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Introduction

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You could only describe Halloween 2020 in the United States as strange. In Indianapolis, parents drove their children past the jail downtown where deputies wearing gloves handed out sanitized candy packages to kids in costumes who remained locked in cars, looking on at the waving officers. Just Born Quality Confections in Pennsylvania, which makes "peeps," the popular Halloween marshmallow treats that come in the shape of birds and ghosts, suspended production until it could put protocols in place to protect employees. The Centers for Disease Control recommended avoiding high-risk activities—no traditional trick-or-treating, no hayrides, no haunted house walks. Thirty-seven states in 2020 canceled Halloween events. And where there was Halloween dress-up, in addition to the ever-present princess costumes and characters from movies, some of the most popular costumes of 2020 were frontline healthcare workers, Dr. Anthony Fauci—lead scientist on the Whitehouse Coronavirus Task Force—and the anachronistic long-beaked, heavily costumed plague doctor. All of them were masked. Halloween is one of the very few places where masks don't bother us. Normally a special association with costume and carnival, masks for us have generally been "othered"—we associate them with global diseases affecting countries halfway around the world, with the work of surgeons and other medical professionals, or with crime and violence. But in 2020 we were asked to own them, to protect ourselves and the world around us by donning a mask.

The iconic heavily masked plague doctor traces back to 1619. The costume was first described by Charles de Lorme, who served as the royal physician to King Louis XIII of France. Plague doctors were sometimes physicians, but just as frequently they were laypeople who treated patients at a time when there were no antibiotics and only a very basic concept of immunity. They treated plague patients with leeches and cupping and herbs, but they more often laid out the dead, witnessed wills, kept track of deaths, and performed body removals. The plague doctors' costume consisted of a waxed ankle-length overcoat, gloves, boots, a wide-brimmed hat,

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and a wooden walking stick used to examine patients without getting too close—it was a sort of seventeenth-century hazmat suit. The truly notable part of the uniform was the mask, which was tight fitting and birdlike, with glass eyes and a long beak with slits or holes on either side. The beak, which startled everyone, measured at least six inches long and contained a chamber for herbs, flowers or other aromatics, or vinegar-soaked sponges. It was thought to prevent the wearer from suffering *miasmas* from breathing diseased air.

Writing about pranksters dressed as plague doctors in England in May 2020, Greg Kelley (2020) argues:

> I would submit that by donning the garb of plague doctors who centuries before tended to victims of the pestilence, these pranksters are, in a sense, staging a legendary past in the present. This is performed anachronism, and the plague doctor *habiliment* brings with it a cluster of associations of the bad old days before vaccines and germ theory—associations that, although outdated, feel uncannily relevant to the contemporary circumstances of the COVID-19 pandemic. Pointing the way for us, these present-day pranksters conjure and embody a complex of age-old legends around early modern medical procedures, folk curatives and prophylactics, mysterious immunities, and eerily preternatural practitioners. (48–49)

Kelley ends by noting, "In reality, the plague doctor's protective gear, for all its orphic allure . . . had little preventative effect during the great plagues in Europe. But the mythos around them was persistent, providing perhaps some thread of hope amid dreadful circumstances" (66).

If we jump forward a few centuries to the Spanish flu of 1918, masks again appear, this time closer to the cloth or paper surgical mask to which we are now accustomed, sometimes recommended or even legislated for the general population. Just as today, there was mask resistance. Some people snipped holes in their masks to smoke cigars. Others argued they were symbols of government overreach. There were fines and jail terms and fights, people who hung the mask around their necks, and there was even—in parts of the US—an anti-mask league. Suffragettes felt the masks hurt their necessary visibility and barbers complained of lost business. Masks were multivocal and multivalent, as were the pandemics that initiated their use.

Really understanding the terrifying image of the plague doctor or the complicated Spanish flu mask fights meant seeing behind the mask to the vernacular understandings and meanings invoked there. How were people living in the face of a pandemic? What were they really doing to keep themselves healthy or to treat themselves if sick? How were they finding supplies?

What were they talking about and how were they passing pandemic time? With both the plague and the Spanish flu, we actually know very little about the vernacular responses of regular people. Now, with COVID-19, we offer a look behind the mask at the vernacular culture affected or inspired by this pandemic.

COVID VERNACULARS

Arising initially out of a coronavirus interest group at Indiana University, this volume explores the nature and shape of vernacular responses to the public health crisis. Although the current volume originates from this core group, we have branched out to include folklorists and other scholars from the US and Western Europe. While this group is more expansive than our original base, we recognize our inability to provide a global view. Nevertheless, we have tried where possible to place observations and discussions in conversation with other vernaculars internationally. For the purposes of this collection, we define the vernacular as a broad category of local knowledge production and action that is reflective of a particular group or region and focused on community-based forms of expression. As Margaret Lantis (1960) notes, the vernacular is "culture as-it-is-lived appropriate to well-defined places and situations" (203). Based on Leonard Primiano's work, we also highlight in the vernacular the "personal, aesthetic, cultural, and social investment [of an individual] . . . as well as the way individuals privately and creatively adapt [culture] to their specific life needs" (1995, 43). As such, vernacular culture can be flexible, dynamic, multi-sourced, and global.

While vernacular culture may or may not run against the grain of prevailing discourses—incorporating concepts and ideological content derivative of hegemonic forms; borrowing, appropriating, or commodifying—it makes its fullest sense out of the cultural context in which it arises. Despite its potential nod to dominant or external culture, it is its strong connection to the local that helps ground the vernacular within the experiential context that it occupies. Locked down in our homes and separated from the normal ebb and flow of life, our experience of COVID-19 highlights community and creativity, adaptation and flexibility, traditional knowledge, emergence, resistance, and dynamism. In its removal from assumed norms and dailiness, the pandemic provides a moment of insight into the nature of vernacular culture as it is used, abused, celebrated, critiqued, and discarded. It is this insight that our volume documents, ranging from bread competitions and sidewalk chalk rainbows to the exacerbation of racism and economic precarity caused or suggested by COVID.

Three themes crisscross through contributions to this volume despite the individual focus of each chapter on different COVID-related issues and practices.

The Vernacular to the Rescue: Community, Creativity, and Coping with COVID-19. In section I of this volume, we investigate the ways in which individuals and communities have used the vernacular to deal with the public health crisis as some found themselves suddenly experiencing strains on budget and supply chains, sheltering in place with inadequate resources, or missing community connections. As is so often the case, people found creative means of coping with the challenges presented to communities through vernacular culture. Within this context we explore vernacular creativity, including such topics as scavenger hunts, the creation of vernacular education opportunities for children, COVID cooking, sustainable living, and folk artistry.

The Failure of Experts and the Rise of Vernacular Expertise. In section II of this volume, we explore the places where governmental and organizational cultures were unwilling or unable to adequately address concerns of different groups. Our interest here is not only in the failure of experts within these contexts but also in the way vernacular culture expanded to fill the needs of communities. Within this context, COVID-19 existed alongside social justice issues including Black Lives Matter, a contentious election, the events of January 6, 2021, product shortages, and economic challenges. The pandemic did not happen in a vacuum; it dovetails with a variety of other social and political phenomena. We discuss lay health theories, the creation of rumor and conspiracy theory to fill the information vacuum, and local responses to xenophobia and hate.

