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"I just can't go back": Challenging Places for Older Americans since the COVID-19 Pandemic Onset

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Abstract

During the pandemic, many older adults felt 'out of place' in their home, work, and community spaces with potentially long-term consequences for health and wellbeing. Using national data from the COVID-19 Coping Study, thematic analysis of online long-answer responses (n = 1171; mean age 68 years; 71% female; 93% non-Hispanic White; 86% with at least a 4-year college degree; data collected April–June 2022) identified four themes regarding *why* particular places are challenging since the pandemic onset: (1) viral exposure fears, (2) frustrating regulations, (3)

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Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

CRediT authorship contribution statement

Jessica Finlay: Conceptualization, Data curation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Supervision, Validation, Visualization, Writing – original draft, Writing – review & editing. **Viveka Guzman:** Formal analysis, Methodology, Validation, Visualization, Writing – original draft, Writing – review & editing. **Gabriella Meltzer:** Formal analysis, Methodology, Validation, Visualization, Writing – original draft, Writing – review & editing. **Brendan O'Shea:** Data curation, Formal analysis, Methodology, Validation, Visualization, Writing – original draft, Writing – review & editing. **Jarmin Yeh:** Formal analysis, Methodology, Validation, Visualization, Writing – original draft, Writing – review & editing.

Appendix A. Supplementary data

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uncomfortable and hostile social dynamics, and (4) 'out of place' negative emotions. Participants also shared *how* they continuously address or adapt to place-based challenges through lifestyle adjustments and coping strategies. Novel findings may inform multi-scalar policymaking and interventions to support wellbeing in later life in times of stress and instability.

Keywords

Geographical gerontology; Aging in place; COVID-19 pandemic; Qualitative

1. Introduction

The COVID-19 pandemic upended routines and transformed civic life. Services and amenities temporarily or permanently closed or operated under tight restrictions. Public health guidelines recommended avoiding crowded places, isolating at home, and transitioning to online services. In addition to being at increased risk for morbidity and mortality from COVID-19, older adults experienced secondary adverse impacts due to closures and reduced access to places and resources that facilitate their physical, mental, and social health and wellbeing (Douglas, Srinivasa, Martin, McKee, & McCartney, 2020; Lee et al., 2021; MacLeod et al., 2021; Guzman, Doyle, et al., 2023; (Finlay, Meltzer, Cannon, & Kobayashi, 2022)). This included sedentary behaviors, poor diet, and sleep quality; mismanagement of chronic conditions due to delayed provision of care; reduced cognitive stimulation; and heightened social isolation (Cannon et al., 2023; (Finlay, Eastman, & Kobayashi, 2023; Kobayashi, O'Shea, Joseph, & Finlay, 2022) Hayden et al., 2023; Teramura, Kimura, Hamada, Ishimoto, & Kawamori, 2022; Morgan et al., 2023; Na, 2022).

Little is known about everyday pandemic impacts on aging in place (the ability to live in one's home and community safely, independently, and comfortably, regardless of age, income, or ability level [Centers for Disease Control and Prevention, 2009]). Where do older adults feel safe and comfortable, versus struggling, in shared spaces since the pandemic onset? Our study focuses at a basic level on *place engagement*: experiences and emotions anchored in first, second, and third places (home, work, and community gathering sites [Oldenburg, 1999; Bornioli, Parkhurst, & Morgan, 2018]). Place engagement involves intertwining two situation-specific elements: *personal place identification* and the *identity of places* (Supplementary Fig. 1). Personal place identification captures the way in which we uniquely experience and react to environments shaped by a multitude of factors including physical capacity, life history, worldview, and personality (Rowles, 2018). For example, individuals may react and engage differently to a local shop displaying a flag in support of the queer community, or a public park with a loud and busy children's playground. The identity of places captures how environments are designed, inhabited, and modified over time (Finlay & Rowles, 2021). For example, a public park with a war memorial statue has cultural meanings and identities that are independent and transcendent of individuals. Over time, positive place engagement experiences and emotions can facilitate *place attachment:* rich cognitive and affective ties to particular places through a sense of 'insideness' (Rowles, 1983), notions of feeling 'at home' (Finlay, Gaugler, & Kane, 2018), and person-place fit (Weil, 2020). This generates 'being in place': a sense of belonging, involvement, purpose,

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and meaningful connection in an environment (Relph, 1976; Hayden, 1995). However, this experience is always precarious and in flux. Negative experiences, such as shifting personal place identification or the identity of a place, can lead to feeling 'out of place' (Guzman, Foley, Doyle, & Pertl, 2023). This can result in discomfort, alienation, hostility, and isolation (Relph, 1976; Finlay & Rowles, 2021). While there is abundant literature on varying abilities to form place attachments and a sense of 'being in place', much less attention is paid to potential losses of place attachment–particularly at the widespread and rapid time scale of a global pandemic.

The COVID-19 pandemic posed new challenges to 'being in place' and place attachment by altering place engagement experiences. Older adults may have felt 'out of place' in familiar first, second, and third places. Personal place identifications (reactions to places) may have shifted, as well as dramatic and rapid changes in the identity of places given new physical health risks and social tensions. However, limited studies to date have explored these dynamics among older adults beyond the acute phase of the pandemic, nor examined how potential societal shifts in place attachment and the ability to 'be in place' may not be experienced uniformly by everyone in this age bracket. This study analyzes rich national data on challenging places since the pandemic onset to investigate how older adults are experiencing, perceiving, and (re) negotiating their place attachments and where they feel 'in' versus 'out' of place. Novel findings deepen theorizations of place attachment and inform multi-scalar interventions to support individual and collective wellbeing among older adults during times of societal tension, stress, and physical and social isolation.

2. Materials and methods

We analyzed qualitative data from 1171 participants of the COVID-19 Coping Study, a national longitudinal cohort study of aging adults living in the US. Study design and data collection are described in Finlay et al. (2023), Kobayashi et al. (2021), and Appendix A. The University of Michigan Institutional Review Board approved the study protocol (HUM00179632), and all participants provided informed consent.

Given the large sample size, we utilized a 'Big Qual' (Brower et al., 2019) approach to qualitative inquiry that was guided and shaped by postpositivism (Creswell, 2007; Denzin, 2008). Postpositivism is a qualitative paradigm that is often "at work among individuals with prior quantitative research training, and in fields such as the health sciences" (Creswell, 2007, p. 20). This approach "view [s] inquiry as a series of logically related steps, believe [s] in multiple perspectives from participants rather than a single reality, and espouse[s] rigorous methods of qualitative data collection and analysis" (Creswell, 2007, p. 20). Importantly, under postpositivism, findings are viewed as contextually related and could be inductively applied with reference to similar cases that hold elsewhere (Clark, 2002; Creswell, 2007). This aligns with Guba and Lincoln's (1982) naturalistic inquiry of trustworthiness wherein the interpretation of findings that are drawn from "multiple, intangible realities" (p. 237) should be evaluated following four criteria: credibility, transferability, dependability, and confirmability (see section 2.1 Thematic analysis). Creswell (2007) also believes Lincoln and Guba's criteria of trustworthiness should be employed when evaluating qualitative research (Cohen & Crabtree, 2006). A

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postpositivist paradigm is in contrast to a positivist paradigm, which aligns with rationalistic inquiry; assumes a single, tangible reality; and advocates for immutable law and universal generalizability to all cases and in all situations (Clark, 2002; Denzin, 2008; Guba & Lincoln, 1982).

