“It Doesn’t Matter What I Think”: Perceptions and Experiences of COVID-19 in Rural Northern California

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Abstract

Much remains unknown about how COVID-19 has been interpreted in rural America. This knowledge gap is increasingly problematic as cases in rural areas have proliferated, overwhelming local health systems. For this reason, this thesis investigated how residents of Shasta County, California, made sense of the early months of the COVID-19 pandemic, using ethnographic moments, vignettes, observations, and 30 in depth qualitative interviews with Shasta residents to convey how people perceived, experienced, and responded to coronavirus during the summer of 2020. This paper pulled out a variety of worldviews and responses in this demographically homogenous region, identifying various mechanisms through which residents felt disenfranchised from the political process and isolated from other communities. As a result, this paper advocates for a more measured policy response to infectious disease pandemics that reframes necessary public health interventions in terms of one's personal responsibility to protect each other. This research further underscores the necessity of federal relief funding and directives to facilitate compliance and understanding.
1. Introduction

How and why did rural Californians respond to COVID the way they did in the summer of 2020? This thesis deconstructs the perceptions of outsiders as well as those of locals in thinking about, responding to, and living with viral threat and social controversy. Understanding the different motivations of the inhabitants in Shasta County can inform the creation of more effective policy for future outbreaks. The perceived irrelevancy and inadequacy of state and federal policy speaks to the need for a better understanding of rural Californians’ needs, desires, and experiences. Although this thesis highlights the diversity within and amongst rural areas, some common cultural trends emerged that can be applied to rural areas across the United States.

The WHO first declared COVID-19 a pandemic in March of 2020, and since then the disease has been an incessant topic. Many were in shock as it hit high-income countries such as the United States and in Europe, which were previously considered “safe” from an infectious disease outbreak (Dalgish 2020, Ball 2020). SARS-CoV-2, known as the novel coronavirus, has caused over one million deaths and countless more disabilities, widespread lockdowns, and destabilized the biggest economies in the world over the past 7 months (International Monetary Fund 2020, “Generation Coronavirus?” 2020). Many discuss “the new normal” as people attempt to adjust a host of new realities – missed life events, new childcare responsibilities, mass unemployment, disability and death, and the mental health toll of experiencing a globe in crisis (Connell 2020). The inequitable distribution of the disease and aid has sparked social unrest in countless countries (Connell 2020).

COVID-19 in turn sparked political controversy as the 2020 presidential election in the United States came up. The US government’s response to COVID faced several setbacks: the nation experienced serious shortages of N95 masks and other PPE at the beginning of the pandemic and once again during the winter of 2020-2021 (Ranney, Griffith, and Jha 2020). Experts discussed a “second wave” since the first COVID-19 surge in spring (Xu and Li 2020), hypothesizing that it would particularly
affect rural communities (Karim and Chen 2020). Although these predictions came true and policymakers were warned, there was little preparation in advance.

President Trump was heavily criticized by policy experts and the media for his response to the virus and unscientific recommendations. He initially pinned much of the blame (and responsibility) for the virus on the Chinese government, labeling the disease the “China virus” (Jaworsky and Qiaoan 2020). This in turn sparked racially motivated hate crimes against Asian people in the US (Gover, Harper, and Langton 2020). President Trump (and many others’) exploitation of the confusion surrounding the viruses has led to such movements as the “anti-masker” movement across the United States, with significant impacts on the epidemiology of the disease (Esposito et al. 2020).

President Trump elicited further controversy when he contracted and recovered from the virus after a presidential debate (Chaggaris 2020). Both of the two opposing main parties seized on recent events to emphasize the importance of voting for their particular candidate. President-elect Joe Biden ran on a Democratic platform with the promise that he would respect the science and solve many of the issues the Trump administration faced, presenting a complete “Pandemic Plan” (Subbaraman 2020).

As such, the COVID-19 pandemic inspired extreme polarization across the country (Hart, Chinn and Soroka 2020). The pandemic took on a political dimension, particularly in terms of mask-wearing practices (Smith 2020). This essay will in part examine how local contexts and understandings influenced people’s perspectives during the pandemic, as well as how people prioritized the various risks that the COVID-19 pandemic presented.

2. Background and Context

The Sacramento River is often described as the “lifeblood of California.” Similarly, the river forms the basis of several overlapping geopolitical identities which encompass each other, as depicted in Figure 1. The Sacramento River runs directly through Redding, California, which is the main town in Shasta County, the area of study. This area has been described as “where the mountain meets the
valley,” creating a rich array of natural resources (Rocca 2001); the Sacramento River has also
influenced the mineral deposits and other natural resources in the region. Members of Shasta County
conceive of themselves on a regional as well as a county level. The northern half of the state of
California, referred to the “North State” or more colloquially, as “NorCal,” claims an independent
cultural and geographical identity from the southern half of the state, “SoCal.” More historically, the
larger region of Northern California and Southern Oregon have claimed a distinct political culture from
their respective states and lobbied to form the independent state of Jefferson (Jefferson Public Radio,
2020).

Figure 1. Annotated physical map of Northern California. The legend depicts several differing
gopolitical identities that are further explored in this paper. County lines are outlined in white. Map

Shasta County’s history is rife with resource extraction and the subsequent boom-and-bust cycles
associated with the practice. Local historian Al Rocca identified four main historical events that have
determined the direction of Shasta County’s growth since its foundation: the gold rush of 1848-1859,
the copper mining and smelting from 1896-1920, the construction of Shasta Dam from 1938-1945, and the various rises and falls of the lumber industry in the region (Rocca 2001).

Before any of these events happened, however, Northern California was home to several different Native peoples; the Wintu, the Yana, the Okwanuchu, the Achomawi, and the Atsugewi (Rocca 2001). The Wintu lived in the flatter plains to the south of the region, the Yana lived in the eastern foothills, and the Okwanuchu, the Achomawi, and the Atsugewi lived in the intermountain regions to the northeast. (Rocca 2001)

The intermountain region has a different history than the rest of Shasta County, partially owing to the different tribes that lived there as well as the terrain. This name stems from its geographic location between the Sierra Nevada and Cascade mountain ranges, which separate Fall River Valley from the rest of Shasta County. The first white people to see the Fall River Valley came to the area in the 1830s as trappers employed by the Hudson Bay Company (Neasham 1985). A second wave of farmers arrived soon after, founding towns such as Fall River Mills to process grain in the region (Neasham 1985). These settlers quickly came into conflict with local tribes and waged a series of bloody massacres against them (Neasham 1985).

Despite the atrocities committed in Shasta County against Native peoples, many tribes still survive and have established their own political bodies within Shasta County. The federal government recognizes six tribes: the Redding Rancheria, Pit River Tribe, Hoopa Valley Tribe, Klamath Tribes, Quartz Valley Indian Reservation and the Karuk Tribe (US Department of Agriculture Forest Service). In addition, the federal government does not officially recognize seven more tribes: the Winnemem Wintu, Tsnungwe Tribe, Nor-Rel-Muk Wintu Nation, Wintu Tribe of Northern California and Toyon-Wintu Center, United Tribes of Northern California, The Shasta Tribe Inc., and Shasta Indian Nation. Due to its location in the biggest city in the region, Redding Rancheria is a relatively influential tribe in Shasta County. In addition, Redding Rancheria welcomes members of Pit-River, Wintu, and Yana
descent into its tribe (Redding Rancheria) This may have helped strengthen their political power to negotiate within the Redding area.