When Vernaculars Meet. In the third section, we address how the rules that evolved in the face of the pandemic suggest numerous areas of incongruity. The term *social*, for example, would appear inconsistent with "social distancing." Likewise, masks, which have traditionally been markers of chaos and crime (within the US context), are meant to acquire meanings of safety and trust. *Home* typically suggests comfort and warmth, but this was not necessarily the case for those following "stay-at-home orders"—some found themselves shut in or shut out of desired contexts, such as individuals experiencing homelessness or people experiencing domestic abuse. In this section we explore emergent notions of community, understanding that the dynamic of the pandemic requires exploring preexisting and emergent vernacular forms.

For many of us, COVID-19 and its changing dynamics have made our experience feel as though we have recently lived through three or four epidemics, not one. Quarantining our mail and groceries, searching for toilet paper and diapers, baking banana bread, and participating in scavenger hunts to find slogans or symbols left out for neighbors to see—these activities seem to have occurred years ago, and yet just yesterday. The events of the pandemic seem to have operated outside of time, in a unique dimension—in what we might want to refer to as "COVID time." The corona crisis has

shaken up our rhythms with work, childcare, schooling, eating, and sleeping, all of which seem to have been rearranged. Curfews and lockdowns have affected our natural patterns, social time has broken down, and past, present, and future feel like they have become confused. Clear separations between work and time at home are challenged. Days and weeks are disordered, even indistinguishable.

As German memory scholar Astrid Erll noted after asking what COVID-19 has done to time, the "new rhythms of everyday life may almost seem medieval, pointing back to a time when workplace (the bakery, the pottery, the blacksmith's forge) was part of the home, and working rhythms were weaved together with domestic rhythms" (2020, 862). While the rapidity of the spread of the virus is mind-boggling, for some, the slowness of COVID time was a relief from our otherwise accelerated lives—like a school snow day for children or a sick day off work. Of course, for physicians, medical researchers, and caregivers, as they strain under the burden of rising cases and unimaginable death rates, the reverse is true: COVID time is a speeding train, threatening at any moment to go off its rails. An existential puzzle extraordinaire, COVID is both a digital marvel—moving information, interventions, and science rapidly across the world and providing in digital social media new and better ways to pretend we are together (see Brooke, this volume)—and yet at the same time it is an almost old-fashioned return to ways of coming together in vernacular practices like baking and singing across balconies (see Eriksen and Kverndokk; Inserra, this volume). And lest we lean too far into romanticizing COVID time, countries responded differently to the COVID experience, based on the nearness in recent memory of other related traumas, such as the epidemic of Ebola in West Africa, wildfires in Australia, Brexit in the United Kingdom, or the rise of authoritarian governance and threats to democracy in the United States, Brazil, Hungary, and elsewhere. Our concerns about the slowness and speed of time were completely intertwined with our fear of and desire for change.

This simultaneous break in and coexistence of temporal experience compelled a sort of liminality throughout the pandemic, a variable van Gennepian period of social limbo.[1] However, people did not initially intend to engage in any sort of ritual reemergence or reidentification. The resulting moments of "betwixt and between" often seemed to move at a molasses-like pace because we were compelled to exist temporally between the timelines of pre-pandemic status quo and the eventuality of a "new normal." The progress of science, medicine, and the vernacular was swift, perhaps faster than many people had previously experienced. However, the

new normal many strove to find connoted a new system, a new whole, some sort of finality. The slowness of COVID time, then, was perhaps experienced, and felt, in light of that daunting task of a reintegration, or incorporation, that was widely contested. This light at the end of the tunnel barely flickered as people and their communities around the globe constructed ways to understand this different experience of time and sociality. The once-normal bustle of everyday life was replicated by some in the realm of the online; however, others found that embodied being and the collapsing of social space could be understood, or could become more familiar, in the words and practices of previous generations, what many imagine as "simpler times" that, perhaps, also moved slowly. And so, we should not be surprised that COVID time over the two plus years of the pandemic seems to require the rehearsal of a timeline to remind us of where we are and where we have been.

DAYS LIKE NO OTHER

December 1, 2019 was, for many of us, a day like any other. We went about our business, attended school or work, stopped at the gym, the post office, the grocery store, or a friend's house on our way home, ate a quick dinner, and then perhaps went out again. Little did we know that a few months later all of that would become impossible.

On January 9, 2020, the World Health Organization announced a mysterious coronavirus pneumonia reported from Wuhan, China. By January 21, the Centers for Disease Control confirmed the first American case of the novel coronavirus, diagnosed in a Washington State resident who had returned one week earlier from a trip to Wuhan (Centers for Disease Control and Prevention 2020). Europe began to face several major outbreaks by the end of February, beginning in Italy, and the first Latin American case was reported that same month. On March 11, the World Health Organization declared COVID-19 a pandemic. In the United States later that week, California became the first state to issue a stay-at-home order mandating that all residents remain in their dwellings, venturing out only to engage in essential tasks. As hospitals became overwhelmed and case numbers skyrocketed, more and more states followed suit, suggesting or mandating that their residents stay home. By the end of March, most of the United States was in lockdown and gatherings of all kinds were canceled or moved online, including weddings, parades, and conferences. There was a run on grocery stores, which quickly sold out of hand sanitizer, detergents and, inexplicably, toilet paper. Public health officials stressed the

need for mask wearing and "social distancing" at the same time as there was a nationwide shortage of personal protective equipment (PPE) needed by healthcare workers. Countries around the world sealed their borders, sports teams canceled their seasons, schools closed, and employees increasingly were laid off or instructed to work from home. By April 2, more than 1 million people in 171 countries across six continents had gotten COVID and fifty-one thousand deaths had been reported. By May 28, the CDC reported US deaths in excess of one hundred thousand, and by November 8, the number of US cases surpassed 10 million (AJMC Staff, 2021). At the end of December 2020, cumulative global numbers stood at 79 million reported cases, with 1.7 million deaths (World Health Organization 2020), and by March 1, 2022, the virus had infected almost 390 million people worldwide and deaths had reached 5.96 million (Ritchie et al. 2022). The most severely affected countries included the US, India, Brazil, Russia, and the United Kingdom (Taylor 2021).

In December 2020, the FDA granted emergency use authorization to Pfizer and Moderna, indicating that both mRNA two-dose vaccines were shown to be safe and effective against COVID-19. The Johnson and Johnson single-shot vaccine was approved in February. By the end of December, the UK approved emergency authorization for the AstraZeneca and Oxford AZD1222 vaccines. As the year closed, the approved vaccines started to roll out, first to healthcare providers and first responders, then to the elderly and the immunocompromised, and finally to the general population. China, Brazil, India, and Russia were producing and manufacturing vaccines at scale, and by June 30, 2021, more than a dozen vaccines had been approved around the world. Residents of the US, Europe, Canada, and a few other wealthy countries had access to a vaccine, while those who lived in lower-income countries, particularly in sub-Saharan Africa, would likely have to wait until 2023. Later in summer 2021, more than 3 billion doses of vaccines had been administered worldwide. Several countries, including Bahrain, Israel, and the United States, had made significant progress in immunizing their citizens. Other countries had no access to vaccines and had yet to start. By the end of summer 2021, as the Delta variant continued to rapidly spread, only 1 percent of Africans had been immunized. Today, as finances, logistics, and politics affect global access to the vaccines, COVID-19 continues to mutate, with scientists anxiously watching new variants emerge wherever the spread of infection has not been significantly curtailed (Taylor 2021; Terry 2021). In November 2021 a new variant, Omicron, was discovered, which had far greater transmissibility, creating a new significant wave of infections in the months that followed.

