clear and understandable messages to the public about those behaviors (Covello, 2003). To date, the U.S. has largely failed on these fronts.

Early in the pandemic (March–April 2020), 42 states and Washington, D.C. put in place stay-at-home orders in attempts to “flatten the curve” and avoid overwhelming the healthcare system with COVID-19 hospitalizations (see Table 1). This was the phase of the U.S. response that had perhaps the most clarity, with a relatively simple and straightforward message: stay at

home, with exceptions only for critical activities, such as shopping for groceries. In addition, cities often had detailed lists of what activities were allowable, and in some places, had enforcement behind them. We know from prior work that campaigns with enforcement (such as seat belt campaigns) are more effective than campaigns without enforcement (Snyder et al., 2004).

This is not to say that communication about stay-at-home orders was as clear as it could have been. During this period, several terms were used interchangeably, such as “stay-at-home,” “shelter-in-place,” “self-isolation,” and “social distancing,” potentially causing confusion. In addition, we failed to communicate about how to make sanctioned activities as safe as possible, such as what precautions to take when visiting a grocery store. While this early period of the U.S. pandemic was characterized by uncertainty, confusion, and fear, it also seems to have been the most effective. Indeed, evidence suggests that these stay-at-home orders reduced novel coronavirus infections (Castillo et al., 2020).

Mixed messages: What now and what next?

Once these brief “stay at home” periods ended, things became much more complex, and there was a failure to replace a relatively simple message (i.e., “stay at home”) with clear and consistent messaging about behaviors to prevent the spread of the virus. For instance, the U.S. could have launched a national campaign focused on key behaviors that the public should engage in to prevent the spread of the novel coronavirus, as was done with HIV/AIDS (Ratzan et al., 1994). A well-crafted national message had the potential to build unity around the goal of defeating the virus through behavior change, preferably with clear, unambiguous recommendations of what actions to take. Unfortunately, no such federal effort was undertaken, which amounted to a missed opportunity to galvanize public will to prevent the spread of the virus. Interestingly, in the U.K., a national campaign *was* implemented, but the key message (“Stay Alert, Control the Virus, Save

Table 1. Timeline of Selected Milestones in the Novel Coronavirus Pandemic in the US, January – October 2020.

Date	Event	Confirmed US cases
January 21	First travel-related case in US confirmed in Washington State by CDC	1
January 29	President Trump announces formation of White House Coronavirus Task Force	
January 30	WHO declares global health emergency	
February 3	US declares public health emergency	
February 3	-	>10
March 1	First confirmed case in NY State	
March 5	-	>100
March 6	President Trump signs 8.3 billion dollar emergency funding bill to fight novel coronavirus	
March 11	-	>1,000
March 11	WHO declares the novel coronavirus crisis a pandemic	
March 13	President Trump declares novel coronavirus a national emergency	
March 18	-	>10,000
March 19	California becomes first state to issue a stay-at-home order	
March 21–27	22 more states issue stay-at-home orders	
March 27	President Trump signs the CARES act to address the economic fallout from the pandemic	
March 27	-	>100,000
April 3	CDC recommends everyone wear face masks in public, reversing prior stance on masks	
April 7	46 states and Washington DC issue state-at-home orders since 3/19	
May 24	New York Times publishes front page story with names of the dead to commemorate nearly 100,000 deaths from COVID-19	
April 29	-	>1,000,000
June 30	US cases hover around 40,000 per day; Dr. Anthony Fauci testifies before congress that cases could hit 100,000 per day given current trajectory	
August 9	-	>5,000,000
September 22	On the first day of fall, the US surpasses 200,000 deaths from COVID-19	
October 2	President Trump announces that he and first lady Melania Trump have tested positive for the novel coronavirus; the president is taken to Walter Reed Medical Center	
October 5	President Trump is discharged from Walter Reed Medical Center and returns to the White House	
October 7	-	>7,500,000

Note. WHO = World Health Organization; CDC = Centers for Disease Control and Prevention.