Redding would not exist without the railroad. The Central Pacific Railroad Company began building a railroad in 1870 with the plans to connect Oregon with California (Rocca 2001). After two years, they decided the terrain was unfavorable and decided to build a railway depot at “the topographic head of California’s great Central Valley” (Rocca 2001). Although the area has grown out of its railroad stop origins, the Redding Station still sends plenty of trains out on the same track that cuts right through the middle of town.

But many people did not come to Redding through the railroad; instead, they found their ways to Shasta County, and to Redding, for various reasons and through different migrations. Some came for gold, like many who flocked to California. Others came for mining and smelting jobs that took advantage of the mineral deposits in the region, especially copper. After World War I ended and demand for copper for ammunition dried up, many in the region lost their jobs in the copper industry and moved into Redding looking for any work (Rocca 2001).

This economic depression only ended 18 years later in 1938, when construction began for Shasta Dam as part of the New Deal (Rocca 2001). Many of these workers were Midwesterners fleeing the Dust Bowl in the Midwest, particularly Oklahoma (Alexander 2004). Due to their socio-economic status, many found themselves excluded from the label of “Californian.” (Alexander 2004) In turn, many of these migrants eventually adapted their Oklahoman identity into that of “Okies,” referring specifically to this exodus of Oklahomans and other Dust Bowl-era migrants. (Alexander 2004) In fact, linguistic studies of the region have revealed that the local Redding dialect has been more heavily influenced by southern and midwestern linguistic patterns because of this migration. (King 2012). Although “Okies” have been accepted as Californian today, the distinct identity, history, and speech patterns of the
region reflect the differences between the Central Valley region of California and the coastal, more urban regions of the state.

The fourth, more recurrent industry in the region has been lumber and wood processing. Northern California contains the largest timberland areas in California, concentrated in Humboldt, Mendocino, Plumas, Shasta, and Siskiyou Counties (Laaksonen-Craig et al. 2003).

Local historian Jeremy M Tuggle writes,

In 1844 the lumber industry became the second major industry in Shasta County, eclipsing fur trapping, the first major industry that began around 1828... The 1852 California State Census reported that there were eight mills established within Shasta County and additional sawmills would be erected in following years. Although eclipsed by other industries, the lumber industry continued to thrive and still operates today (Tuggle 2017).

The area experienced its first boom in 1849, fueled by gold miners who needed wood for buildings such as cabins, business houses, and shoring for mine tunnels (Smith 2013). Dottie Smith from the Shasta Historical Society writes, “So scarce was cut lumber that some of the early business establishments and cabins were constructed with canvas, or anything and everything that could be used to create walls” (Smith 2013).

Timber experienced a second boom in the 1880s in the Fall River Valley. After the passage of the Timber and Stone Act of 1878 allowed speculators to buy large tracts of land for low prices, many moved to the area (Neasham 1985, p.87). This boom was short lived, however, and the region’s timber and water resources were not tapped until much later (Neasham 1985, p.87). As the promise of riches faded away from the region, Fall River Mills “settled down to the isolated existence of a small town in cattle country” (Neasham 1985, p.87), sidelined by the same railroad that propelled Redding to prominence and the seat of the county (Neasham 1985, p.86).
From the 1920s to 1930s, the lumber industry again skyrocketed in Shasta and Siskiyou Counties (May 1953). At the same time, the lumber industry has contributed to health issues in the area and subsequently received backlash from community members; in the 60s and 70s, local residents called for a reduction in the pollution caused by the disposal method that the “vital” wood manufacturing industry used (Dost 1969).

In 1996, Shasta County contained 1,231,000 acres of timberland, the third highest in the state behind Siskiyou and Humboldt Counties. The National Forests of the US Department of Agriculture (USDA) own the majority of this region, but there is “significant private forestry in Shasta and Siskiyou Counties” as well (Laaksonen-Craig et al. 2003). Sierra Pacific Industries, the second-largest lumber producer in the United States and largest private landowner in California, is headquartered in Shasta County (Curiel 2008, Sierra Pacific Industries 2020). From 1975 to 2000, private lumber companies acquired nearly 10% more timberland as the number of lumber of companies simultaneously shrank (Laaksonen-Craig et al. 2003).

The shifting boom-and-bust cycles of the lumber industry have driven migration in the region. One participant explained how she and her husband, a lumber broker, moved from Medford, Oregon to Spokane, Washington. “Then his company closed up,“ and so they moved to Eureka “for a company he got a job with.” The shifting demands of the lumber industry moved this participant across Northern California and Southern Oregon until her husband’s lumber job led them to Redding. Another participant described meeting people whose families had lived in these lumber towns for “more than 150 years” in towns like Loyalton, where “especially over the last 20 years or so.... they have lost their only bank. They lost their only pharmacy. So people have to travel for half an hour to one hour in the snow to get the medicines even they only have one gas station left and the population has declined from three thousand to 1000 over the last 10, 20 years or so. Jobs have left and it has become a vicious cycle of economic downturn which has devastated them. So what they told me was this the reason there was
because the major industry used to be lumber, and that was shut down. The sawmill. And once that was shut down. Everything went down." As such, the past glory of the lumber industry also figures prominently into the mythology of Northern California. One participant explained that the federal and state governments had issued “extreme regulations on cutting trees,” where “even if it’s only private property, you have to get permission from different central government regulatory authorities, which may be very expensive and very time consuming. And if you cut a single tree, even in your backyard, they are penalized big time, up to ten thousand dollars or so. And they these people solely and squarely blame the government regulations for killing the lumber industry and killing the town and community and economy. And this this thing is not alone." Subsequently, many have identified with Trumpian nostalgia, connecting it with this regional longing for the lumber industry of the past (Scheide 2017).

One participant felt that “the people who live in San Francisco .... Have dominance in the politics of California and they decide what is good for their state, including the northern state.” Although Northern California contains “almost one third of the state and is rich in natural resources, water, timber and agriculture.... the people in big cities like San Francisco and L.A. wanted to control those resources, but they are not concerned with the livelihood and the well-being of the people who live here.” Consequently, many feel as if they have “lost their say in their own life” and are externally controlled by urban politicians who are not affected by the local regulations they put into place.