The COVID-19 Coping Study used online mixed-methods surveys that asked participants a combination of closed and open-ended questions to probe their ongoing experiences, perspectives, significant life events, and health statuses. This manuscript analyzes open-ended, journal-style responses to a long-answer question fielded April to June 2022: "*Since the start of the coronavirus pandemic in March 2020, is there a place that you have particularly found challenging to spend time in? If so, where is this place and what are your experiences and thoughts about it?*' This question was designed to be *fully* qualitative to capture rich and complex accounts: participants' subjective experiences, narratives, practices, and positionings (Braun et al., 2021; Terry & Braun, 2017). While participants described their place engagements (semantic descriptions of challenging experiences and emotions in *their* language and terminology), we anticipated analyzing the data for higher-level latent meanings of place attachment and struggles to 'being in place'.

Most participants provided lengthy responses (approximately 100–300 words) narrating their personal perspectives and experiences. Responses ranged from short phrases to multi-sentence and even multi-paragraph written answers. Overall, the majority of participants provided valuable accounts of their experiences and perspectives since the pandemic onset. The high level of felt anonymity (Terry & Braun, 2017) may have boosted their willingness to share sensitive experiences and intimate thoughts. When viewed in their entirety, the data were rich and highly varying, even if individual responses might themselves be brief.

2.1. Thematic analysis

All data were organized in the software package Dedoose. We used thematic analysis (Braun & Clarke, 2021; Weil, 2017; Appendix A) as a flexible and inductive qualitative approach to investigate our research question: *Why are places challenging for older adults since the pandemic onset?* First, all authors read the data to become familiar with the content. We recorded analytical notes to share and discuss as a team. Second, we generated preliminary codes and conducted initial coding to capture semantic to latent meanings and to generate our flexible codebook. All authors met regularly to compare interpretations and points of divergence to refine, clarify, and collate codes. We independently coded sub-samples of responses to check for consistency in meaning and application of the codebook and identify differing interpretations. We iteratively refined the codebook, test coded it, and met to review and discuss. After finalizing the codebook, all authors coded a data subsection, and reviewed each other's coding to ensure completeness and accuracy. Third, all authors met to identify shared patterns of meaning across the dataset. We compiled clusters of codes into initial themes that provided meaningful insights into our research question. Fourth, all authors checked themes in relation to both the coded extracts and full dataset to ensure themes highlighted important patterns across the dataset in relation to our research question. Fifth, we ensured that each theme was distinct, clearly demarcated, and built and named around a strong core concept. Sixth, all authors wrote up results to share the analytical

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narrative with compelling and illustrative data abstracts. Quotes were lightly edited for readability while retaining their original meaning (i.e., fixed typos).

Methodological rigor was pursued through four techniques to establish trustworthiness (Guba & Lincoln, 1982; Lincoln & Egon, 1985). First, credibility was enhanced through a team approach, peer debriefing, and negative case analysis. For peer debriefing, the authors consulted with colleagues who had no personal interest in the project to enhance our validity. For negative case analysis, we identified, discussed, and incorporated outliers and contradictions. Second, transferability was established through author reflexive journaling and discussion notes through each phase of analysis to inform our understanding and interpretation of the data. Third, dependability was enhanced through inquiry audits by consulting with and discussing our study with colleagues outside the data collection and analysis to examine the processes of data collection, analysis, and results. Qualified, impartial colleagues and mentors independently reviewed and assessed de-identified participant responses, our methodology, and findings. Fourth, confirmability was sought through clear audit trails. We maintained a transparent description of research steps taken from the start of the research project through each phase of development to write up. This included organized raw data files, journal and analytical notes through each phase, versions of codebooks with detailed notes and decisions made, test coding results and discussion notes, and multiple manuscript versions with tracked changes.

3. Results

Participants were on average 68 years old, and 71% identified as female (Table 1). The majority were non-Hispanic White (93%), lived with others (72%), highly educated (86% with at least a Bachelor's degree), and were retired (66%).

We identified four themes regarding *why* particular places were challenging since the pandemic onset. Participants also shared *how* they addressed or adjusted to pandemic place-based challenges in attempts to meet their needs and maintain quality of life (Fig. 1). Additionally, nearly 20% of participants did not find any places challenging and were coded as "not really", "nowhere", and "no" (n = 228).

3.1. Fearful of viral exposure

The majority of participants found places where they feared catching COVID-19 to be challenging. These places were characterized by limited enforcement or adherence to evidence-based precautions to protect against viral transmission.

3.1.1. Risky places—Participants described places where challenges emerged due to a lack of public health adherence combined with the nature of the place itself, leading them to feel at risk of infection.

3.1.1.1. Crowded.: Instances of risky places comprised inherently crowded places that challenged participants' ability to maintain distance from others, particularly on public transportation. Lisa (57F) in urban Massachusetts expressed: "I hate taking public transportation. I pretty much hate being forced to be close to people anywhere, but it's

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particularly bad when you can't get away from people." Participants felt similarly about air travel on crowded and tight airplanes.

Several participants commented that they no longer felt safe attending sports and entertainment venues. Karen (57F) in New York felt that theaters were especially challenging:

> There is no way I am getting out of there without getting sick. [Theaters] are hundred plus years old, tiny, crowded and I have to ride [the] subway to get to them. I was double vax'd when I got covid and it derailed me. I can't afford to get it again.

Religious services, especially around holidays, could be challenging. For Barbara (73F), who has seven chronic health conditions:

> Church is problematic for me. I didn't return to live services for almost 18 months but when I did, I was amazed by how few people were there and it was easy to stay 6 feet away from others. Then came Christmas Eve and I was shoulder to shoulder with a mostly unmasked crowd. Now I am back to staying home.

3.1.1.2. Required close contact.: An additional illustration of risky places were environments that required close interpersonal contact and inhibited participants' ability to distance themselves from others. Michael (60M) delayed receiving medical care from his optometrist and doctor for two years, while James (78M) and Kimberly (56F) found the barber shop and nail salons respectively to be challenging. Some participants' workplaces were risky because they necessitated close contact with clientele. Debra (65F), a therapist with two chronic health conditions, wrote: "Since I share [my office] with others, it hasn't felt safe to be there without a mask, but that impedes my seeing my clients, so it's better on Zoom." Carol (78F), a retiree, explained:

> Since returning to airport travelers assistance volunteer work, I find the work and the setting is more challenging because I am in contact with a lot of people … I am less likely to spend a lot of time on one particular person's travel problems because it may prolong contact with someone. So my contacts and the kinds of help I give are, I feel, more superficial than in the past.