Sources. <https://www.brookings.edu/research/the-federal-governments-coronavirus-actions-and-failures-timeline-and-themes/>

<https://www.who.int/news-room/detail/29-06-2020-covid19-timeline>

<https://www.kff.org/other/slide/when-state-stay-at-home-orders-due-to-coronavirus-went-into-effect/>

<https://www.ajmc.com/view/a-timeline-of-covid19-developments-in-2020>

<https://abcnews.go.com/Health/live-updates/coronavirus/?id=73467884%2373468138>

<https://www.cidrap.umn.edu/news-perspective/2020/09/us-covid-19-deaths-top-200000-mark>

<https://www.forbes.com/sites/rachelsandler/2020/10/07/the-complete-trump-covid-19-timeline-what-we-know-about-the-presidents-diagnosis-and-what-we-dont-#3086f8ae1e29>

Lives”) was vague and seemed to lack the clarity needed to enable public understanding.

As the pandemic continued, the behaviors most effective in preventing COVID-19 became clearer as scientists better understood the nature of how the virus spread. While frequent handwashing was a fairly standard behavior that the public was already familiar with, communication around the novel behaviors key to preventing viral spread – physical distancing and masks – was unfortunately full of mixed messages and contradictions.

Physical distancing

As described above, physical or social distancing was implemented early in the pandemic in the form of stay-at-home orders to prevent the spread of the novel coronavirus. Due to economic pressure from various quarters, however, many states began to accelerate “re-opening” phases even as some public health officials warned of potential negative or even dire consequences. As states began to re-open, two dominant messages in the public domain were diametrically opposed: a health message (i.e., continue to stay at home as much as possible to avoid contracting or spreading the virus) versus an economic message (i.e., begin returning to normal economic activity to re-start the economy).

The fact that the pandemic unfolded in an election year – a year in which the economy always looms large – appears to

have led the incumbent party in the White House (i.e., Republicans) to downplay the severity of novel coronavirus in hopes of reviving the economy. The President himself heavily criticized several states’ stay-at-home orders (Table 2). Despite contrary predictions from infectious disease experts, the President stated several times that the virus would simply “disappear,” and he emphasized “treatments” that lacked robust scientific evidence, such as the use of hydroxychloroquine. In addition to his words, the actions of the president and his administration sent the wrong message about physical distancing. For instance, the President and key advisors continued to hold public meetings without physical distancing in March, and in June, the President held a large reelection rally in Tulsa, OK, with no requirements for physical distancing. These words and actions downplayed the severity of the pandemic and politicized it in ways that communicated – especially to the President’s followers – that they should not take COVID-19 or recommendations to physically distance seriously.

Masks and facial coverings

While the wearing of masks or other facial coverings is another behavior that is key to preventing the spread of the novel coronavirus (Hendrix et al., 2020), the U.S. Surgeon General strongly discouraged mask use early in the pandemic (see Table 2). In fact, even nonpolitical health officials, such as

Table 2. Examples of Mixed Messages from the US Government during the COVID-19 Pandemic.

Physical Distancing and Stay-at-Home Orders	
Against/Ambivalent	For
<p>"LIBERATE MICHIGAN!" "LIBERATE MINNESOTA!" "LIBERATE VIRGINIA..." <i>President Trump, Twitter, April 17, 2020</i> (while states were under governor-sponsored stay-at-home orders)</p> <p>"Well, I think we do have a sobering guidance, but I think some things are too tough. And if you look at some of the states you just mentioned, it's too tough..." <i>President Trump, Press Conference, April 17, 2020</i></p> <p>"I think elements of what they've done are too much. I mean, it's just too much." <i>President Trump, Press Conference, April 17, 2020</i></p>	<p>"Everyone has a role to play to reduce & slow transmission of #COVID19. Physical or social distancing is one way to prevent the spread of COVID-19. This means avoiding crowded places and maintaining distance from others. More prevention tips: https://bit.ly/2QbLFkW." #StayAtHome <i>CDC, Twitter, March 21, 2020</i></p> <p>"My advice to America is that these guidelines are a national stay at home order. If we really do our part - stay at home, social distance, then we can flatten our curve even below those projections, but it really depends on all of us." <i>U.S. Surgeon General, Today Show, April 1, 2020</i></p>
Masks and Facial Coverings	
Against/Ambivalent	For
<p>"Seriously people- STOP BUYING MASKS! They are NOT effective in preventing general public from catching #Coronavirus..." <i>U.S. Surgeon General, Tweet, Feb. 29, 2020</i></p> <p>"Early am flight. No one with masks (they aren't recommended for general public) but noticed several people using antibacterial wipes on seats (I do this too). I'm not worried about #COVID19 - I'm worried about #flu, & the guy reclining all the way back into me before takeoff." <i>U.S. Surgeon General, Tweet, March 6, 2020</i></p> <p>"...the CDC is advising the use of non-medical cloth face covering as an additional voluntary public health measure. So it's voluntary; you don't have to do it. They suggested for a period of time. But this is voluntary. I don't think I'm going to be doing it." <i>President Trump, Press Conference, April 3, 2020</i></p>	<p>"In light of new evidence, CDC recommends wearing cloth face coverings to slow spread of #COVID19 in public settings where other social distancing measures are difficult to maintain (e.g., grocery stores, pharmacies, etc) especially in areas of significant community-based transmission" <i>CDC, Twitter, April 3, 2020</i></p> <p>"I have no problem with the masks. I view it this way: Anything that potentially can help, and that certainly can potentially help, is a good thing. I have no problem. I carry it. I wear it. You saw me wearing it a number of times, and I'll continue." <i>President Trump, Press Conference, July 21, 2020</i></p>