As southern Oregon has similar geography, demographics and history to Northern California, over the years different groups have proposed combining these two entities into a single cohesive state named “Jefferson.” This idea first became popular in 1941, where “men from the counties that comprised the proposed state would gather weapons and patrol the “state’s” borders on a weekly basis, while “declaring their intent to secede from Oregon and California as an independent state .... until Jefferson was made a reality” (Ancestral Findings). This movement had enough support in both California and Oregon state governments that a governor was elected “in preparation for Jefferson
being given official state status.” However, these plans “were scrapped” after Pearl Harbor “so residents of all states in the United States could focus on the nation’s participation in WWII” (Ancestral Findings). The State of Jefferson movement “symbolized the rugged individualism and self-sufficiency of the people who live in the region and became a way to refer to the area to attract tourists and businesses.” (Jefferson Public Radio) In 2013, the movement experienced a revival in Northern California; this modern iteration of Jefferson has campaigned to recall Governor Newsom, particularly in response to COVID restrictions imposed by the state government.

The new State of Jefferson movement has also rallied around water politics in the state, which have become contested in recent years due to frequent droughts. (Scoville 2015) The Central Valley Project has transported water from Lake Shasta in Shasta County to Bakersfield in the Southern San Joaquin Valley since the 1930s (California Department of Water Resources). Many perceive this water transfer as another form of resource extraction for the more populous southern half of the state.

Redding has experienced a smaller economic boom with the exploding popularity of Bethel Church (Rancano 2019). From their Wikipedia page, “Bethel Church is an American non-denominational charismatic megachurch in Redding, California with over 11,000 members. Bethel Church is a congregation rooted in the love of God and dedicated to worldwide transformation through revival. Their goal is for God’s love to be manifest in signs, wonders and miracles.” Bethel’s School of Supernatural Ministry (BSSM) has become an “epicenter of modern Christian culture” that attracts students from around the world to learn miraculous healing (Rancano 2019).

At the same time, Bethel Church has proven to be a major political and economic player locally; the megachurch owns Redding Convention Center as well as several popular secular stores in town. As Bethel’s following is over 1/10th of Redding’s population, many locals who are not affiliated with the church feel that Bethel exercises undue influence in town (Chamberlain 2020). Others have criticized Bethel for its actions (and perceived inaction) during the Carr Fire, which devastated the community.
More recently, Bethel leaders’ response to COVID-19 has drawn ire from locals (Chamberlain 2020). Prominent individuals affiliated with Bethel, such as Sean Feucht, organized mass gatherings without masks in July. (Shulman 2020) It recently came out that Kris Vallotton, one of the founders of BSSM, hosted a larger outdoor wedding in October (Benda 2020).

The local Health and Human Services department has identified eight main concerns at the moment: COVID-19, gonorrhea, head lice, marijuana, measles, meningococcus, syphilis, and wildfire smoke (Shasta County Health and Human Services Agency 2020). Some estimate that more than 40% of the school-age population has not been vaccinated for measles, in large part due to prominent a prominent “anti-vaxxer” culture in the area (Ingraham 2015). This culture of vaccine refusal has been proven to significantly affect the epidemiology of measles (Phadke et al. 2020).

Due to other pre-existing vulnerabilities in this population, such as a high prevalence of COPD and other respiratory issues, cardiovascular disease, and diabetes and obesity, (HHSA 2014), many residents are especially vulnerable to COVID-19 (Centers for Disease Control 2020). At the same time, the rate of homelessness has dramatically risen in recent years (SC HHSA 2014); the homeless population is especially vulnerable to COVID-19 because of a lack of existing healthcare as well as the ease of spread in congregate settings such as homeless shelters (Lima et al. 2020).

As the world dealt with COVID-19, the west coast of the United States experienced widespread wildfires throughout the summer (Xu et al. 2020). These fires were more widespread and intense than ever, in part due to climate change (Xu et al. 2020); throughout the west coast, the sky turned gray and rained ash. Even if one never directly encounters a wildfire, they severely impact human health in more subtle ways; the stress from wildfires can affect survivors’ mental health and the smoke can cause respiratory issues both in the short-term and long-term (Xu et al. 2020).

Locals perceived the COVID-19 pandemic through the lens of the ongoing fires as well as past traumatic experiences with fires, such as the 2018 Carr Fire, which devastated the area economically.
and destroyed hundreds of homes (Atieh 2020). As they dealt with the double-threat of COVID-19 and 2020 Zogg Fire, many Shasta County residents described reliving the trauma they experienced during the Carr Fire (Atieh 2020).

The electrical utility company PG&E additionally factored into how Northern Californians experienced COVID-19 and the fires. PG&E began implementing power shutdowns throughout the North State in summer of 2020 (Chapman and Benda 2020). These shutdowns were implemented due to PG&E’s part in starting the deadly Camp Fire of 2018; their faulty power line sparked the blaze that would kill 85 people and destroy the entire town of Paradise (Romo 2020). At the same time as these power outages may have prevented further fires during the dry, windy part of late summer, they also placed additional strain on local residents (Jacquez 2020).

The different boom-and-bust cycles have characterized Northern Californian history since the arrival of white settlers in the 1850s. Different natural resources and disasters (water, lumber, various minerals, and fires) have placed rural Northern Californians’ interests into conflict with larger corporate and government entities, which many perceive as from the Bay Area. These geographic and economic rivalries have also been transposed onto the framework of national bipartisan politics – Northern California largely votes Republican, while the rest of California votes Democrat (Shasta County Elections). Consequently, these preexisting political, geographic, and economic rivalries influenced the way Northern Californians perceived state regulations related to COVID-19 and in turn, COVID-19 prevention measures in general.

3. Literature Review

Recently, Michael Lewis, author of Moneyball and Bloomberg Opinion columnist, visited Shasta County to document how this area has responded to COVID. His scathing article paints the local response as a complete revolt. He describes how crazed extremists have threatened the local health officer’s life and attempted to perform a citizens’ arrest on the Board of Supervisors. Lewis marvels at
how a stay-at-home mother from the Bay Area could have ever organized the “vaguely lunatic groups” of Northern California (Lewis 2020).

Lewis’ column presents a sensationalized summary of real events. Shasta County officials have encountered noncompliance with COVID-19 regulations and guidance, which recently culminated in a spike in cases. Shasta County is not the only place with COVID-19-related dissent, however. This small region can provide a snapshot of larger trends throughout the United States. Analysis of these trends can then inform policy response which can ensure and promote local cooperation with public health directives. This paper surveys existing literature on the topic of rural public health, crisis and risk perception, and identity (re)formation.

3a. Rural Public Health

Rural areas have vastly different demographics, needs, and health outcomes than urban areas (Centers for Disease Control 2017). Public health mainly analyzes rural areas’ needs in terms of two perspectives: health systems and population health. A health systems perspective focuses on the resources that are available to rural areas. Previous studies have already documented that rural health departments generally receive less funding than their urban counterparts (Dearinger 2020). Rural areas additionally face large healthcare worker shortages and issues. Overall, rural health perspectives tend to focus most on health systems, as they can advocate for specific and concrete actions, such as preservation of rural hospitals (Hartley 2004).