Politics and economics always play a critical role in health policy and care. Healthcare is gendered and racialized, different for the poor, the marginalized, and the isolated than it is for those who inhabit spaces of dominance. Minorities and the poor were particularly affected by COVID-19, experiencing discrimination in access and service availability; disproportionate representation in occupations and geographical areas with greater exposure to COVID; educational, income, and wealth inequalities; and housing conditions that rendered prevention strategies more difficult to implement (Bonotti and Zech 2021, 3). Rising unemployment, food insecurity, a housing crisis, overfull hospitals, and diminished access to services all were byproducts of the pandemic and lockdown, which aggravated preexisting inequities. Food lines were long, eviction notices became plentiful, and lack of childcare and transportation made work impossible even for those whose places of employment were open. Lockdowns exaggerated the situations of those who were housing insecure, those who faced heat shortages, and those who shared their homes with domestic abusers. A shortage of PPE—including masks and gloves—placed caregivers in danger, made factories petri dishes for closely placed workers, and added to the isolation and loneliness of the elderly or vulnerable.

Throughout the pandemic, social distancing and more time at home compelled by lockdowns and community expectations resulted in a meteoric rise of media consumption, particularly in places where such was already commonplace. Media—social, news, fake, mainstream, online, radio, streaming, videos, signs, discussion boards, games—solidified its existence as a buzzword and, for some, a way of extending and negotiating one's identity and continuing with life. During our collective pandemicking, the role of the virtual and of media in general cannot be overstated, and some contributors in this volume thoroughly explain some of the particularities of people's interactions, understandings, and negotiations with it (see Graper; Brooke; Inserra). On a larger scale, according to a Nielsen report examining media consumption during the early stages of the pandemic (spring 2020), the amount of time television was consumed (in multiple formats, including streaming) went up nearly 75 percent in this quarter alone (Adgate 2020). Similar trends can be seen across various spectrums of media, including an over 50 percent rise in hours watched on the popular platform Twitch.tv.[2] It is intuitive that, given the nature of the initial lockdowns and uncertainty compelled by a global pandemic, many would turn to their televisions and various media outlets to stay up to date with events and even stay in touch with their communities, while others searched for new forms of entertainment.

According to the same Nielsen report, some respondents even described their radio programming as their "comfort food." Juxtaposing the molasses-like tempo of "COVID time" detailed above, the ability of the internet and media to "small up" the world at a pre-pandemic pace was profound, as new identities were formed and ideologies were negotiated, constructed, and spread between disparate geographies. On the one hand, media was one avenue by which people could continue to form and interact with community. Social media platforms such as Facebook and Instagram provided sites for imagined and once-embodied communities to share their efforts and creativity amid lockdowns and social distancing, among other things, while other platforms such as Zoom and Teams gained widespread acceptance as alternatives to the socially embodied, brick-and-mortar workplace. On the other hand, and certainly not completely separated, media in all forms was used to attempt to understand the pandemic. This can be seen and heard in the politicization of pandemic performances and practices, which were swiftly negotiated via social media and disseminated through multiple channels, including "news" organizations both online and on television (see Bock; Graper, this volume).

But the COVID-19 picture was also interwoven with and complicated by a series of ongoing political and social issues in the United States and globally. As the pandemic spread, the Trump administration continually underestimated, minimized, misunderstood, and ignored the nature of the threat presented by COVID-19; damaged efforts to prepare for testing, treatment, and prevention; sabotaged work to slow the spread of the disease and to speed care; engaged in disinformation and the stigmatization of groups and individuals; and diminished the importance of mask wearing and social distancing. These actions continually politicized the virus, most particularly as it related to mask wearing and ultimately vaccine use—themes that became central to a partisan fight—with anti-mask, anti–social distancing and anti-vaccination positions becoming the stance of many lawmakers and politicians on the right (see Kitta, this volume). Outside of the United States, the same politicization was reflected in the COVID attitudes and policies of populist right-wing leaders including, among others, British prime minister Boris Johnson and president of Brazil Jair Bolsonaro. Not only in the US but globally, COVID-19 became entangled with right-wing agendas, especially in terms of anti-immigration sentiment, anti-China sentiment, and technophobic conspiracy theories.[3]

While COVID-19 raged, other cultural issues and moments of import swirled around the pandemic in the United States (and elsewhere), making the situation even more complicated. In the background to the anti-mask,

anti-distancing, anti-vax movements, numerous political campaigns were underway, including a contentious battle for president of the United States that ultimately came down to a contest between incumbent Republican Donald Trump and Democrat Joseph Biden. Due to the pandemic, new, untried campaign events and tactics occurred daily, testing the limits of safeguards between political activities and prohibitions on using the White House or the executive branch for political purposes (prohibited by the Hatch Act.)[4] The pandemic also tested the limitations on the use of video and other technology to replace campaign events, even the Republican and Democratic National Conventions. In an effort to allow socially distanced voting, numerous states tried to ease the burden at the polls by instituting mail-in voting, drop boxes, drive-through polls, early voting, and longer polling location hours. These efforts (particularly mail-in voting) created a GOP backlash alleging election fraud and ultimately leading to a Stop the Steal campaign instituted by Trump and his followers. That campaign resulted in the so-called insurrection—on January 6, 2021, a mob of Trump supporters attacked the United States Capitol in an attempt to disrupt the counting of electoral votes that would formalize Joe Biden's win in the 2020 presidential election. On January 13, 2021, one week before his term expired, Donald Trump was impeached (for a second time) for "incitement of insurrection."

Sometimes referred to as the double pandemic, COVID-19 also intersected with a wave of anti-Black and anti-Asian racism and antisemitism in 2020 and 2021. While notions of the "Chinese virus" stoked anti-Asian and anti-immigrant tensions that had been simmering just under the surface, public health closures, mask mandates, and eventual vaccine mandates incited white nationalists to protest the infringement of American "civil liberties." White supremacists and nationalist extremists saw COVID-19 as an opportunity to push their agenda and recruit, spreading pandemic disinformation and promoting their ideas on social media to inspire and fuel protests around the country. Extremists dismissed COVID as a hoax, a result of Jewish-run conspiracies, or a disease spread by immigrants.