Dr. Anthony Fauci, did not recommend widespread use of masks, primarily because of shortage concerns for health care workers. However, as supplies improved and scientific evidence increasingly pointed to the efficacy of masks (Chu et al., 2020), this advice changed. On April 3, 2020, the CDC began recommending the use of cloth face masks in public settings where physical distancing was hard to maintain.

While much of the public has followed this public health advice to wear masks, unfortunately, this behavior was heavily politicized, and perhaps for that reason, the use of masks has been met with resistance in some quarters. The President has continually called the wearing of masks "voluntary," even as his own CDC recommended their widespread use (Table 2). For a period of time, the President refused to wear a mask in public at all, and Vice President Mike Pence refused to wear a mask in a high-profile visit to the Mayo clinic on April 29, 2020, despite the Mayo Clinic's mask requirement policy. Sadly, this politicization of masks turned a simple public health measure into a political statement, likely reducing adherence among segments of the public.

Motivating the public to change behavior

To effectively promote key COVID-19 preventive behaviors (i.e., wash hands, physically distance, wear a mask), we need to communicate with the public not only *what* to do but also *why*, and to communicate clearly, consistently, repeatedly (i.e., high exposure), and with credible, nonpolitical sources (Covello, 2003; Noar, 2006). Insights into *why* people might or might not engage in these behaviors can be informed by behavioral theories (Fishbein & Ajzen, 2010; Noar & Zimmerman, 2005). Undertaking studies to quickly understand beliefs about preventive behaviors,

especially in populations that are most vulnerable or less likely to be engaging in such behaviors, is critical. For instance, what beliefs about mask-wearing best predict behavior (e.g., self-protection, protection for vulnerable others, etc.)? Such beliefs can provide a basis for messages promoting mask-wearing. Similarly, what barriers about mask-wearing most predict behavior (e.g., the way they look, access or availability, political beliefs, etc.)? Such barriers can also be addressed in messaging.

Crisis communication in infectious disease suggests that the perceived predictability, controllability, and responsibility for infectious disease threats impact public response to these risks (Jin et al., 2020). Related to this, another useful perspective is the Extended Parallel Process Model (Witte, 1992). Much of the public perceives a clear threat: a novel virus they could themselves catch (perceived susceptibility) and that could sicken or even kill them (perceived severity). Unfortunately, early coverage of COVID-19 reported that the disease was not impacting young people significantly, while in reality, young people are at risk and can spread the virus to older and more vulnerable populations, an important message younger populations need to hear.

Additionally, early on COVID-19 was compared to flu and colds in terms of symptoms and impact – a comparison that likely led many to downplay perceived severity and made the disease seem more predictable and controllable. Once people view COVID-19 as a threat (as many already do), self-efficacy can be boosted by clear communication about the behaviors that can mitigate the threat. We can also build response efficacy by emphasizing that these behaviors do indeed reduce transmission and keep one (and others) from getting sick. Indeed, research has demonstrated that efficacy is strongly linked to behavior, including in the context of outbreaks (Avery & Park, 2016).