A population health perspective analyzes how certain prevalent conditions and factors over one’s life can result in systemic differences in health outcomes (Hartley 2004). Recent public health literature has advocated for a stronger focus on how socioeconomic determinants of health, such as income level, race, gender, and predisposition towards certain diseases, might influence health outcomes (Hartley 2004). Population health might also analyze the proportion of the population that experiences
diabetes, that smokes, that has heart disease, and so on. Rural areas tend to have higher rates of poverty than urban areas, which in turn results in higher rates of heart disease and diabetes (Hartley 2004).

Due to the novelty of the COVID-19 virus, few articles have analyzed how COVID-19 has impacted rural health. Melvin et al. (2020) note that high levels of poverty, lack of healthcare infrastructure and healthcare professionals, aging populations, and higher rates of chronic illness might render rural portions of the southeastern United States especially vulnerable to the threat of COVID-19. They propose a more health systems-oriented solution, specifically how to redirect emergency response resources towards the southeastern US in collaboration with local organizations.

In contrast with most existing literature, this study will approach rural public health from a cultural perspective. It will borrow from sociological and anthropological approaches to examine how rural beliefs influence residents’ health-related decisions, focusing on the context of COVID-19. This work will highlight how health systems and population health approaches do not sufficiently capture the complexities of this pandemic or rural health as a whole. Furthermore, the paper will provide insight into how rural areas particularly experienced a pandemic, which can inform future pandemic response.

3b. Crisis and Risk Perception

Crises bring out vastly different responses – some people may run away from a fire, while others will run in. This is partially based on how people perceive the risk they will receive in a crisis situation. Different perceptions of the risk at hand, as well as their personal social responsibility in alleviating that risk, in turn influence their response.

Previous research has drawn out several attributes which may inform how an individual perceives the risk of a situation - namely, voluntariness, knowledge, visibility, and trust (Cori et al. 2020). According to this framework, perception of the risk associated with COVID-19 is relatively high
since the virus is perceived as involuntary and uncontrollable, it is unusual and there is little knowledge of the issue, and because trust in the institutions managing the situation has been severely undermined (Cori et al. 2020). However, this method is mainly limited to the initial response to the virus. It does not analyze longer-term responses to the pandemic, nor does it factor in more specific factors in an individual’s risk perception.

Others have distinguished the initial “panic” response to COVID-19 from a subsequent reaction to this panic. As the pandemic stretched on, many felt an urge to return to the normalcy of their lives before COVID-19, including social interactions (Manderson and Levine 2020). A risk perception analysis that discusses both short-term panic and long-term complacency is important for consideration of how and why anti-mask and other COVID denialist sentiments may arise. This study will further investigate how and why people attempted to return to normal and combat their initial panic in response to COVID-19.

Many have noticed how certain demographics, such as age and ethnicity, can influence one’s perceptions of their surroundings, and thus their risk. The cultural theory of risk “indicates that individuals in different groups or contexts would have varied perception of risk because of different collective experiences that coordinate their way of living” (Xu 2018). Various studies have confirmed the cultural theory of risk by seeing how different identities, such as ethnicity, may result in different senses of social responsibility in response to the same disaster (Mullin and Soetanto 2013). Others have applied this theory to the pandemic; de Bruin et al. (2020) identified how individuals’ perception of the risk of COVID-19 is influenced by age. They further noted that people of different ages had different concerns that affected their mental health during the COVID-19 pandemic. Especially considering how rural areas, including Shasta County, have largely older populations as compared to urban areas, it is important to take de Bruin’s data on the elderly’s concerns in response to COVID-19.
Another body of literature on risk perception analyzes health care workers’ perceptions of risk. Health care workers may respond more like professionals in general, but when faced with disaster situations, they tend to act more like the general public and rely more on emotional and cultural cues to inform their perception of risk (Gesser-Edelsburg et al. 2014). COVID-19 has proven to be no different; healthcare workers did not rely on their education, but rather their emotions in response to COVID-19 (Peres et al. 2020). These studies prove that particularly in the face of an unprecedented crisis such as COVID-19, it is important to analyze the cultural influences which may override education and reasoning.

The cultural theory of risk has proven that media framings can significantly alter the effect of individualism and collectivism on risk perception (Xu 2018). Collectivists also tend to perceive more serious risks and have more intense emotional responses to a risk than individualists would have (Xu 2018). Some have argued that the more individualistic frontier culture that makes up American culture is in part responsible for the United States’ weak COVID-19 response (Bazzi et al. 2020). Some have suggested reframing consumer desire in order to encourage a deeper sense of collective responsibility and action in more individualistic cultures and groups (Atkinson 2012).

Many studies on risk perception recommend application of the same framework to different communities, different settings, and different hazards, as results may differ according to the cultural theory of risk (Xu 2018). As such, this study will contribute to understandings of risk perception by applying previous frameworks to new, previously unstudied contexts. This study’s analysis of Shasta County will reveal new aspects of risk perception as it traces the unique pathways that led to risk perception in the area. This new application will influence theories of risk perception that can be applicable to different settings.
3c. Identity Formation and Mobilization

People’s perceptions of risk influenced by their previous experiences and how they consciously choose to identify. Fukuyama writes that “identity grows... out of a distinction between one’s true inner self and an outer world of social rules and norms that does not adequately recognize that inner self’s worth or dignity” (Fukuyama 2018). People have mobilized behind certain identities and created political movements in order to attain a basic dignity that they feel others are afforded (Fukuyama 2018). However, these identities have increasingly fractionalized as time has gone on, preventing a cohesive, broad movement on the left (Fukuyama 2018). More recently, digital media has facilitated the increasing individualization of social mobilization (Bennett 2012). In turn, group-based “identity politics” have evolved to encompass personal lifestyle values, which can engage with “multiple causes such as economic justice (fair trade, inequality, and development policies), environmental protection, and worker and human rights” (Bennett 2012).

In the United States, different understandings, or “matrices” of morality have influenced the two main political parties (and their disagreements) as well as religious conflicts (Haidt 2012). These political parties have taken on their own meanings and become independent identities as well, influencing individuals’ perceptions of the threat of COVID-19 (Cavillo et al. 2020). This paper identifies several different forms of identity that may have influenced the frames that developed in Shasta County during COVID-19; these identities may be political (such as identification with a particular party), geographical (such as inhabiting a certain state), or more individual (based on race, gender, ethnicity, or health status).

Research in the United States has found that inhabitants of mountainous areas are more likely to have certain psychological traits corresponding with this “frontier mentality” (Gotz et al. 2020). Caroline Fraser traces the invention of this frontier mentality, focused on ideas of self-reliance and freedom, through the myth-making process of writers such as Laura Ingalls Wilder and her widely
influential “Little House on the Prairie” series (Fraser 2017). At the same time, she deconstructs the narrative of independence that has been faithfully reproduced in modern libertarianism and demonstrates the reality of American interdependence (Fraser 2017). In turn, this national mythology has created an attitude of “rugged individualism” that led to the collective inaction many have witnessed from the United States during the COVID-19 pandemic (Bassi et al. 2020). Despite rural social organizations and other individuals’ semi-successful attempts to create a cohesive rural culture and identity, rural settings have demonstrated their own diversity of beliefs, opinions, and groupings (Neal and Walters 2008).