3.1.1.3. Presence of germs.: Participants described places 'teeming with germs' or with signs of illness from other patrons as risky. Sandra (77F), who was recently diagnosed with type 2 diabetes, wrote: "I have done some medical appointments via video but that's not always possible. Twice, when visiting 'immediate care' clinics, there have been people in the same waiting room who are obviously sick." She felt uncomfortable taking her husband to the emergency room for a pulmonary embolism. Immunocompromised participants often found indoor recreation facilities to be risky due to the potential spread of germs. Robert (72M) wrote: "The thought of going inside a gym with lots of people breathing heavily and sweating is not something I can see myself doing again." Participants also commented on the presence of germs at stores. Cynthia (57F) wrote that "the cleanliness of shopping carts is iffy." Pamela (62F) found department stores to be challenging "because people still do stupid things like coughing and sneezing without covering their mouths or using their

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sleeves." Brenda (61F) wrote about her experiences in grocery stores: "Never noticed how swine-like people were in the produce sections. There should be a new life pro tip - quit manhandling food you're not buying."

3.1.1.4. Enclosed.: Indoor spaces felt risky given evidence of reduced COVID-19 transmission in outdoor or well-ventilated venues. Tammy (58F) wrote: "Spending time at work is challenging because my building is overcrowded and has poor ventilation." Kathleen (71F) felt uncomfortable the first time she attended church in Florida. She described "doors closed tightly, no windows open," so she left. Indoor dining venues were often mentioned. David (56M), who lives alone, used to rely on a monthly dinner with friends for socialization. He has not done this since the pandemic due to lack of comfort eating inside a restaurant." Nancy (66F) not only felt "cautious about other patrons," but also "staff that may need to work despite having COVID."

3.1.2. Risky people—Participants found places challenging where people's lack of public health adherence put others at risk.

3.1.2.1. Lack of social distancing.: Patrons who chose *not* to maintain a safe distance made places feel challenging. Sharon (71F), who has three health conditions, wrote: "Public transportation in NYC and waiting on checkout lines anywhere [are challenging]. So many people are oblivious to the distancing guidelines and are so, more and more, as the death statistics improved." Judith (77F), who also has three health conditions, similarly reported:

> I have had a few experiences in recent weeks where people behind me at the checkout line have stood very close. When I said something to one of them about staying 6-ft apart, his response was "Oh, that ended a long time ago."

Participants felt especially frustrated by risky people in places with plenty of space to socially distance. William (56M), for example, shared: "Several times, I have been the only person for a [movie] showing in a 150-person auditorium and had an unmasked group come in late and sit down immediately behind me!"

3.1.2.2. Lack of masking.: People who refused to wear masks or wore them improperly made places feel challenging. Some of these places were essential to people's everyday lives and therefore unavoidable. For instance, Lori (60F) in a New York apartment felt challenged in "any area that has too many unmasked people, such as the laundry room or public bathrooms." Another New York resident, Kathy (63F), observed: "When I first returned to riding the subway, it was not crowded and everyone was masked. Now, it is very crowded and some people no longer wear masks, which makes me uncomfortable." Other essential places where people refused to wear masks included stores and medical facilities. Richard (75M) found grocery stores "the most challenging", and Margaret (73F) her chiropractor's office given lack of masking. These situations could extend into people's homes, as Diane (71F) wrote about her anxiety being at home "in the presence of service/work people who don't always wear a mask." Inconsistent masking also presented challenges in recreational places. Mark (59M) responded:

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> I like to go to casinos now and then, and they feel more dangerous in the last couple years. Seem to have a lot more people who won't wear masks and are vocal or angry about it. Have made one trip to Las Vegas, in January, and was uncomfortable in very crowded casinos with people laughing, smoking and yelling.

3.1.2.3. Lack of vaccines.: Some participants felt at risk when frequenting places with large numbers of unvaccinated individuals. Thomas (66M) in rural South Carolina felt anxious in local restaurants because of low vaccination rates. Lack of vaccination also interfered with participants' abilities to do their jobs. As Cheryl (66F) answered: "It's been difficult to accomplish my work as farm manager, since so many people in rural areas reject the vaccines. I have to be very, very careful during my visits to Ohio." Betty (81F) commented that her entire Georgia community was challenging due to the presence of unvaccinated individuals.

3.1.3. Fear of infecting others—

Participants found places challenging due to fear of contracting COVID-19 and unknowingly infecting others. As Laura (59F) wrote: "Normally, I enjoy shopping, but now I feel somehow 'irresponsible' for being around that many people." This fear was particularly salient among those with immunocompromised or unvaccinated loved ones. Cindy (65F) reflected:

> Since June 2021, I have flown on commercial airlines to see our daughter a few times. It is challenging to be in crowds at the airport, wondering who hasn't been vaccinated and whether I might give COVID to my unvaccinated grandchild.

Teresa (60F) feared passing the virus to her mother-in-law through social gatherings:

> Everyone else in my [friend] group works in an office, goes to restaurants/pubs, travels, and/or regularly socializes indoors. Each time we get together, I worry that one of them has the virus, and that (in particular) I will take it to my elderly mother-in-law. A few months ago, I had a scare after visiting with one couple [at their home] … The experience made me even more skeptical about my friends' precautions (and even my own), and nervous about being in the presence of potential "plague rats."

3.2. Frustrating regulations

Fluctuating, inconsistent, or minimal enforcement of COVID-19 regulations contributed to participants' place-based challenges. These challenges were either the result of discomfort with establishments' lack of enforcement of COVID-19 mitigation strategies, or frustration with the burden of having to comply with them.

3.2.1. Reduced protection—

In relation to frustrating regulations, some participants cited the lifting of mask mandates as a source of discomfort and concern. Carolyn (76F), who has multiple health conditions, previously attended movie theaters and performance centers during mask mandates. She wrote: "when numbers are no longer limited, and masks are no longer required, I'm not sure what I will do." Participants such as Christine (70F) were concerned about the lifting of mask mandates because they and/or their spouses were at high risk for serious illness from COVID-19. Elizabeth (70F) shared: "Dine-in restaurants

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[are challenging], especially since mask mandates have been lifted. I still need to wear one and wish others would, too, since I'm going through chemotherapy. I feel forgotten."

In addition to local governments' decisions to remove mask mandates, participants were also affected by individual establishments' disregard of COVID-19 regulations. For example, Cheryl (66F) shared: "There are some local businesses that refused masking when it was required. I find that I just can't go back." Participants equated COVID-19 regulation compliance with concern for others and had negative feelings towards establishments that did not enforce mitigation policies. Charles (70M) noted "certain restaurants that ignored the covid rules" and was "upset that they helped continue the pandemic."