Finally, norms perspectives suggest that behavior change may beget behavior change (Cialdini et al., 1990). That is, while the widespread wearing of masks may have seemed unfathomable a short time ago, it is now increasingly a part of public life. As more people wear masks, the normative pressure for others to do so will increase, reflecting rapidly changing injunctive norms. In addition, people's perceptions of descriptive norms (e.g., that wearing a mask is simply 'what you do' when you go out) affect behavior. Thus, as more people change their behavior, especially public behaviors such as mask-wearing, the more norms will change, driving further changes in behavior.

Concluding thoughts

While thus far the US has failed to follow many of the best practices in health and crisis communication, we still have a significant opportunity to slow the spread of the novel coronavirus and save many lives by applying effective communication. But how can this be achieved? While a unified, national campaign would have been ideal for setting the communication agenda for the country, in the absence of this, state and local officials, public health organizations, and other entities such as colleges and universities can and must fill the communication void.

First, entities such as state and local health departments can and should communicate with the public about both what behaviors the public should engage in and why, emphasizing benefits that target populations themselves value. These behaviors are what many have come to refer to as the three W's – wash your hands, watch your distance, and wear a mask. The use of credible, nonpolitical sources and spokespeople in such messaging is critical for impact (Boynton, O'Hara, Tennen, & Lee, 2020; Jin et al., 2019). Given the politicization of prevention measures such as masks, messages should emphasize the fact that the virus does not discriminate and can spread to anyone, and that the only way to end this pandemic is if we all do our part. Indeed, even after vaccines begin to be distributed, it is likely that widespread engagement in preventive behaviors will still be important to reducing the spread of the virus for some period of time.

Second, targeted messages are needed for special populations. While older populations and those with underlying health conditions may be most motivated by self-protection, younger populations may be more motivated by other considerations, and this should be reflected in messaging to those populations. For instance, young adults may be more motivated by the fear of spreading the virus to more vulnerable others (e.g., parents), or the concern that their college campus will be shut down if the virus spreads. Indeed, as many college campuses re-opened in August and September of 2020, they became a major driver of new infections nationally (Walke et al., 2020), and some campuses had to reverse re-openings and send students home. Reaching young people with effective messaging will be crucial to keeping the number of new infections in check, and college and universities thus have a responsibility to invest in effective prevention and communication efforts, as well as enforcement when the rules are broken.

Finally, as the pandemic continues for months and potentially years, novel public health and communication

strategies will be needed to balance prevention behaviors with mental health considerations and the human need for social connection (Block et al., 2020). One approach that appears to be gaining traction is the use of social pods, also called social bubbles or "quaranteams," where individuals or households agree to become a "pod" with a limited number of other individuals or households. After quarantining for 14 days and setting ground rules, the individuals or households can spend time together without the use of masks and social distancing, but those measures must be strictly applied when outside of the pod. This approach could be used among many different populations, including families and college students, and it is one that balances transmission risks with the need for social interaction and connection. Efforts are needed, however, to communicate with the public about what social pods are, how to create one, and how to negotiate the various aspects of a social pod in order to enjoy the benefits while also reducing transmission risks.