Race has proven to be a particularly influential factor in the differential treatment and experiences of various rural Americans (Pearson 2015). The national mythology of the self-sustained frontiersman conveniently and intentionally glosses over the explicit racial subjugation that facilitated westward expansion, characterized by games of “Cowboys vs. Indians.” This attitude has been intentionally reproduced in modern rural American societies in myriad ways (Pearson 2015). Analysis of media coverage of both the (urban, Black) heroin epidemic and (suburban and rural, white) prescription opioid epidemic has revealed that differential coverage contributed to the “racialized deployment of the War on Drugs,” which “color blind ideology” sustains (Netherland and Hansen 2016). White supremacy lives on in rural settings partially to buoy the white rural American in the face of rising poverty and worse health outcomes, but also contributes to these same trends (Metzl 2019).

In short, available literature shows that identity influences individuals perceptions of risk in response to a crisis and how they make sense of their surroundings. Analysis of these perceptions is essential in order to inform a public health crisis that has been facilitated by societal beliefs (Connell 2020).
4. Methods

This study draws from ethnographic approaches based in anthropology and history to understand how COVID was experienced and perceived in Shasta County, CA between June and November 2020. Shasta County is a semi-rural county in the northern portion of the Sacramento Valley and southern parts of the Cascade Mountains. The county is one of the more conservative in the state - as of 2020, 50% of registered voters were Republican, compared with 24% Democrat, 20% NPP, and 7% other (Shasta County Elections); 64% voted for Trump in the 2016 election. The vast majority of residents are white (87.1%) and Christian (USC Center for Religion and Civic Culture 2009). Shasta County is a popular retirement destination; as such, the population is proportionally older, a trend that is only increasing (Shasta County Health and Human Services Agency 2014). In 2018, the median household income was $50,905 and the per capita income was $27,983 (Census 2018).

This project primarily draws from 30 semi-structured ethnographic interviews of participants mainly residing in Redding, the central town which contains roughly half of the county's population. Approximately 83% of study participants were white, which roughly corresponds with the general population. Most participants alluded to practicing or being raised in some form of Christianity. The participants ranged in specific religious traditions, incomes, occupations, and political affiliations. These 30-120-minute interviews were subsequently analyzed in tandem with evolving events, ethnographic observations, and media depictions of Shasta County during this period in order to understand how local residents perceived multiple crises at the same time.

Interviews consisted of 3 main sections: background, perceptions of COVID, and social experiences of COVID. The background section discusses a participant's life before COVID. “Perceptions of COVID” investigated participants’ main sources of information, focusing on media sources. This section also asked participants about prevention methods, their opinions on local government leadership, and political leaning. The third section focused on participants’ experiences as
businesses began reopening. The final question asked participants to reflect on what the “new normal” meant and would look like.

In addition to these ethnographic interviews, I recorded extensive field notes from January 2020 to October 2020. I documented important community events and analyzed county, school, and community responses to these events. In constructing this timeline, I was able to reflect on how policies influenced certain communities’ responses within the area of study. Additional data was collected from social media and other media sources.

Much of the data collected during this time period was also grounded in my personal experiences of the situation. I grew up in this region and my family still lives there; although I spent college in Washington D.C., I have been living in Redding since March of 2020. Many of the participants were recruited through personal connections, both direct and indirect. These personal ties allowed me to more deeply and frankly discuss COVID-19 with many participants, especially since there is a deep distrust of outsiders. At the same time, my own place within my community most likely influenced our discussions.

After recording and transcribing interviews, I identified recurrent topics that came up throughout these interviews. Using this as a starting point, I drafted a preliminary code book and expanded definitions throughout the analysis. These recurrent topics, or codes, were organized into ten main categories: personal background, personal impacts, informational sources, emotions, prevention and solutions, ideals, political aspects, healthcare aspects, business and job status, and historical context. For example, I extracted codes for “masks,” “freedom,” “anti-vaxxers,” “election influence,” and “trust.” This inductive approach led me to return to the data and rework analysis several times. I altered codes and narratives based on ongoing discussions with other researchers, new events and observations of the local context, and my own evolving understanding of the theory underlying many of the topics that emerged.
5. Results

Table 1 demonstrates demographic characteristics of the interview sample. Within this sample, there was a roughly even distribution amongst age categories: 36.7% of participants were between 31-49 years old, while 30% were younger and approximately 33% were older. I interviewed 12 women and 17 men. 83.3% of participants identified as white, 10% identified as Asian, 3.3% identified as Native, and 3.3% identified as Black. Approximately one-third of participants had completed a 4-year degree, and 40% of participants considered themselves to be middle-class. Most people self-identified as having moderate politics but did not disclose party affiliation (33.3%); others identified themselves as Republican (20%), Democrat (30%), Libertarian (6.7%), or Independent (6.7%). One person did not disclose a certain political leaning. 20% of participants perceived a high risk, 26.7% perceived themselves at moderate risk, 46.7% perceived themselves to be at low risk, and 6.7% perceived themselves as low-risk, but were “unsure.” This conception of risk could refer to either their personal risk or the risk of the larger community. Participants also discussed their health, mostly in reference to COVID-19. 83.3% of participants identified themselves as healthy; 10% mentioned a chronic or current illness/condition that would make them more vulnerable to COVID-19, i.e., immunocompromised. An additional 6.7% identified themselves as “healthy, but” they had asthma, diabetes, or another chronic condition that did not affect their overall health status. This demonstrated that “immunocompromised” status did not necessarily correlate with local conceptions of health. At the time of interview, none of the people interviewed had contracted COVID-19; two participants disclosed that they knew people who had contracted the virus. Over the time during which these interviews were conducted, approximately 8 people died in Shasta County; as of 11/24/20, 43 people have died (Shasta County Health and Human Services 2020).