While white supremacy flourished in response to COVID, so too did social justice movements such as Stop Asian Hate and Black Lives Matter.[5] One of the most significant intersections with our experience of COVID-19 was a contemporaneous societal reckoning with police brutality against people of color in the United States (and elsewhere) as well as a response to the structural violence that limits the opportunities of Black and Brown communities and causes health disparities. The murder of George Floyd at the hands of white Minneapolis police officers on May 25, 2020 reenergized the Black Lives Matter movement, which began in 2013 after the

acquittal of George Zimmerman in the shooting death of Trayvon Martin. During 2020, an estimated 15 to 26 million people participated in Black Lives Matter protests in the United States, making it one of the largest political movements in US history (Buchanan et al. 2020). Activists around the world also engaged in Black Lives Matter efforts to reform global Black discrimination, marginalization, and state violence in their respective countries. COVID-19 intersected with BLM in multiple ways, creating large social protest gatherings that challenged public health measures known to exacerbate inequities (including increased unemployment and financial inequity experienced through pandemic-related job losses and economic threats), amplify health disparities through higher rates of COVID infection and death in Black communities, and induce a resurgence of historical mistrust of medical research and care stemming from both the abuse of Black bodies in Tuskegee-like experiments throughout American history as well as maltreatment in healthcare settings and situations. COVID-19 amplified virtually every social and political issue facing the population.

The pandemic also amplified the performance and understanding of "health" broadly understood. Almost overnight, people across the globe were compelled to renegotiate how they participated and performed in their worlds with a new awareness of the ramifications for those around them. Before the pandemic, one could have thought of health in many cases as a silo of practice, or a practice that silos particular spaces, performances, practitioners, and ideologies, among other things (even if this was not actually the case then). However, the pandemic shone a light on the ubiquity of health and the far-reaching effects that its recognition can have on our lives. The customary embodied practice of a handshake, for example, was immediately utilized as a model for unhealthy behavior—a compromise of social distancing. A common form of social networking emerged in the form of "bubbles" or "pods," a creative adaptation to interactional restrictions in which small groups of individuals agreed to limit in-person contact exclusively to one another. With the assumption that everyone committed to an identical social bubble, all participants would presumably remain healthy or—if an infection were to occur—limit its spread to a single network of people. Such methods were even promoted as part of lockdown exit strategies in the UK, New Zealand, and Germany (Leng et al. 2020). Yet for many, such circles were more imagined networks of exclusivity than rigorous health code abidance (Gutman 2020). Differing social expectations and perceptions of COVID could be enough to burst a bubble, leaving individuals left to negotiate new means of maintaining relationships in pandemic contexts. While the global ubiquity of a particular strain of health

behavior is fairly unprecedented in living experience, the ways that health is amplified and creatively expressed in response to the unknown, the social, and the political is hardly novel and can thus be traced through other pandemics, epidemics, and crises.

SPIT SPREADS DEATH: REMEMBERING (AND FORGETTING) PANDEMICS

As we struggle to reflect on or even remember the absurdity of the timeline we have just lived through and are still experiencing, numerous authors have inspired a revitalization of reflections on that other devastating flu, the Spanish flu of 1918–19, caused by the H1N1 influenza A virus. It is believed that the 1918 pandemic killed between 50 million and 100 million people, representing 5 percent of the world's population at the time, and possibly exceeding the death toll of both world wars. Half a billion people were infected. Although it has been referred to as "the greatest disaster of the twentieth century, possibly any century" (Spinney 2018, 171) and "the mother of all pandemics" (Erll 2020, 864), there is, oddly, very little information about the Spanish flu that has survived the century since its ravages. Historian Guy Beiner notes: "Considering the sheer magnitude of the phenomenon, there is a relatively slim body of literature on the topic, a dearth which stands out in comparison to the voluminous historiography on the First World War. Overall, the Great Flu remains a remarkably under-studied field in modern history" (2006, 503). According to Beiner, it took eighty years until the first conference on the subject was convened, in Cape Town, and no cultural history of the pandemic has been written to date (503). Erll observes, "There are no major contemporaneous (or later) memoirs, paintings, novels, or films dedicated to the Spanish Flu" (865). And to date, there are no monuments or memorials to the pandemic. Beiner and others call the 1918 flu the "forgotten pandemic," and Pete Davies (1999) refers to it as the "forgotten Tragedy." COVID has created a new wave of Spanish flu historiography, as well as new fiction, film, and museum exhibitions reflecting back on the 1918 influenza pandemic.

The suggested reasons for the "collective forgetting" associated with the 1918 flu are multiple, and perhaps all the suggestions have some merit.[6] Beiner posits that it was difficult to associate meaning with an illness that came so fast and killed so quickly, extensively, and incomprehensively. "In all patterns of remembrance," he argues, "what matters is that individuals acted in certain ways to the past—that they had choices . . . For many, such was the fate of the influenza pandemic of 1918–19, one of those moments

difficult to fit into narratives of meaning . . . Out of social agency," says Beiner, "out of mind" (2021, xxvi). Erll argues that there was a question of the discreteness of historical events, that the flu was deeply entangled with other rampant illnesses, war, and other entrenched events (2020, 865). Ryan Davis (2013) argues that the mundaneness of the notion of "flu" worked against it being marked or remembered—that there was a certain embarrassment about something as simple as the flu having such an effect. Erll appears to agree, writing that the flu "lacked tellability: Harrowing as they were, flu deaths were less tellable (i.e.: less noteworthy, they had less of a 'point') than stories of heroic deaths on the battlefields of the First World War" (865). And yet there are areas where extant information on the pandemic *can* be found—including the reconfiguration of the virological and genomic data preserved from the illness, traces of information depicted in the arts, and what remains in family history and in the attics and garages of later generations (Beiner 2006).

One wonders what from the Great Flu might have been useful to our current experience had we greater access to those memories. What might we have come to understand about quarantines or masking or resistances? Stories of epidemics do not only describe illnesses, they also create illness realities.[7] While Beiner highlights for us the residual information that the arts or family history might have provided about the 1918 epidemic, the suggested usefulness of both of these categories of information stands as a reminder of the ways that vernacular forms encode experience and memory for the future.

It is worthwhile to think about pandemic memory as embodied—not just in the sense of the ways the disease itself interfered with bodily function, but in terms of how we all experienced the pandemic through our bodies. What did it mean to have and be a body during COVID? How did our bodies work together while not in physical proximity? How did we co-create socially distant space? How did smell, sound, or sight change in bustling spaces that were now empty? How did "the inactivity and immobility of doing nothing, do something?" (Vallee, 2020). Such stillness induced a sense of stagnation or even tranquility for some people, but it also compelled many others into creative action.

COVID CREATIVITY AND PANDEMIC *BRICOLEURS*

It is Friday afternoon at Linda's house. She is going through old fabric scraps looking for ones that might make suitable masks. Her husband is at the bar they own, which is closed down, all the employees furloughed.

He's trying to learn how to make hand sanitizer out of the alcohol on the bar shelves. Linda's two children are online finding clues that will help them later during the family walk as they locate painted and molded unicorns hidden by their neighbors, who created scavenger hunts to entertain the families confined to home. Linda and her husband, and even their children, have become pandemic *bricoleurs*, applying combinations of the resources at hand to solve the new problems created by COVID.[8]

Locked down in our homes, with public gatherings prohibited, businesses and schools closed, restricted access to stores and restaurants, and with museums, theaters, and sporting events curtailed, we were all forced to turn to forms of work, creativity, and social interaction that were different from our regular norms of production and entertainment. Whether exercised to cope with, escape from, think through, or endure the hardships wrought by COVID, the revived and introduced traditions served as tools for living through the pandemic.