3.2.2. Burden of compliance—In contrast, some participants stated that their frustrations with COVID-19 regulations emerged from adherence challenges. Debbie (63F) voiced frustration with confusing, strict, and inconsistent regulations that she felt were not in the best interest of public health. Others felt that regulations were hypocritical. Denise (65F) shared:

> Health clinics have decided that my washable cloth masks are not good enough for them so I have to use one of their disposable "surgical" masks which are available about 30 feet INSIDE the main doorway, from a box that has been open for *how* long(?), with the masks tipped up on end and fanned out so they're easier to grab from!!! Just how sanitary/sterile is that???!?!

Janice (66F) noted that her employer's COVID-19 protocols were "inconsistent—over enforced, under enforced, and seemed to be based more on public relations appearances than actual evidence-based transmission prevention."

A minority of participants felt that certain types of establishments had overbearing COVID-19 regulations. Healthcare facilities were described as having "absurd mask requirements" and "so many restrictions." Varying state and international travel regulations were also stressful. Gloria (71F) wrote:

> Any art exhibit, museum that requires a vaccine or Covid 'test' … ridiculous. Just keep discriminating and dividing people but then everyone goes to Costco or [university] football games! The irony is astounding. And, laughable to many of us, but you don't dare mention it.

3.3. Uncomfortable and hostile social dynamics

Tensions emerged as the risk of infection inherent in face-to-face interactions in places conflicted with the need to build and maintain connections with others.

3.3.1. Diminished social connections—Participants experienced social tensions in confined spaces that did not allow for social respite, particularly when people unwillingly experienced "too much togetherness" (Rebecca, 66F) at home. Other participants mentioned that their main challenge stemmed from fewer opportunities to interact *outside* their homes. Robin (67F) shared that spontaneous gathering around porches in her neighborhood had decreased, close neighbors had moved out, and it was harder to connect with new people.

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Similarly, Beverly (68F) wrote that disrupted social interactions in public spaces reduced opportunities to feel connected: “Impatient people everywhere. Can’t see smiles or give them. I like to engage people in conversation and my count each day was nil.”

Uncomfortable or awkward social interactions occurred in spaces shared with others. For instance, Joseph (62M) wrote: “Every place where the public can enter is challenging. But it’s not the place, it’s the public. Most people are ignorant.” Public spaces were perceived as dangerous because of the uncertainty related to “never know [ing] who will be there” (Anne, 66F) or how they may behave. Julie (58F) referred to challenging places as:

> Every public place, even my job (eyebrow threading salon). People are assholes about having to wear a mask, people are going back to breathing right down your neck at a store when there is nothing wrong with keeping a little distance for safety.

Participants working in public-facing jobs, such as healthcare workers and service staff, faced hostile interactions. Marilyn (69F), who worked part-time at a grocery store, shared that “there was so much anger directed at cashiers” who were “being blamed for the mask policies, and working in a very volatile time.” Similarly, Michelle (55F), a nurse, recalled being confronted at work when asking families if they or their kids are vaccinated: “Half of the people you ask will jump on you as if you personally caused every single bad thing they believe was caused by the pandemic.” These negative place engagement experiences diminished their sense of ‘being in place’.

3.3.2. Hostile interactions—Further instances of uncomfortable social dynamics were described as feelings of animosity that often emerged when individuals with different behaviors or perspectives concerning COVID-19 restrictions shared the same places for leisure and essential activities. For example, Dorothy (74F) found grocery stores particularly challenging: “There are some aggressive anti-vaxxers and anti-maskers who wouldn’t keep distance and sometimes were intentionally intrusive, blocking aisles, mouthy, or rude.” Threat or actual escalation of hostilities between people with opposing beliefs and behaviors was perceived as a challenge by participants such as Melissa (55F):

> In the beginning, I was unsettled by some people’s attitudes about not masking. And fearful of being around if any confrontations with store staff occurred. As mandates have eased up, I don’t like the aggressiveness I have encountered since I prefer to continue to wear a mask. I strongly believe that being in a wheelchair has kept me free of confrontations on at least one occasion.

Participants who continued to mask despite the relaxation of mandates referred to the threat and experiences of verbal and/or physical harassment, such as being ridiculed or receiving “the look” from other shoppers. Such hostilities disregarded individuals’ personal circumstances and rationale for continuing to mask. For example, Gail (68F) shared: “I was teased by other adults/senior citizens when I continued to wear a mask [at the senior center] even when I stated I was wearing it primarily to protect the unvaccinated grandchildren I cared for.” Participants with invisible disabilities or chronic diseases, such as Jeffrey (56M), were also targets of hostility for differing masking practices:

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> Despite being in a small community where most people knew I had heart surgery I was at times verbally berated for not wearing my mask how people wanted. To the point a neighbor down the street raged at me for 10 minutes telling me I was a mass murderer and serial killer.

A minority of participants, such as Kim (64F), found it challenging to meet "anywhere out in public where OTHER people seem paranoid about contact." These participants also felt that the public health measures and other people's fear of COVID-19 infection impinged on their individual freedom. For instance, Louise (64F) referred to the barriers created by others to re-engage in travel: "If you are afraid of catching COVID then do not go on a cruise! Let everyone else live their lives."

3.3.3. Lack of social cohesion and increasing polarization—Social hostilities threatened participants' sense of community and generated negative place engagement. For instance, Annette (63F) shared:

> It felt unsafe, and not just from a COVID point of view, but also unsafe emotionally that people just didn't care enough about other people, and that some of them were not wearing masks [in public] in order to make a stupid political statement.

Paula (68F) shared that she could not rely on others' behaviors to stay safe:

> I don't trust other people to have gotten the vaccine or to wear masks if they feel sick … I also have no interest in going to eastern or southern Oregon, where a lot of people refused to get a vaccination or wear masks, and politicized the public health solutions.

Challenging social dynamics were not only reflective of individual behaviors, but also a function of broader political sentiment and polarization throughout the country. For example, Diana (65F) shared:

> The university where I worked and college town [are challenging]. Too many unvaccinated and unmasked people routinely in crowded bars and restaurants, then sharing the virus in the local retailers, classrooms, etc. As a liberal, educated person in a right-wing Republican state, I was especially fearful of public places. Too many people here listen to Fox 'news' and other misinformation channels.

Polarization trends filtered down to neighborhoods and local organizations, and even among family and friend networks. Jennifer (58F) illustrated:

> I have had a hard time with extended family gatherings because some members of our family are not vaccinated and had views about covid that I believe made them more likely to get and pass the virus to others. It was hard because not going to events, or being the only ones there to wear a mask felt like we were judging family members or being unreasonable and unfriendly. Since vaccine and masking views are closely tied to politics, it also made us more aware of deeply different world views within our family.

Social pressure influenced individuals' emotions, behaviors, and abilities to form and maintain place attachments. particularly as public health measures were relaxed and more

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weight transferred to individual choices. Participants were forced to self-evaluate risk and decide what measures to follow with the possibility of becoming socially estranged or being trapped in uncomfortable or high-risk situations.