Table 1. Demographics

<table>
<thead>
<tr>
<th>Age</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Count</td>
<td>Percentage</td>
</tr>
<tr>
<td>---------</td>
<td>-------</td>
<td>------------</td>
</tr>
<tr>
<td>18-30</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>31-49</td>
<td>11</td>
<td>36.7%</td>
</tr>
<tr>
<td>50+</td>
<td>10</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>12</td>
<td>40%</td>
</tr>
<tr>
<td>Men</td>
<td>17</td>
<td>56.7%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Income</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low or low-middle</td>
<td>6</td>
<td>20%</td>
</tr>
<tr>
<td>Middle</td>
<td>12</td>
<td>40%</td>
</tr>
<tr>
<td>Upper-middle</td>
<td>8</td>
<td>26.7%</td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>High school</td>
<td>3</td>
<td>10%</td>
</tr>
<tr>
<td>Technical</td>
<td>7</td>
<td>23.3%</td>
</tr>
<tr>
<td>Some college</td>
<td>5</td>
<td>16.7%</td>
</tr>
<tr>
<td>4-year degree</td>
<td>10</td>
<td>33.3%</td>
</tr>
<tr>
<td>Graduate</td>
<td>5</td>
<td>16.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Politics</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Libertarian</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Republican</td>
<td>6</td>
<td>20%</td>
</tr>
<tr>
<td>Democrat</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>Moderate</td>
<td>10</td>
<td>33.3%</td>
</tr>
<tr>
<td>Independent</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Unsure</td>
<td>1</td>
<td>3.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perceived Health</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy</td>
<td>25</td>
<td>83.3%</td>
</tr>
<tr>
<td>Healthy, but... *</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Illness (chronic, acute, recovered)</td>
<td>3</td>
<td>10%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perceived COVID Risk</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>14</td>
<td>46.7%</td>
</tr>
<tr>
<td>Low, but</td>
<td>2</td>
<td>6.7%</td>
</tr>
<tr>
<td>Middle</td>
<td>8</td>
<td>26.7%</td>
</tr>
<tr>
<td>High</td>
<td>6</td>
<td>20%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Coronavirus Infection</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>No</td>
<td>30</td>
<td>30%</td>
</tr>
</tbody>
</table>
This study revealed the numerous facets of the Coronavirus pandemic. After reviewing my field notes and transcripts of the interviews, I identified several prominent topics that consistently occurred across interview data. I then arranged these topics into several code groups and subcategories. These codes are depicted below in Tables 2-9 and 11. I will further break down each section of these code groups, highlighting prominent codes and providing examples for each.

Throughout my interviews, I found people alluded to their own backgrounds and experiences to explain why they thought a certain way. Interviewees described identities that became particularly salient to them throughout the pandemic – for example, race. Shasta County is approximately 87.1% white. One Vietnamese participant described the microaggressions they experienced as the result of resentment due to the “China virus.” Others referred to their profession in the health care field as informing their understanding of the virus and government actions taken to mitigate it.

Compared to the national average median income of $61,937 and state average of $61,489, Shasta County’s median income is $44,556 annually (HHSA 2014). As such, local economies were an important theme for many interviewees. At the time of the interviews, many participants voiced concerns about the diminished economy, often prioritizing it over COVID-19 mitigation measures. However, I found that response to COVID-19 was dependent on far more than any single identity. In addition, participants might change their position based on new information or recent events, such as the dramatic spike in cases since September (Figure 2).

**5a. Informational sources**

Table 2. Codes related to where participants obtained information. Codes that appeared over 30 times are highlighted in yellow.

<table>
<thead>
<tr>
<th>Informational Sources</th>
<th>Definition</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When heard</strong></td>
<td>What month they heard about COVID</td>
<td></td>
</tr>
<tr>
<td>December</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>January</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>News</td>
<td>Where they get most of their news</td>
<td></td>
</tr>
<tr>
<td>------</td>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td>National Right</td>
<td>Fox News, PragerU</td>
<td></td>
</tr>
<tr>
<td>National Left</td>
<td>NY Times, MSN/CNN</td>
<td></td>
</tr>
<tr>
<td>National Central</td>
<td>Reuters, NPR</td>
<td></td>
</tr>
<tr>
<td>Regional News</td>
<td>KRCR, Record Searchlight</td>
<td></td>
</tr>
<tr>
<td>Social Media</td>
<td>Twitter, Facebook, Apple News</td>
<td></td>
</tr>
<tr>
<td>Diverse News Intake</td>
<td>any mention of consuming news from multiple, contrasting sources</td>
<td></td>
</tr>
<tr>
<td>Distrust of News</td>
<td>any mention of distrust of major news sources</td>
<td></td>
</tr>
<tr>
<td>Other people</td>
<td>Any mention of hearing things by word-of-mouth, from unverified sources or anecdotes, etc.</td>
<td></td>
</tr>
</tbody>
</table>

As the majority of participants had minimal to no personal experience with COVID-19 up until the summer, informational sources dramatically impacted their perceptions and understandings of the virus. Most participants reported that they first heard about the virus in January, when it first appeared to be a concern in China, or in March, when the virus reached the United States and many areas began instituting lockdowns and/or stay-at-home orders. Many people relied on regional news sources, such as KRCR on public television or the Record Searchlight, a local newspaper. Participants equally cited national informational sources on either side of the political binary, such as Fox News or CNN. Some explained they consumed both sources because they were “both targeted to a specific side of the political spectrum.” Others would lean more towards one news source, but might occasionally “overhear” another viewpoint because they lived with a family member of opposing political views.

As shown in Table 1, social media tended to be the most important source of information – various participants described their daily news intake as mainly coming from Twitter, Facebook, or Apple News. Many acknowledged the limitations of these resources, noting that “a lot of it’s someone’s opinion” or that “when it first shows up on Facebook, it’s a panic situation. You just don’t know what’s the underlying information.” One participant prefaced their explanation with “of course... you can’t trust anything on Facebook,” but expressed confusion that they could find both “some nurses crying and
saying how horrible [Coronavirus] was and they were really scared” as well as “nurses saying, ‘...what they’re showing [on TV] is not what’s really happening.’” At the same time, social media often seemed most accessible, as some participants explained that they were unsure “how to research that kind of thing” further.

Several participants expressed distrust and confusion in regard to informational media. One participant believed that “media is showing you what they want you to see. And I think that being at this day and age, we need to search a little bit harder for the accurate and right truth of the information.” This criticism was not limited to social media; many condemned news sources such as CNN for “always giving [their] opinion 24 hours a day, it’s not news. It’s opinion.” As such, many participants described consuming diverse forms of information specifically in order to discern the reality of the situation.

Many people also described relying on more politically neutral news sources, such as NPR and Reuters. This differential consumption of politicized news sources may correspond with the demographics of participants. As depicted in Table 1, the majority of participants (33.3%) described themselves as politically moderate. As such, they may have struggled to make sense of what seemed like highly divisive political rhetoric and chose to consume various forms of this media as well as more centralized sources.

Overall, participants described a range of informational sources that contributed to their understanding of COVID-19. They often perceived that these various news sources filtered the raw facts of a situation through their own opinions and understandings in their social media postings, in turn influencing others who relied on social media for their knowledge of the pandemic. These news sources additionally impacted residents’ understandings of their personal risk and responsibility in regard to the COVID-19 pandemic (Xu 2018).