References

- Avery, E., & Park, S. (2016). Effects of crisis efficacy on intentions to follow directives during crisis. *Journal of Public Relations Research*, 28(2), 72–86. <https://doi.org/10.1080/1062726X.2016.1165681>
- Block, P., Hoffman, M., Raabe, I. J., Dowd, J. B., Rahal, C., Kashyap, R., & Mills, M. C. (2020). Social network-based distancing strategies to flatten the COVID-19 curve in a post-lockdown world. *Nature Human Behaviour*, 4(6), 588–596. <https://doi.org/10.1038/s41562-020-0898-6>
- Boynton, M. H., O'Hara, R. E., Tennen, H., & Lee, J. G. L. (2020). The impact of public health organization and political figure message sources on reactions to coronavirus prevention messages. *American Journal of Preventive Medicine*. <https://doi.org/10.1016/j.amepre.2020.08.001>
- Castillo, R. C., Staguhn, E. D., & Weston-Farber, E. (2020). The effect of state-level stay-at-home orders on COVID-19 infection rates. *American Journal of Infection Control*, 48(8), 958–960. <https://doi.org/10.1016/j.ajic.2020.05.017>
- Chu, D. K., Akl, E. A., Duda, S., Solo, K., Yaacoub, S., Schünemann, H. J., Schünemann, H. J., Chu, D. K., Akl, E. A., El-harakeh, A., Bognanni, A., Lotfi, T., Loeb, M., Hajizadeh, A., Bak, A., Izcovich, A., Cuello-Garcia, C. A., Chen, C., Harris, D. J., Borowiack, E., ... Schünemann, H. J. (2020). Physical distancing, face masks, and eye protection to prevent person-to-person transmission of SARS-CoV-2 and COVID-19: A systematic review and meta-analysis. *The Lancet*, 395(10242), 1973–1987. [https://doi.org/10.1016/S0140-6736\(20\)31142-9](https://doi.org/10.1016/S0140-6736(20)31142-9)
- Cialdini, R. B., Reno, R. R., & Kallgren, C. A. (1990). A focus theory of normative conduct: Recycling the concept of norms to reduce littering in public places. *Journal of Personality and Social Psychology*, 58(6), 1015–1026. <https://doi.org/10.1037/0022-3514.58.6.1015>
- Covello, V. T. (2003). Best practices in public health risk and crisis communication. *Journal of Health Communication*, 8(sup1), 5–8. <https://doi.org/10.1080/713851971>
- Fishbein, M., & Ajzen, I. (2010). *Predicting and changing behavior*. The reasoned action approach: Taylor & Francis.
- Hendrix, M. J., Walde, C., Findley, K., & Trotman, R. (2020). Absence of apparent transmission of SARS-CoV-2 from two stylists after exposure at a hair salon with a universal face covering policy — Springfield, Missouri, May 2020. *Morbidity and Mortality Weekly Report*, 69(28), 930–932. <https://doi.org/10.15585/mmwr.mm6928e2>
- Jin, Y., Austin, L., Vijaykumar, S., Jun, H., & Nowak, G. (2019). Communicating about infectious disease threats: Insights from public health information officers. *Public Relations Review*, 45(1), 167–177. <https://doi.org/10.1016/j.pubrev.2018.12.003>
- Jin, Y., Iles, I., Austin, L., Liu, B., & Hancock, G. (2020). The Infectious Disease Threat (IDT) Appraisal Model: How perceptions of IDT 310

- predictability and controllability predict individuals' responses to risks. *International Journal of Strategic Communication*, 1–26. <https://doi.org/10.1080/1553118X.2020.1801691>
- Noar, S. M. (2006). A 10-year retrospective of research in health mass media campaigns: Where do we go from here? *Journal of Health Communication*, 11(1), 21–42. <https://doi.org/10.1080/10810730500461059>
- Noar, S. M., & Zimmerman, R. S. (2005). Health behavior theory and cumulative knowledge regarding health behaviors: Are we moving in the right direction? *Health Education Research*, 20(3), 275–290. <https://doi.org/10.1093/her/cyg113>
- Ratzan, S. C., Payne, J. G., & Massett, H. A. (1994). Effective health message design: The America responds to AIDS campaign. *American Behavioral Scientist*, 38(2), 294–309. <https://doi.org/10.1177/0002764294038002010>
- Snyder, L. B., Hamilton, M. A., Mitchell, E. W., Kiwanuka-Tondo, J., Fleming-Milici, F., & Proctor, D. (2004). A meta-analysis of the effect of mediated health communication campaigns on behavior change in the United States. *Journal of Health Communication*, 9(Suppl 1), 71–96. <https://doi.org/10.1080/10810730490271548>
- Walke, H. T., Honein, M. A., & Redfield, R. R. (2020). Preventing and responding to COVID-19 on college campuses. *JAMA*. <https://doi.org/10.1001/jama.2020.20027>
- Witte, K. (1992). Putting the fear back into fear appeals: The extended parallel process model. *Communication Monographs*, 59(4), 329–349. <https://doi.org/10.1080/03637759209376276>