3.4. ‘Out of place’ negative emotions

Particular places generated grief, unhappiness, loneliness, boredom, and anxiety since the pandemic onset, thereby leading to feeling ‘out of place’.

3.4.1. Loss and isolation—The loss of places was highly reported given the consequent diminishment of routines, enjoyment in everyday life, and healthful activities. Ronald (77M), for example, missed and regretted terminating a hospital chaplaincy program when the pandemic began. For Jane (69F):

> I have not been back to the rec center where I used to swim and work out 2–3 times a week since the pandemic started and they were closed or had very restricted access for over a year. I really miss swimming.

Participants missed dining in restaurants, attending arts and cultural activities, group activities, and travel. Remote activities were generally viewed as an inadequate replacement for in-person engagement, especially in the case of losing a loved one. Angela (56F) shared:

> COVID deprived myself and other siblings of saying goodbye to my mom in person. We had to say goodbye over the phone. It was a horrible experience, and one we will always regret. There should have been floors and rooms quarantined off for families to be with their loved ones to say goodbye. This pandemic deprived elderly people of their loved ones, which there is no excuse for, and for people to die alone. It’s unforgivable, and there should be an exception for people dying.

Strict regulations overlapping difficult personal circumstances in hospitals and long-term care facilities generated newfound negative personal place identification.

Being unable to go places and do activities contributed to place detachments and perceived physical, mental, and cognitive health losses. Joan (85F) wrote: “I don’t do anything physical anymore and sometimes I just feel like a lump of flesh sitting and watching TV or reading.” Peggy (71F) felt that she was “losing sharpness” given lack of activities and engagement. Virginia (75F) expressed: “Covid forced a total cancellation and the clubs will not survive and restart. This is a significant social, intellectual and entertainment loss which will now be permanent.”

Participants discussed lost third place face-to-face contacts at the grocery store and places of worship. Laurie (62F) previously spent much of her time in a recreation center to exercise and at the local coffee shop, “which has a history of being a place where people hang out and connect with each other.” She elaborated: “I feel much more disconnected from other community members since I can’t hang out in those places.” Participants who were older and/or had multiple health conditions, such as Jean (73F) post-cancer diagnosis, felt particularly isolated and left out. For Dawn (58F): “I’m immunosuppressed, so I am very careful, which makes me feel isolated.” She missed yoga (but felt unsafe in a gym or exercise studio), and still avoided most social invitations.

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The identity of ‘home’ shifted for some participants as it became a site of prolonged isolation and confinement. Gary (67M) found staying at home “often claustrophobic,” with additional stressors of food and shelter insecurity since the pandemic onset. Kathryn (71F) wrote:

> I am an introvert, so at first staying at home and in my neighborhood was okay. But as time went on, I didn’t feel I was able to safely fly to see family and friends and this made me resent my home-which is usually so cozy and comforting.

Ruth (77F) felt “just so tired of seeing the same 4 walls. I love being with my family but I am a person who needs to balance family with friends.” Participants living alone, in comparison, more often felt trapped at home. Linda (71F) was “ready to go somewhere, anywhere,” while Phyllis (75F) expressed: “I reach a point at home where I just can’t stand being there anymore and simply have to go out, even if only for a ride in the car.”

When participants *did* engage in places in-person, some noted that they were notably less social than compared to before the pandemic, which altered their place engagement. For Mary (67F):

> I endeavored to get through the [grocery] store and checkout line as quickly as possible. This curtailed my in-person interaction greatly, as the checker was the only human whose presence I was in each week.

Tina (61F) shared: “Going into a huge empty office building was/is creepy and depressing.” For Rose’s (66F) work at a school district: “it was difficult to see a ghost town.”

3.4.2. Disorientation and stress—A further instance of ‘out of place’ negative emotions was apparent in participants’ descriptions of shifting feelings about places that suddenly became uncomfortable, less enjoyable, and more stressful. Frances (81F) shared: “Everywhere outside my safe space is challenging for me.” For Larry (72M), the supermarket was now challenging because of a “total feeling of discomfort.” Some participants, particularly in more rural and underserved communities, shared the eeriness and stress of navigating empty shelves, items not in stock, and food shortages. Malls, stores, gyms, and churches were often mentioned as “not the same” (Patricia, 72F). Rhonda (62F) no longer enjoyed spending time in shopping malls: “There’s no pleasure in it.” Vicki (68F), who navigated multiple chronic health conditions, wrote:

> I am just starting to meet people outside. I feel they stand too close and I fight the constant urge to say something and/or keep backing up. My sense of personal space is definitely altered. I wonder if this will be permanent? I find it hard to relax and enjoy being with the person because this is always nagging at me.

Negative work stress pushed multiple participants to early retirement. Terri (62F) wrote: “I am leaving my position due to the increased stress, anxiety and expectations [at work]. As well as lack of support.” Several of these participants worked in healthcare, including Amy (55F):

> I am a nurse. Even though my unit doesn’t take COVID patients there is no part of healthcare that is unaffected by it … Work is SO HARD now for all of us. I

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> don't know a single nurse who doesn't wish they could do almost anything else. That is so sad. I LOVED nursing. I never thought I could feel this way. I still love my patients, but I feel used up and spit out and TIRED. Over 25 years I was still enthusiastic about my job. 2 years later I can't wait to get out.

3.4.3. Diminished way of life—

The continuing need for vigilance about viral transmission in places caused participants to express pandemic burnout. Lois (69F) expressed:

> In 2020, it was challenging to face the sickness and deaths at the hospital. In 2021 it was challenging to face the people who refused to participate in vaccines and mask wearing for political reasons, denying the pandemic - even when they got ill and died. In 2022 it is challenging that it is still going on.

Participants lamented their lost carefree ways of life and agency in place engagement. Catherine (75F) wrote: "I want to have a happy, be-in-charge life again … not ruled by the CDC." Participants in small towns and rural communities more often reflected on the lost "ability to travel freely" (Kelly, 62F) and frequent the grocery store, church, and other community settings spontaneously and without vigilance.

Making plans to go places was now more stressful and less enjoyable. Theresa (63F) wrote about visiting friends' homes: "I hate having to plan … masks or not, sitting outside, adds another level." The lack of casual chit chatting and unhurried browsing in third places was also challenging. Sherry (60F) explained: "I no longer feel the joy of browsing in the stacks at the public library. It's a more focused visit … get in, get out." The grocery store was most frequently mentioned, especially among women like Jo (63F): "I no longer wander up and down all the aisles. I get what I can and get out."

3.5. Ongoing adjustments to reframe expectations and revise behaviors

The pandemic posed unprecedented large-scale shifts in place attachments and diminished abilities to 'being in place'. The disjuncture between people and their everyday places required adjustments and reconciliations by both individuals and environments. The daily renegotiation and renavigation of challenging places involved deliberate, strategic and resourceful effort. These adjustments were commonly linked with some anticipatory risk assessment and appraisal of the sacrifices or benefits involved. Participants sought to balance their physical and emotional needs and desires with limitations in terms of convenience, preference, and comfort. They withdrew or changed their place engagements to meet basic needs and maintain quality of life.