5b. Personal Impacts
Table 3. Codes related to how Coronavirus impacted participants personally. Codes that appeared over 30 times are highlighted in yellow.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affect life positive</td>
<td>coronavirus has affected life in a positive way (e.g., more time with family, slowed down life, time for reflection)</td>
<td>13</td>
</tr>
<tr>
<td>Affect life negative</td>
<td>coronavirus has affected life in a negative way (e.g., stress, no childcare, have to stay home)</td>
<td>37</td>
</tr>
<tr>
<td>Affect life neutral</td>
<td>discussion of things being pretty much the same, overall being okay, being better off than others, etc.</td>
<td>3</td>
</tr>
<tr>
<td>Avoid discussing</td>
<td>people avoid talking about it because it is too divisive, stressful, etc.</td>
<td>24</td>
</tr>
<tr>
<td>Age</td>
<td>any mention of worry about coronavirus being linked to age</td>
<td>17</td>
</tr>
<tr>
<td>Discuss freely</td>
<td>people have no issue discussing the virus with various groups</td>
<td>14</td>
</tr>
<tr>
<td>Prioritize mental health</td>
<td>mentions putting mental health above coronavirus</td>
<td>6</td>
</tr>
<tr>
<td>Prioritize socializing</td>
<td>any mention of socializing, 'staying sane,' being too bored/lonely/isolated...any prioritization of social life over coronavirus safety</td>
<td>11</td>
</tr>
<tr>
<td>Schools</td>
<td>any mention arounds school decisions</td>
<td>21</td>
</tr>
<tr>
<td>Inequity</td>
<td>Participant mentions that patterns of discrimination or inequity have been impacted by COVID</td>
<td>40</td>
</tr>
<tr>
<td>Religious communities</td>
<td>any mention of how the religious community has responded to COVID-19</td>
<td>7</td>
</tr>
</tbody>
</table>

Although none of the participants had contracted COVID-19 and very few had direct contact with those afflicted with the virus, the majority of participants reflected that the COVID-19 pandemic had negatively affected their lives due to increasing overall stress in their lives, creating issues with managing childcare, forcing them to stay home and not interact with friends and family, and so on. Participants who worked in non-essential jobs expressed uncertainty and fear that their businesses would close or that they would lose their jobs permanently. Younger participants described losing certain opportunities as they began their careers. A few participants complained of the “inconvenience” of wearing masks or other personal protective equipment, of losing tickets to concerts, canceling travel plans, or missing out on major life events such as graduation, prom, weddings, and more. A large proportion of participants expressed concern about how COVID-19 had affected and would continue to impact schooling and learning ability. These people proposed various solutions, but all held a similar concern for how the issue was being handled.
Participants who lived alone described COVID-19 as “isolating” and alluded to mental health issues due to a lack of “human contact.” However, few people described putting their mental health concerns above their concerns about the virus. One participant described a friend who felt they had to maintain physical activity at the gym in order to maintain sobriety. In this way, some chose to prioritize the risk of a relapse over the risk of contracting COVID. A larger number of participants described social activities as essential to prevent them from “going insane in [their] own isolation.” Many tried to “meet those human needs” in a safer manner rather than completely isolating; some identified a few friends to maintain contact with during the pandemic or utilizing technology such as “Facetime and Zoom” to maintain connections with others. However, some chose to eschew caution about social events and large gatherings for various reasons, which culminated in events such as the gathering at the Sundial Bridge, the Mother’s Day Rodeo in Cottonwood, and various protests which will be discussed below (in “Local Context”).

Some participants explained that the subject COVID-19 was so “stressful” and divisive that they avoided discussing it with others. One veteran discussed COVID-19 “as little as possible” because “the death count every morning on the news” reminded them of the Vietnam War. Business owners avoided discussion in order to preserve their customers as COVID-19 was “too political” and they “[didn’t] want to offend anyone.” Many believed that discussing COVID-19 news or prevention methods with family and friends in order to “avoid confrontation” that they did not “have the capacity” to “assess accountability” or “[make] healthy boundaries with people.” As such, discussion of Coronavirus actively damaged even close relationships as many felt stuck in a gridlock where they could not change people’s minds and would only waste their own time.

This data also revealed significant concerns about how COVID-19 exacerbated existing inequities or created further inequalities. Participants conceptualized these inequalities in various ways; some focused on racial disparities in COVID-19 as well as in police treatment, such as those that ignited the
George Floyd protests in June. Others expressed concerns about the way incarcerated and homeless people were treated, mentioning that they were often “forced to shelter with people who tested positive for the virus.” Participants condemned such actions as “inhumane.” One participant who worked in the local Public Health department explained the difficulties of communicating COVID-19 information to marginalized groups in the area:

> So now what we’re looking at is how best to message that to particular groups. And so some groups are more marginalized than others. When we mention marginalized communities, we’re talking about folks that may not have economic resources or come from histories of displacement or discrimination. So some of those might be the Native community, and actually even breaking it down into the different Native communities within the Native community. The South Asian community, breaking it down into those categories of the Southeast Asian community. The Black community. Or also folks with different types of disabilities, whether it be hearing-impaired or sight-impaired or different things like that, as well as the LGBTQ communities could be seen in this particular community as being a marginalized community. And also we have like, as Cornell West calls, the precious poor. Many communities are very poor, and they have intergenerational poverty.

The diversity within this setting, as well as how different communities perceived themselves in relation to public health and governmental authorities, complicated messaging. One participant described that the significant minority Mien and Hispanic populations particularly might not trust local government.

Others focused more on how small businesses faced more severe enforcement than “box stores” because local public health authorities had “more leverage over the smaller businesses.” One participant elaborated that “some restaurants said, ‘forget it, we’re staying open,’ basically saying ‘come and arrest us’” with the knowledge that enforcement would not occur. Some participants complained that “essential” and “non-essential” designations “pick[ed] winners and losers” during the pandemic. One participant expressed shock that “an individual who sold popcorn at a movie theater
could now be getting unemployment benefits plus $600 a week. But the poor guy working the fry machine at McDonald's, they got nothing. And how is it that you can even begin to say that this is fair? I mean, it is dumbfounding that the government did this, and that is exactly what they did. They said your business is closed. You're unemployed. Here's $2,400 a month extra, enjoy. And some poor guy who's working pizza delivery... You're screwed, dude. You're not unemployed. You're gonna work. You're going to put yourself at risk. And you're going to work to make a lot more than the guy who doesn't get to work and gets to get free money." At the same time, other participants noted that unemployment and other COVID relief was both inadequate and unfairly distributed, explaining that “the money ran out” before many could obtain PPP loans, or that they waited for months before qualifying for unemployment benefits.

Some participants found a silver lining amidst the challenges the pandemic posed. They hoped that the “tragedies” of COVID-19 would “make people wake up” from their “daze of a routine” and “pay attention to things they hadn’t before.” This may have been in reference to the belief that COVID-19 had created a “shock to society” and galvanized civil rights movements such as the Black Lives Matter or George Floyd protests. The notion of “waking up” may have also reflected larger discontent with current societal and political realities. As such, COVID-19 provided a ray of hope in that people hoped it would shake people out of their routine and fight for positive change. Others noted that COVID-19 had “slowed life down,” allowing for more time for reflection, for bonding with family members. Those who maintained stable jobs throughout the pandemic noted that it had in fact benefitted them by restricting more unnecessary expenses such as going to the movies and eating out at restaurants.

Very few people, even those who were relatively unaffected by financial concerns, described COVID-19 as a relatively neutral occurrence in their lives. The paucity of this code demonstrates how the pandemic dramatically affected everyone in various ways, even before they may have directly experienced the virus.
Table 4. Codes related to the emotions that coronavirus elicited. Codes that appeared over 30 times are highlighted in yellow.