The creative forms prompted by or produced during COVID performed a variety of functions, ranging from personal protection to means of social engagement. Homemade hazmat suits and face masks modeled vernacular interpretations of medical advice, as did the balloon hats that comically extended in six-foot circles to promote social distancing. Graduations and birthday parties happened from the comfort of one's own car, and friends could congregate around their own computers for a synchronized watch party of shows and movies. Domestic artistic traditions, such as baking, gardening, or sewing, surged in households as individuals preoccupied themselves with indoor activities. Board and video game sales spiked in 2020 for similar reasons (Wannigamage et al. 2020), and daily walks became regular rituals for folks seeking to get outside (Anderson 2020). Even museums and galleries became available to visit virtually, with content becoming readily and often freely accessible to spectators (King et al. 2021).

The renewed investment in artistic creativity, coupled with public health concerns and access to online shopping, spurred a demand economy for homemade masks and other art, which was readily supplied by artists using virtual storefronts such as Etsy, Shopify, and Instagram. Although more than 12 million masks had been sold on Etsy by April 2020, mask sales ultimately accounted for only 10 percent of gross merchandise sold on the platform during its highly successful year, indicating a proliferation in homemade art sales overall during COVID (Richter 2020). Blogs and videos of DIY mask making emerged for those who wanted to try the craft at home, as did resources for home construction and landscaping projects. Instagram's Checkout feature, rolled out a year earlier, catalyzed

the art-making and selling capabilities for many artists during COVID, too. With an invigorated public interest in buying from Black- and Indigenous-owned businesses on the heels of the aforementioned social movements, marketplaces dedicated to such companies and individuals sprung up, such as From the People, Collective49, and Miiriya.

People also sought ways to connect with others outside the home while working within the recommended or enforced restrictions imposed on social interactions. "Zoom" entered the lexicon of computer owners, the video networking software quickly becoming a verb among colleagues, friends, and family members who wanted to chat with each other remotely. Many neighborhoods started scavenger hunts or sidewalk chalk galleries that allowed adults and children alike to interact with their neighbors from safe distances (Anderson 2020). Some people entered trade networks with friends, taking turns shopping for groceries or running errands, thus limiting cumulative public interaction. Workers rearranged their living rooms into offices, students into classrooms, and musicians into concert halls to accommodate the online space, some even turning to virtual backgrounds to be simultaneously at and away from home.

Many people assumed the bricoleur role that Linda and her family aptly embodied. The creative manipulation of materials found at home, online, and in socially distanced public spaces allowed people to express themselves and connect with others while operating within appropriate public health guidelines. For these bricoleurs, COVID presented an opportunity to kindle relationships with close friends and family through shared adaptations to imposed limits. Even strangers could build upon one another's creations in collective settings, such as collaborative chalk murals or TikTok memes, akin to Lynne McNeill's (2007) concept of serial collaboration. Notwithstanding the hardships wrought by COVID, the defining characteristics of 2020—lockdowns and social distancing—often fueled moments of artistic creation and community building that helped many people navigate through the pandemic's troubling times (see Geist et al.; Long and Vaughan, this volume).

STORIES LIKE SO MANY OTHERS

In his book *An Epidemic of Rumors: How Stories Shape Our Perception of Disease*, Jon D. Lee wrote:

> In 2003, for a frantic few months, a virus assaulted humanity with a fury that seemed apocalyptic. This novel disease came from China but quickly

> slipped that country's boundaries to bound halfway around the world in a matter of hours. Its speed left doctors and researchers gasping in the wake, struggling to erect walls both physical and intellectual against the onslaught. But their reactions were nothing compared to the fear that gripped the nations of the world as they suddenly confronted a strange, invisible, and unexplained foe that killed one out of every five people it touched. Panic ensued. Thousands of people were involuntarily quarantined. Thousands more simply chose to stay home rather than risk catching the new virus from a coworker or stranger. The tourism industry ground to a halt. Airlines, theaters, restaurants, hotels, and other businesses showed record losses. Chinatowns all over North America virtually emptied. And people were dying, not only laypersons, but doctors and nurses too, cut down by the very disease they were struggling to understand . . . And then almost as suddenly as it had arrived, the virus disappeared. (2014, 4–5)

Although this description refers to the 2003 SARS epidemic, Lee continues: "Change the date to 2009, the word China to Mexico, and the name of the disease from SARS to H1N1, and with little further effort we have a new etiological narrative that still proves surprisingly accurate in describing the H1N1 pandemic. With just a few more changes, we could have a series of paragraphs describing the origins of avian flu, Ebola or AIDS" (5). Lee's focus is on the narratives in circulation at the time pertaining to SARS, but, he argues, "These same processes—akin to using a word processor's find and replace tool on a series of oral narratives, are the very ones that appear over and over in actual disease epidemics." Indeed, the narratives that arose during the SARS epidemic resembled those that emerged during Ebola, the H1N1 epidemic, and the AIDS epidemic.

Shortly after the beginning of the COVID-19 pandemic in 2020, COVID-19 started to be referred to by some (including then President Trump) as the China or Wuhan virus. The adoption of a disease nickname associated with a country or a group of people is, of course, not uncommon. In fact, in May 2015, the World Health Organization (WHO) issued a policy paper on the best practices for the naming of new human infectious diseases, suggesting that diseases *not* be named after geographic locations (cities, countries, regions, or continents); people's names; species or class of animal or food; cultural, population, industry, or occupational references; or terms that incite undue fear (World Health Organization 2015). The tendency to resort to disease name-calling, however, runs throughout history. The 1918 flu epidemic popularly known as the "the Spanish flu" most likely did not originate in Spain. In Spain it was referred to as "the French flu," in Brazil it was "the German Flu," in Poland it was called "the Bolshevik disease," and

in Senegal it was "the Brazilian Flu" (Cohut 2020). It is not new to name a disease after a political opponent, nor is it new to associate the disease with beliefs about germ warfare. Throughout Europe, the Spanish flu was linked in the newspapers to German sub boats that were said to have brought the disease to the shores of Spain. In the US, the story spread that a camouflaged German ship infiltrated Boston Harbor and "released the germs that seeded the city" (Aderet 2020). In 2020, the story began to spread that the coronavirus was a genetically engineered bioweapon that escaped from a high-level lab in Wuhan, China. Chinese officials at the same time claimed that the US Army had introduced the virus to China. Matteo Salvini, the leader of Italy's anti-migrant League Party, contended that the outbreak of the virus was a result of the Chinese deliberately cultivating a "lung supervirus" from "bats and rats" (see Graper, this volume). And on social media, people shared speculations that Bill Gates, on behalf of Big Pharma, was behind the emergence of COVID-19. As the coronavirus became a global pandemic and posed a major challenge to health systems, numerous rumors, stories, and hoaxes spread regarding causes, transmission, prevention, and cures of the disease.