To further interpret these dynamics, we drew inspiration from Lawton and Nehemow's (1973) 'Competence Press Model' and theories of 'being in place' (Rowles, 2018) and adapted it to conceptualize how our participants negotiated places that became challenging since the COVID-19 pandemic onset (Fig. 2).

The vertical y-axis represents a continuum where older adults had low to high capacity or control about their degree of integration in a challenging place. It captures varying abilities to integrate given one's individual resources and capabilities (e.g., ability to adjust daily

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routines, afford high-speed internet, wear a mask, walk outside independently, physical health status). The horizontal x-axis represents a continuum of strict to lax environmental restrictions for integration in a challenging place (e.g., temporary or permanent business closures; mandatory vaccine requirements; no guidelines for masking or distancing). We included the slice cutting across the x and y plane to demonstrate the *Person-Place Adjustment Zone*. This is the zone where behavioral adjustments occurred that positively reframed expectations or made a challenging place more tolerable. The adjustments within this zone represent how older adults optimized and continuously reappraised their circumstances in relation to place. They adjusted their expectations and/or behaviors to integrate with that place to meet their essential needs and maintain health and quality of life, which captures and reflects themes described in sections 3.5.1 to 3.5.4.

At the left end, our figure shows that despite the degree of personal capacity or control for integration in a challenging place, older adults who were faced with strict environmental regulations for integration tended to withdraw because these places became highly inaccessible given restrictive enforcement or because they permanently closed. For example: a participant's favorite neighborhood cafe went out of business during the pandemic. Even if they could wear a mask and walk there independently, the cafe simply does not exist anymore, leading to 'out of place' negative emotions.

At the right end, our figure shows that despite the degree of personal capacity or control for integration in a challenging place, older adults who were faced with lax environmental regulations for integration also tended to withdraw because these places became so de-regulated for masking and distancing that participants avoided these places to shield themselves from potential viral exposure. For example, participants commented on airports with no masking and little protective policies enforced. For immunocompromised participants, some deemed the airport a 'risky place' and self-selected not to make air travel plans.

Our data showed that participants' adjustments included decisions to withdraw from in-person places altogether, despite the social sacrifice. For example, Donald (76M) stopped attending his grandchildren's arts or sports venues. Wanda (66F) withdrew from air travel: "I think it will be a long time before I am willing to get on a plane again because I just do not trust that everyone on the plane will behave themselves." Many participants had not returned to gyms, yoga studios, or group exercise environments. Tracy (58F) shared: "I would like to join an exercise or yoga class but still will not do that. Working out with a mask on is hot and uncomfortable, and everyone is breathing hard."

Participants' decisions to withdraw from some places also meant sacrificing fulfilling employment, volunteering, or civic place engagements. Maria (67F), for example, was accustomed to attending a recurring Saturday meeting. Since the pandemic, she refrained from attending due to loosely enforced safety protocols where the meetings were held, stating: "It's held in a crowded basement room with no windows. Vaccine status unknown and loose compliance with masking. I am no longer attending."

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If withdrawal was not a viable option, participants made behavioral adjustments to their individual practices. Behavioral adjustments involved constant negotiation and reciprocity between individual agency and environmental opportunities to (re)form place attachments. Participants sought to balance their physical and emotional needs and desires with limitations in terms of convenience, preference, and comfort. Participants expressed agency and decision-making to reappraise their circumstances and potential risks. They changed their place engagements to meet basic needs and maintain quality of life. This dynamic is represented by the *Person-Place Adjustment Zone* in the middle of our figure, which captures and reflects themes described in sections 3.5.1 to 3.5.4. The meaningfulness of visually highlighting the narrow *Person-Place Adjustment Zone* is to illuminate how older adults constantly worked to reframe their expectations and revise their behaviors, balancing their physical and emotional needs and desires with the limitations and sacrifices they made to navigate places that became challenging since the pandemic onset. This has implications for considering who public health responses benefit, harm, or exclude to perpetuate structural ageism and ableism in society.

3.5.1. Antimicrobial individual practices—To assuage discomfort or fear in challenging places, participants made personal decisions to adhere to public health measures, such as mask-wearing and vaccination, to protect themselves irrespective of policy changes or others' behaviors in places. For example, Stephanie (59F) wrote, "Even during the mask mandate, many wore their masks around their necks. Now, I feel people think I am weird because I still wear a mask." Wendy (62F) described: "A lady recently came up to me and said – *'You're not alone.'* It took me a minute to realize she was referring to masking. There might be less than half a dozen people (shoppers & staff) masked."

Several participants expressed that wearing a mask was uncomfortable, but they continued to do so. Glenn (69M) wrote: "Grocery shopping is still challenging … I have trouble seeing as my glasses fog over." Some participants viewed masked singing and other worship activities to be difficult, as expressed by Jill (58F): "Singing in a KN95 is challenging, but possible." Mask-wearing challenges were particularly difficult for participants with lung and breathing conditions such as asthma and chronic obstructive pulmonary disease.

3.5.2. Routine adjustments—To limit contact with others and reduce the likelihood of viral exposure, participants changed how and when they engaged places. This included special grocery shopping hours with reduced crowds and keeping in-person interactions to a small number of people. Valerie (64F) explained:

> I had to stop shopping at the larger discount grocers because of their lax policies around masking indoors. Instead, I patronized [chain grocery stores] during their Senior Citizen shopping hours because it seems that the patrons were more mindful of masking, cleansing, and maintaining physical distance.

Rita (71F) adjusted her restaurant engagement:

> We have rarely eaten indoors even lately and wear masks until food arrives. We go early with less people and ask for a table as isolated as possible. We also eat alone or within our family bubble.

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Participants such as Joanne (69F) sought external assistance to help mitigate pandemic challenges: "Since I have COVID right now, my daughter has offered to send groceries through Instacart, which is nice." Kenneth (75M) also received help from children: "I never go to the barbershop anymore. My daughter now cuts my hair."

An additional place adjustment for some participants included a shift to online or outdoor activities if feasible. For example, Annette (63F) shared: "I almost never go inside [retail stores] anymore. Do curbside pickup or online." Bruce (73M) wrote:

> We live in a red state where idiocy can run rampant, particularly over masks. Our ridiculous legislature, in their infinite wisdom, killed county and city mask mandates. As a result, we try to shop on Amazon and every two weeks at the grocery store. But for a variety of things, not visiting stores makes deciding very difficult. But when we do go into a store, we're generally the only ones wearing masks.

A few participants found online or outdoor options to be off-putting alternatives given technical challenges trying to order online, frustrations using Zoom, and discomfort with the climate or weather. For example, Alice (78F) wrote:

> As president of a small board of older people, I have found it difficult to schedule meetings because many find Zoom meetings difficult and unpleasant. Meeting outdoors is impossible in cold seasons and uncomfortable in warm seasons, and many people are afraid even as the danger wears off.

Participants living in southern climates particularly noted that during the summer it was too hot outside to gather.

3.5.3. Essential-only activities—Further adjustments to reframe personal place identification expectations and revise behaviors occurred when participants limited their exposure to challenging places by only participating in activities they viewed as essential. These activities were often associated with going to the grocery store or engaging in meetings and work-related activities. Air travel was frequently mentioned as a difficult decision because there was no online or outdoor alternative. Despite knowing the stress air travel would incur, several participants described taking necessary trips to see family. For example, Elaine (74F) wrote:

> We flew to Ireland to attend the life-long vows of our son as a Monk. The flights, the airports, and particularly navigating the various COVID-related regulations involved were very stressful. We wouldn't fly at present, especially internationally, except for a very strong reason.

Beth (63F) echoed the sentiment, stating, "We have flown twice and both times have been very stressful and anxiety producing. Only done to visit family and is the only reason I would do it again for the foreseeable future."

3.5.4. Engagement in places with favorable policies—Participants described how some places enforced public health policies, which eased the need for individual place engagement adjustments and lessened negative emotions. For example, Norma (84F)

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explained: "I was concerned about seeing my dentist, but she had all kinds of extra equipment to keep both of us safe and had done all the sanitations that were needed to keep her clinic safe." Similarly, George (75M) shared:

> The gym I go to re-opened in September 2020 following all of the CDC guidelines regarding masking, sanitizing, etc. I still did not feel comfortable on the exercise floor. Fortunately, I was able to continue to use the lap pool through a very effective online reservation system. They appear to be paying attention to the changing infection rates and updated guidelines.

4. Discussion

This study explores nuanced perspectives and highly varied experiences of challenging places since the COVID-19 pandemic onset. Participants identified challenging first, second, and third places (home, work, and community spaces) because they no longer situated safety, comfort, happiness, connection, or belonging–critical experiences and emotions of personal place identification needed to build place attachment and a sense of 'being in place' (Finlay et al., 2018; Rowles, 2018; Finlay & Rowles, 2021).

4.1. Pandemic challenges to personal place identification

Older Americans surveyed more than two years since the pandemic onset continued to find places challenging because of viral transmission fears. These included crowded, close contact, and enclosed spaces; as well as places where others were not physically distanced, masked, and/or vaccinated. Our findings affirm existing studies of heightened anxiety and social stress given fears of COVID-19 exposure, particularly among older adults (Ecwonye et al., 2022; Finlay et al., 2023); and extend the timeframe of findings beyond the acute first pandemic phase. They suggest common and potentially longer-term shifts to personal place identification.

Study participants were divided in their frustrations of either perceived inadequate public health regulations (e.g., lifting of mask mandates) or over-regulation (e.g., vaccine requirements). Their perspectives reflect heightened politicization of COVID-19 public health responses, and increasingly divergent health behaviors between politically liberal and conservative Americans (Stroebe et al., 2021; Hardy et al., 2021; Jost, Baldassarri, & Druckman, 2022). Polarized national politics filtered down to the local scale to generate hostility and animosity in third places such as grocery stores, sites of worship, eateries, and recreation centers. This caused uncomfortable and tense social interactions, as well as fears of confrontation and violence over mask-wearing and other health behaviors. Individuals on both sides of the political spectrum expressed diminished civic unity and weakened sense of community in public places as an enduring challenge. Participants navigating chronic health conditions or with immune-compromised family members felt forgotten and/or stigmatized given their continuing need to mask or avoid 'risky' places and people entirely.

Participants navigated newfound grief, loneliness, boredom, and other negative emotions anchored in first, second, and third places. Home, for example, became a confined and entrapped space for some living in close quarters with others. Multiple participants

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expressed pandemic workplace stressors that led to early retirement if they had financial security. Most participants missed the opportunity and ease to socialize, have fun, exercise, and pursue personally meaningful activities in third places such as restaurants, recreation facilities, and faith communities. This finding affirms emerging research among older adults of how the virus has reduced human connection, diminished leisure activities, and disrupted lifestyles with implications for physical, mental, and social health and wellbeing (Lee et al., 2022; Hayden, Warren-Norton, Chaze, & Roberts, 2022; Teramura et al., 2022; Finlay et al., 2022; Finlay et al., 2023). Some participants in our study, especially those with multiple health conditions, speculated that these place engagement changes may be permanent.

The COVID-19 pandemic and associated public health response caused unprecedented societal-level feelings of fear, frustration, discomfort, hostility, and loss in everyday places. Personal place identification where individuals feel comfortable, purposeful, supported, and at-home rapidly changed. Many older adults still feel uncomfortable in crowded spaces given viral transmission risk. New and widespread place-based challenges since the pandemic onset include feelings of confinement, isolation, and boredom at home; heightened vigilance and lost carefree interpersonal engagement in social places; rushing through grocery stores and other service environments to avoid contact; and newfound hostility and even violence in public spaces given heightened sociopolitical polarization. Lack of masking and vaccination diminished older adults' individual sense of security and control, which continues to inhibit abilities to re-engage in places safely and securely.

4.2. Limitations

This study had notable limitations. First, the online survey required Internet access and digital literacy. Given the study sampling methods (Kobayashi et al., 2021), men, racial/ethnic minority groups, Spanish speakers, and those with less education were underrepresented relative to the general population, while Michigan residents were overrepresented. Second, while the use of open-ended survey responses was useful to anonymously share personal perspectives, responses varied in richness and depth from a single word to paragraphs. The survey format did not enable immediate follow-up to clarify and probe deeper, which likely limited the richness of the data collected. However, the overall dataset included abundant rich data to analyze and interpret. Third, while the data captured fluctuating pandemic impacts, our findings were unable to account for or trace the timing of participants' sentiments to specific changes in local or federal policies over time. Fourth, our Ecological Model of Aging ('Competence Press Model' adapted from Lawton & Nahemow, 1973) for negotiating challenging places since the COVID-19 pandemic onset does not universally apply to all older adults because it was derived from responses to our research question. Some participants did not find any place challenging (e.g., n = 228 responses [19.5%] were coded as "not really," "nowhere," and "no"). Future analyses that are stratified by individual and state political affiliations could deepen understanding of heterogeneous place-based experiences since the pandemic onset.

4.3. Implications

Changes to built and social environments driven by the COVID-19 pandemic and mitigation measures may have profound and long-lasting impacts on everyday place engagement and

(re)formations of place attachment. The challenge for policymakers is to balance future pandemic preparedness and public health responses while ensuring that vital social and civic places can continue to support individual and collective wellbeing. This study demonstrates that some older adults with newfound awareness of their physiological vulnerability to COVID-19 and other infectious diseases may encounter longer-term challenges to navigating shared spaces, whereas others wish to "return to normal" and no longer adhere to heightened public health practices. Understanding the complexities of shifting place engagement and attachments since the pandemic onset can inform community-to national-level policies. For example, the return of special shopping hours, mask-encouraged community gatherings, and hybrid online/in-person events may accommodate and support individuals and families with health vulnerabilities to feel safer and more supported.