Rumors included suggestions that wearing masks will make you sick; that COVID is transmitted through 5G networks; that the vaccines contain a microchip designed to track your movements; that certain foods and drink were effective against COVID, including lukewarm water, alcohol, onion, ginger, sea lettuce, and bleach; and that one should avoid spicy foods and drink cows' urine. Other rumors suggested it was unsafe to receive packages from China, that you could get COVID from eating in Chinese restaurants, and that the origin of COVID was Chinese people eating bat soup. There were stories of numerous individuals who were deliberate infectors, such as those who spat or coughed on produce in the grocery store (see Bock, this volume) or "superspreaders," such as the woman in Korea referred to as Patient 31 who was believed to have infected thirty-seven people.

Such rumors are not without consequence. Stories, for example, that indicated hand sanitizer could protect those who drank it from contracting COVID resulted in 5,900 hospitalizations, eight hundred deaths, and sixty cases of blindness (Doheny 2020). But these rumors and narratives are neither new, unpredictable, nor surprising. A look at the recycled stories of epidemics demonstrates the patterns that stories of disease replicate and how they illustrate lay perceptions of risk.

Although legend analysis demands that we recognize changes in narratives over time and space, legend scholars have simultaneously paid attention to historical consistencies in narrative plots and motifs, sometimes tracing them back hundreds of years. The repetition of narratives

that have remained culturally viable and that resurface—albeit in new clothing—centuries later underscores the cyclical nature of cultural attitudes and the centrality of narrative articulations of pervasive concerns. Although HIV/AIDS, for example, was a relatively new disease, its legends were often reformulations of narratives that circulated in response to smallpox, leprosy, bubonic plague, syphilis, and numerous other historical epidemics. The precursors of current popular health legends are bone-chilling in their suggestion that hundreds of years of modern medical advancements have made little difference in our gut reactions to illness and disease.

By way of example, one of the most widely disseminated and frequently told HIV/AIDS legends involves a man who meets a woman in a bar, takes her to a hotel or back to his apartment, and sleeps with her. In the morning when he wakes up, the woman is gone. He gets out of bed and walks into the bathroom, where he finds a message written on the mirror in lipstick: "Welcome to the World of AIDS." Often the narrative also contains a coda in the message: "I am going to die, and so are you." Daniel Defoe's *Journal of the Plague Year*, set in London in 1665, provides an early analogue to the "Welcome to the World of AIDS" narrative.

> A poor unhappy gentlewoman, a substantial citizen's wife, was (if the story be true) murdered by one of these creatures in Aldersgate Street, or that way. He was going along the street, raving mad, to be sure, and singing; the people only said he was drunk, but he himself said he had the plague upon him, which, it seems, was true; and meeting this gentlewoman, he would kiss her. She was terribly frightened, as he was only a rude fellow, and she ran from him, but the street being very thin of people, there was nobody near enough to help her. When she saw he would overtake her, she turned and gave him a thrust so forcibly, he being but weak, and pushed him backward. But very unhappily, she being so near, he caught hold of her, and pulled her down also, and getting up first, mastered her, and kissed her; and which was worst of all, when he had done, told her he had the plague, and why should not she have it as well as he? (Smith 1990, 129–30)

There are numerous antecedents to the "Welcome to the World of AIDS" tale told about herpes, gonorrhea, and syphilis. The narratives share the notion of a deliberate infector who, upon finding out about his or her own condition, seeks revenge by transmitting the disease. The longevity of this narrative, continually resurfacing with new diseases and new health concerns, suggests the diachronic persistence of concepts such as the infected body as weapon, the personification of disease, and the evil contaminated "other" seeking revenge.

Over the last decade and a half, folklorists have come to refer to the "Welcome to the World of AIDS" story as "AIDS Mary" (or "AIDS Harry" when the antagonist is male). The reference alludes to the story of "Typhoid Mary," an Irish American cook who spread typhoid to some fifty people in the early 1900s (Brunvand 1989, 197). Typhoid Mary supposedly knew of her "carrier" status and yet continued to spread the disease for eight years after her discovery of the risk. Fast-forward to this century and we find a news story relating that Thomas Duncan, a man who came from West Africa to visit family, died of Ebola in a Dallas, Texas hospital in 2014. The headline, just one among many, notes a Typhoid Mary connection: "21st Century Typhoid Mary: Ebola Tom, the Liberian Medical Moocher, Traveled to US for First-World Healthcare." Numerous news stories have been printed discussing "COVID-19's Typhoid Mary or Patient Zero" (see, for example, Ahuja 2022). In March 2020, a single individual, dubbed "Patient 31," was blamed for a massive rise in South Korean cases of COVID (Kasulis 2020). Legal cases are just beginning to be prosecuted for deliberate transmission of COVID-19. In 2021, Christopher Charles Perez was sentenced to fifteen months in jail for posting on Facebook that he had paid someone with COVID to lick items at a grocery store in San Antonio (see O'Kane 2021). The stories go on, casting blame and creating scapegoats.

The 2014–15 outbreak of Ebola in Liberia, Sierra Leone, and Guinea created the same rumor panic we are accustomed to seeing in epidemics and highlights the traditional nature of epidemic legends and rumors. In Atlanta, following the transport of two patients from Liberia to Emory University hospital, there was a rumor of a massive outbreak of 145 cases in the city. Later in the fall, a Facebook rumor stated that seven Kansas third graders had been infected with Ebola by their substitute teacher, and in Wortham, Texas, seventeen kindergarteners were rumored to have contracted the disease from an exchange student. We heard that the US government had issued a travel advisory after a family of five in Texas had been diagnosed with the disease, that U2 singer Bono had contracted Ebola while caring for a man in Liberia, and that three workers in a Doritos factory had died of the disease. We heard that Ebola was airborne, that it could only be destroyed by nuclear warheads, that the US government was planning to build death camps to intern the millions of victims who were inevitably going to come down with the disease, that Ebola was a biowarfare weapon created by the US, that the iPhone 6 was contaminated by Ebola, that the US government was planning mandatory vaccination, and that the CDC had created Ebola and obtained a patent for it to profit from the development of a vaccine.

Much of this should sound familiar. The rumors address issues that surface in every epidemic—contamination, conspiracy, and stigma. Focusing more closely, we can divide many recycled epidemic legends and rumors up into topical areas that lend themselves to rumor and legend: contaminated food (see Graper, this volume), contaminated spaces, and contaminated people (see Kitta; Bock, this volume). The rumors address gulfs between medical and governmental institutions and the populace, topics of distrust of medicine, greed and Big Pharma, lack of transparency and communication, and medical inequities and incompetence—all red flags of lay concern (see Hiiemäe et al. 2021).

It is also clear that public health and the media are tradition bearers in the disease legendary process. They help mediate these narratives, providing a template for what becomes legend. What's more, public health creates epidemiological trajectories with interstitial gaps—in other words, spaces for legend to intervene. Contact tracing, just as an example, inadvertently personifies epidemics and creates a profile of the disease carrier, shaping public perceptions of vulnerability, rates of infection, and geographic and ethnic associations with a disease.[9] Further, the disease itself becomes a character, imbued with disregard for morality or borders. The notion of contaminated foods, spaces, and people, continually recycled in the narrative traditions of laypeople, the media, and public health, makes it clear that the vernacular, popular, and scientific constructions of disease all fall predictably along the lines of home and away, familiar and foreign, civilized and uncivilized, moral and immoral.