With potentially enduring changes to personal place identification given COVID-19 and the anticipation of future public health crises, our findings suggest the need for investment, support, and expansion of infectious disease-conscious places. New and enlarged well-ventilated gathering and eating spaces, as well as outdoor educational, artistic, and recreational activities, may facilitate positive place engagement and help rebuild health-promoting place attachments. Lessened need for a mask (e.g., in outdoor and well-ventilated spaces) may reduce persistent social tensions around masking, polarized place engagement, and strains on civic cohesion. In addition to supporting positive place identification, these efforts may evolve the identity of places given an altered world since COVID-19 emerged in 2020. Grocery stores, gyms, restaurants, concerts, and other third places, for example, now have expanded cultural meanings and societal identities given their potential to be 'risky places' with 'risky people'. Environmental redesign, altered inhabitation, and modification is needed to support positive place engagement and wellbeing in our multigenerational society.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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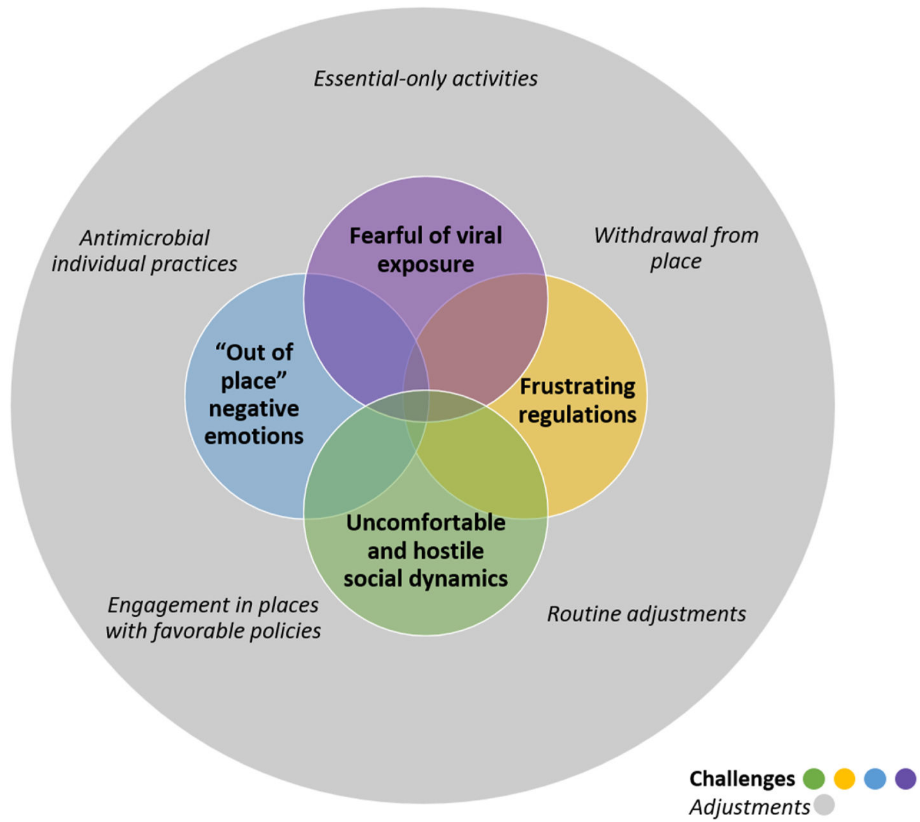

Fig. 1.
Thematic framework of place-based challenges and adjustments since the pandemic onset among older Americans.

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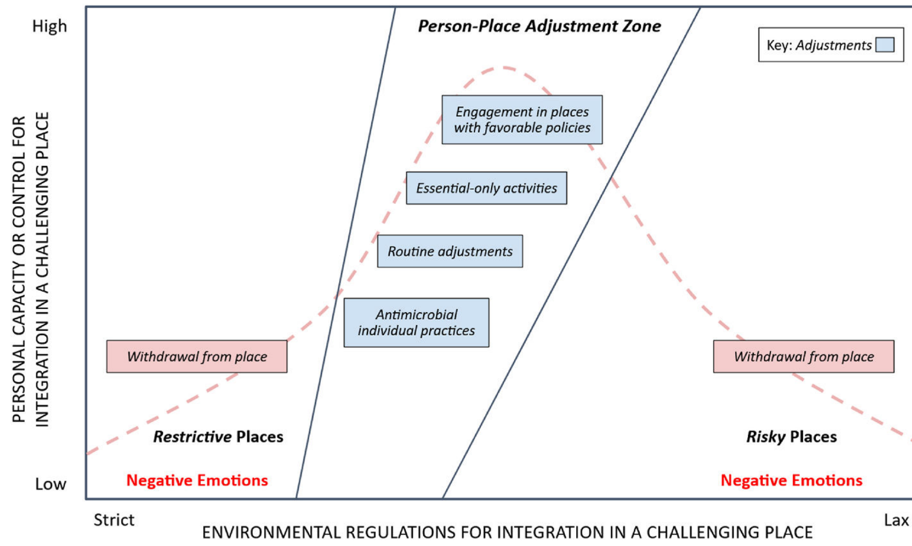

Fig. 2.

Model for negotiating challenging places since the COVID-19 pandemic onset ('Competence Press Model' adapted from Lawton & Nahemow, 1973).

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Table 1

Sample characteristics (N = 1171)[a,b].

Characteristic	N	(%)
Age	mean = 68	SD = 7
Gender		
Male	336	29%
Female	833	71%
Other	1	<1%
Prefer not to answer	1	<1%
Race-ethnicity		
Non-Hispanic White	1088	93%
Non-Hispanic Black	27	2%
Hispanic or Latinx	17	1%
East Asian or Native Hawaiian or Other Pacific Islander	15	1%
American Indian or Alaska Native	12	1%
Asian Indian	2	<1%
Other race	10	1%
Educational attainment		
High school diploma or equivalency	19	2%
Some college or 2-year associate degree	139	12%
Four-year college or university degree	364	31%
Postgraduate or professional degree	649	55%
Employment Status		
Employed	360	31%
Unemployed	25	2%
Retired	775	66%
Other	11	1%
Living alone		
No	836	72%
Yes	331	28%
Number of diagnosed health conditions[c]		
0	321	27%
1	370	32%
2	265	23%
3	152	13%
4+	63	5%

[a]Data from baseline and 24-month follow-up of the COVID-19 Coping Study.

[b]All covariates measured in April/May 2020 except for employment status and living alone, measured in April/May 2022.

[c]Number of diagnosed health conditions calculated based on presence of selfreported diagnoses of hypertension, diabetes, heart disease, asthma, chronic obstructive pulmonary disease, cancer, depression, and anxiety (all yes/no).