CONSPIRACY NARRATIVES AND CONSPIRACY THINKING

Over the weekend of January 22–23, 2022, flyers linking Jewish government officials to COVID were left on the doorstep of hundreds of homes in Miami Beach. The flyers featured a Jewish Star, a pentagram, and the names of fourteen people working for the CDC, the Department of Health and Human Services, and vaccine companies Pfizer and Moderna. At the top of the flyer, it read, "Every single aspect of the COVID agenda is Jewish." The statement is just one in what has become a common conspiratorial linkage of the COVID virus with Judaism. During the COVID years, Jews were frequently blamed on far-right platforms for creating, causing, or spreading the virus. Common antisemitic COVID tropes include Jews developing the virus in a laboratory to create a "superelite designer world," Jews exploiting the virus to get rich, unsanitary Jews spreading the infection, Zionists developing a deadlier strain of the virus to use against Iran,

and Jewish American democratic financier George Soros working with Big Pharma to spread the virus.

Such stories are not new. During the bubonic plague, Jews were accused of poisoning the wells, resulting in a massive massacre of the Jewish community. Antisemitic conspiracy narratives are recycled around the world with nearly every public health crisis. The classic motifs tend to be variations on two ideas—the "poisoning of gentiles" modern mutation of the blood libel story or the "Jews want to control the world" motif. Freeman et al. (2022), in a survey of coronavirus conspiracy beliefs in England, found that almost half of their 2,501 participants endorsed to some degree the idea that "coronavirus is a bioweapon developed by China to destroy the West" and around one-fifth endorsed to some degree the idea that Jews have created the virus to collapse the economy for financial gain.

While conspiracy theories evolve around every major disease, COVID-19 is arguably the most conspiracy-laden disease ever experienced. In the summer of 2020, the Pew Research Center found that 71 percent of Americans had heard the widely circulating conspiracy theory alleging that powerful people intentionally planned the coronavirus, and 25 percent believed the theory to be true (Schaeffer 2020). The YouGov-Cambridge Globalism Project, a survey of about twenty-six thousand people in twenty-five countries designed in collaboration with the *Guardian*, found widespread conspiracy-related skepticism concerning COVID. Among the most widespread of those theories was that COVID death rates had been deliberately and greatly exaggerated. Nearly 60 percent of respondents in Nigeria believed this to be true, along with 40 percent in Greece, South Africa, Poland, and Mexico and 38 percent of Hungarians, Italians, Germans, and Americans. Across nineteen different countries, 20 percent or more of respondents said they gave at least some credibility to the view that "the truth about the harmful effects of vaccines is being deliberately hidden from the public," including 57 percent of South Africans, 48 percent of Turks, 38 percent of French people, 33 percent of Americans, 31 percent of Germans, and 26 percent of Swedes (Henley and McIntyre 2020). A December 2020 NPR IPSOS poll found that more than one in three Americans believe in the existence of a "deep state" (Newall 2020).[10]

The extensive belief in COVID conspiracy theories is likely tied to a wave of disinformation from science deniers, the political/governmental manipulation of COVID information and efforts, and the general rise of social media (Shahsavari et al. 2020). Arising out of waves of politically centered disinformation and the fake news debates (see Mould 2018) centered in the Trump White House, COVID conspiracies found an easy niche.

Perhaps best understood as existing on a continuum of more extreme and less extreme conspiratorial beliefs, conspiracy theories can vary greatly. At the more extreme pole, some COVID conspiracy theories find their inspiration in QAnon, a conspiratorial group that emerged on October 28, 2017, on 4chan, an image-based anonymous internet bulletin board. With origins in the Pizzagate[11] conspiracy a year earlier, QAnon primarily held to the theory that President Trump was waging a secret war against a pedophilic ring of "deep-state" elites linked to the Democratic Party (see Bodner et al. 2021, 143–63). Starting as an American phenomenon, QAnon moved quickly to Europe, creating hotspots in Germany, Britain, the Netherlands, France, Italy, and Spain. QAnon was tied to anti-masking and anti-vaccine theories, claiming that 5G mobile networks created the pandemic, that the pandemic was created to control the masses through lockdowns and vaccines, and that vaccines were useless or harmful medicines devised by pharmaceutical giants with the help of corrupt Democrats. The results of the popular spread of QAnon theories have been dangerous, leading to mask and vaccine resistance, violence against those seen as deep-state actors or defenders, and threatening real-world responses to the narrative. At the end of 2020, for example, Anthony Quinn Walker planted a bomb in downtown Nashville that destroyed several city blocks. Warner's target was an AT&T building, which provided what he believed was the COVID-causing 5G network.

But not all conspiracy theories are as extreme as those pushed by QAnon. Numerous studies show that conspiracy theories have been a staple of American political and public health culture long before COVID. Oliver and Wood (2014) note that a number of national surveys sampled between 2006 and 2011 found that half of the American public endorse at least one conspiracy theory. Anna Merlan defines conspiracy theories as ideas that, in their most fundamental sense, seek to explain upsetting events by identifying a supposed secret group of evildoers who must be opposed in order to bring the world back into a state of calm and order (in Bodner et al. 2021, 2). Anika Wilson suggests a definition that presents a more sympathetic view of conspiracy theories, cognizant perhaps of another, less extreme pole of conspiracy believers. She notes, "As theories based in observation and the authoritative weight of past traditional narratives of suspicion, conspiracy rumors often posit compelling interpretations of real events" (2013, 58). Indeed, some conspiracy theories are based heavily on real events that have indicated a reasonable need for distrust. The forty-year Tuskegee experiment that was intent on observing the course of untreated syphilis in African American males, thereby withholding treatment, had lasting effects on public confidence in medical research, public health, and

the American government, within but also outside Black communities. The long history of involuntary or coerced sterilization of Latinas in the United States has had a similar impact. In each of these cases, health conspiracy theories are based on a sound and appropriate distrust of our medical systems. The perceived threat of "vaccine passports" and other digital and bureaucratic tracking technologies (Rouhier-Willoughby 2020, iv) and the belief in medical experimentation of COVID treatments on minorities are both old traditions, and ones that may not seem at all inconsistent with the prior horrors of inhumane medical research and care. Conspiracy theories existing at the opposite pole from QAnon-type beliefs may be collective narratives or beliefs that are based on community experiences that demonstrate the foolhardiness of placing trust in the medical establishment. While conspiracy theories may seem highly implausible, they are best understood when placed within the larger discursive, social, and political context (Briggs 2004) affecting community and individual concerns about the COVID epidemic and healthcare. Conspiratorial thinking thrives in environments of low confidence and low trust (Shahsavari et al. 2020, 279) and as such, they are informative. They can point to areas of vernacular concern, identify inequalities in the system, and highlight areas where there are clashes in medical worldviews (Goldstein 2004, 53).

NOT THAT, THIS: COVID-INSPIRED FUTURES

Necessity, we remembered so well during COVID, is the mother of invention. As goods and service distribution pipelines became stressed by COVID, a new tradition began that some have called "Not that, this." The idea was that we have, by necessity, become more flexible about substitutions for products we once embraced with fierce dedication. "Not that, this" became a gift for friends, made up of items that we were once forced to use as a substitute but that we now found superior to the original. Just as COVID made the world fearful and bleaker, it also provided suggestions for a better future. As COVID has dragged on, it has become commonplace to see news pieces on the parts of COVID life that will be with us for some time to come—remote work, curbside delivery, Zoom education. Some of those things sadden us, tied to the impersonality of modernity or suspicions that they will increase the work or school week. Yet "Not that, this" reminds us that a part of COVID vernacular culture is not just what we are forced to do now, but also things that will become a more permanent part of our traditions, things that have drawn us in and improved our lives. And in some cases, the vernacular has even inspired more official changes.

We have seen this before as well. Between 1873 and 1945, Dr. Edward Livingston Trudeau ran a center for the treatment of tuberculosis in Saranac Lake, New York. Inspired by reading about Prussian success treating tuberculosis with the "rest cure" in cold mountain air, Trudeau began his own world-renowned sanatorium dedicated to "the fresh air cure." Trudeau's sanatorium was based on the notion that the best way to cure tuberculosis was fresh air and complete bed rest. To facilitate both treatments, Trudeau created what he called "cure cottages"—houses with several porches, balconies, and sunrooms that could accommodate outdoor exposure for multiple patients on cots. Many of the cure cottages had sliding glass walls that could open up a room to the outside. Patients spent at least eight hours a day on the cure cottage porches. As the treatment got more popular, architects collaborated with the doctors to develop better ways to accommodate patients' fresh air needs while protecting them from the elements (Baldwin 1932; Woodward 1994). One of Trudeau's staff physicians subsequently designed a "cure chair," now known as the Adirondack recliner, that had a slightly reclining back, wheels, and wide arms. Both the architecture of the cure cottages and the design of the Adirondack chair became popular and remained sought after long after the fresh air cure was no longer needed for tuberculosis. Many of us today have cure cottage–inspired porches on our homes or Adirondack chairs on our decks.

Just as tuberculosis created designs that reflected new values in living, so too, it appears, has COVID. Balcony singing, eating, and visiting during COVID have led to an international reappraisal of the balcony as a part of home architecture (see, for example, Emekci 2021; Sepe 2021), even in those places where they are not currently used. Once seen as a way to dress up building facades or to create a few square feet of fresh air, balconies during COVID suddenly became important places to share experience and demonstrate national solidarity. Not only were balconies a part of public life under confinement, they also became a part of the reappraisal of the juncture between urban design and disease, as well as notions of lifestyle, sociability, and architecture. Numerous architectural design articles have been published since 2020 suggesting that homes require greater outdoor transitional spaces, including porches, decks, and balconies.

COVID has also changed attitudes toward cooking and eating, at least for the near future. A survey by Hunter, a consumer market research firm, found that 71 percent of people in the US indicate they will continue to cook at home more following their COVID experience. In a survey reported in *Food Dive* magazine, sales and marketing agency Acosta found that 35 percent of those surveyed indicated a post-COVID newfound passion for

cooking (Devenyns 2021). Just as COVID provided inspiration for home cooking and eating, it also engendered experimentation with bread making and sustainable gardening that are likely to be seen as positive future commitments. Family and community regular events like game nights and scavenger hunts are also likely to remain an ongoing part of the post-COVID picture, at least for some. The slower lifestyle and appreciation of those around us may be a part of "Not that, this" for some time to come, and the vernacular traditions that helped us survive "behind the mask" just might carry on.

NOTES

1. Victor Turner (1974) refers to plague transitioning to periods of community health in his reading of van Gennep and discussion of liminality.

2. https://blog.streamelements.com/state-of-the-stream-june-q2-2020-livestreaming-is-getting-much-larger-and-more-global-8acfc3fadbba Accessed February 20, 2022

3. According to surveys, Republicans believe twice as often as Democrats that Chinese scientists engineered the coronavirus and that Bill Gates wants to use a mass vaccination campaign against COVID-19 to implant microchips in people to track them with a digital ID. See Sanders 2020.

4. The Hatch Act of 1939 banned the use of federal funds for electoral purposes and forbade federal officials to coerce political support with the promise of public jobs or funds. The act prohibits federal employees below the policy-making level from taking "any active part" in political campaigns, such as running for office in partisan political campaigns, giving speeches on behalf of partisan political candidates, or soliciting money for such candidates (Asp 2021).

5. Stop Asian Hate is the slogan promoted by Stop AAPI Hate (Asian Americans and Pacific Islanders), which is the organization that tracks related hate statistics. Black Lives Matter is the name of both the slogan and the decentralized confederation of groups advocating for justice, healing, and freedom for Black people.

6. Contrast this with the polio epidemic. Polio was visible for a long time in the population among those who survived the disease but required lifelong access to a wheelchair, crutches, or leg braces, or who retained a limp. Franklin D. Roosevelt contracted polio twelve years before becoming president and despite trying to conceal the extent of its impact, he acknowledged having contracted it. His presidency put polio front and center in the US. Even once a vaccine severely limited the number of cases in the Western Hemisphere (and internationally until 2003, when a break in international vaccination reinstated the disease in developing countries that had previously eliminated polio), the visual remnants of the disease remained. This was especially the case because of post-polio syndrome—potentially disabling symptoms that can appear decades after the initial illness. Polio's hypervisibility kept it in the public imagination; it was (and is) the subject of numerous histories, literature (including children's literature), artwork, and works on public health, virology, and vaccine development.

7. This is shown over and over in the work of folklorists writing on epidemics (see, for example, Turner 1993; Briggs and Mantini-Briggs 2003; Goldstein 2004; Bennett 2005; Wilson 2013; Lee 2014; Kitta 2012, 2019).

8. Claude Lévi-Strauss (1966) theorized the *bricoleur* (bricklayer) as a person who uses their surrounding resources to create something new.

9. Or, as is seen in Julianne Graper's contribution to this volume, various agents, institutions, and ideologies, political or otherwise, can compel the personification of disease in terms of race, ethnicity, or other characteristics to provide profiles and personifications of a scapegoat for crises.

10. While the ISPOS poll does not define "deep state," according to Merriam-Webster, the term refers to "an alleged secret network of especially nonelected government officials and sometimes private entities (as in the financial services and defense industries) operating extralegally to influence and enact government policy" (https://www.merriam-webster.com/dictionary/deep%20state).

11. QAnon alleged that coded words and satanic symbolism purportedly apparent in John Podesta's emails, hacked during his tenure as chair of Hillary Clinton's 2016 US presidential campaign, point to a secret child sex-trafficking ring at a pizza restaurant in Washington, DC, called Comet Ping Pong. QAnon originated out of the Pizzagate conspiracy theory and maintains the central belief that a covert cabal of powerful elites controls the world, using their power to abuse children.

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Figure 1.0. Homemade face masks