<table>
<thead>
<tr>
<th>Definition</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress: mention that coronavirus is stressful.</td>
<td>31</td>
</tr>
<tr>
<td>Fear: mention of fear related to coronavirus</td>
<td>39</td>
</tr>
<tr>
<td>Fear pushback: Mention that they don’t want to live their life in fear</td>
<td>4</td>
</tr>
<tr>
<td>Anger/frustration: mention of anger related to coronavirus</td>
<td>17</td>
</tr>
<tr>
<td>Disappointment: mention of disappointment related to coronavirus attitudes and/or response</td>
<td>1</td>
</tr>
<tr>
<td>Burnout: any mention of feeling burned out, apathetic, because of Coronavirus.</td>
<td>26</td>
</tr>
<tr>
<td>Doubt: any reference to doubting current understandings of coronavirus</td>
<td>23</td>
</tr>
<tr>
<td>Not real: any mention that coronavirus is not real</td>
<td>6</td>
</tr>
<tr>
<td>Exaggerated: any mention that coronavirus is not as bad/not as big of a deal/not as dangerous as it’s been portrayed</td>
<td>3</td>
</tr>
</tbody>
</table>

As a result of the various negative effects many experienced due to the pandemic, participants overwhelmingly described feelings of stress and fear. Some felt stress as they managed the new risk of COVID-19 for themselves and their loved ones. One participant explained that they felt “a lot more stress” as they worried about their children and who they interacted with when they were not staying with him. Another business owner described the stress of making “a tough decision – how do we keep paying the bills and keep paying our staff?” Those who worked in hospital settings worried about direct exposure to the virus; one graduate student described how, upon entering outpatient care, they had to “sign a contract that said if [they] died, [they] wouldn't sue [their] school.” As such, individual stress often compounded in these settings and further strained healthcare systems that were stretched thin as “everybody [got] more tired, more cranky... the whole staff, everyone... it takes a toll on people.” Many felt that the situation was “out of control” and that “it can be hard to be optimistic” in face of what felt like a looming eviction crisis. One participant explained this compounding stress as “a domino effect... so how many dominos can fall before system falls completely?”

Subsequently, many residents burnt out as the pandemic dragged on far longer than they had initially believed. Many initially watched COVID news regularly, but had begun to “tune out” the news after they “got tired after the first few weeks of checking in every day” to see Coronavirus updates.
After they initially assessed the risk COVID-19 might pose on their immediate surroundings – their businesses, their jobs, and their families – many felt comfortable with ignoring any further developments. One participant struggled to explain, “it’s not that I’m used to [Coronavirus]. But at the same time, it is kind of like you’ve gotten used to it... It’s still scary... but it doesn’t seem quite as terrifying as it did at first because it’s been going on for so many months.” Subsequently, many began to “ease up” on COVID-19 precautions as time passed and businesses began to reopen in the end of May. One participant explained that initially, “California responded well” to the virus. However, “after 3 months” of regulations, “when the reins came off, people were just mad and said, ‘forget it, we’re just going to do whatever we want.”

Several people expressed doubt over contemporary understandings of the virus and the threat it posed. The majority believed the virus existed to some extent, although they may have believed its danger was exaggerated or otherwise overemphasized. An older participant explained that:

“there’s just so much conflicting information now. At the beginning, they said heat kills it, and it can’t live through the summer, but now we’re having more cases. It’s confusing. And then again, that’s why I don’t believe the government and all the rules right now... it just seems ridiculous. And the other thing that makes it ridiculous is ... all the protests. People can do that, but you still can’t have a haircut. So that, I question, because it doesn’t make sense. So back to your question. I think that time will tell. I mean, if people really, the experts and researchers, if they don’t really know how the virus is going to act, then the only way to figure that out is just time. Or let it play out how... however it does. Which isn’t under anyone’s control. Other than to do what we already do – wash your hands, sanitize things, and try not to come in contact with it. But those are still all the things we do to try not to get the flu, so... yeah.”

Another participant stated that “we might find out in another 20 years it was either a big hoax or just politicized, the government doing this or that, I mean, who knows. We don’t even know where it came
from, I mean I've heard stories it was made in China in a laboratory, or that people were smuggling certain animals. Who knows?" One participant noted that this messaging often came from the “top down” as local actors repeated the same information which they heard from individuals such as “a governor in Georgia” or President Trump. The following exchange demonstrates how strongly many subscribed to these beliefs:

I: So that's kind of the next thing we're going to talk about. More just about your general experiences with the current pandemic. So –

....

P: And to be honest, I don't think it's considered a pandemic because usually pandemics are gauged on death. And now the big question is on cases. And that's kind of a strange switch because it's a 99, 98% recovery. So I don't think it truly is a pandemic. We are trying to promote it.

This participant felt strongly about my use of the word “pandemic” to describe Coronavirus to the point where she clarified her beliefs several minutes later. Her use of statistics mimics much of the rhetoric that other COVID deniers used to minimize the risks of the pandemic.

Even if they doubted the virus, many believed it was “better to play it safe.” These people took more convenient safety measures, such as social distancing and wearing a mask, even if they were “not convinced that they’re all necessary,” because they acknowledged that they might not “know everything, and so [they]’d rather be safe than sorry.”

A minority described that they wanted to actively oppose the atmosphere of fear that they perceived. Although one participant acknowledged that they themselves were at risk, they noted that “it's not everyone's not going to die with this virus, apparently. People recovering from it pretty quickly, but I'm of the era or the group that would probably be considered at risk because of age and health issues. I have some medical issues. I'm not 20 anymore. So you get my age, I'm in mid 60s, you have health issues come up. So, OK, so that doesn't cause me to sit and cower at home. I go out and I go
sometimes with a mask and sometimes without a mask.” This desire to push back against fear was intertwined with political preferences; one participant commended President Trump for recognizing “that we have to keep living, one way or another.”

Several participants were angry or frustrated due to COVID-19 policies and response. One participant described how they “need[ed] to take a break” from a friend because they advocated for anti-masking behavior. They elaborated that, “I’m not gonna hear this right now. I have listened to this all day, every day, for the last two months, and I don’t need to hear it from you right now.” A store owner was frustrated with dissatisfied, “boisterous” customers who continuously left angry feedback. He vented that “they don’t understand all the things that are going on in the back end just to get them food, and they want to nitpick your operation.” Another participant explained that they would project their frustration with policies onto their family, saying that “you don’t have anyone else to yell at, so you just yell at each other.” This insight reflects on the larger scale of country-wide politics. Many people turned on one another throughout the pandemic as they perceived their own powerlessness to affect policy changes or change their current realities. Instead, they re-directed their frustration towards others of the general public who were more accessible.

Interestingly, there was only one mention of disappointment in response to the virus. This participant felt that the 2-month long quarantine during the spring “hasn’t really accomplished much” and felt that the only real solution left was to let COVID-19 “wear itself out eventually.” In contrast with many COVID doubters who minimized the risk of the virus, this participant acknowledged that it was an “unfortunate and discouraging” solution. However, they seemed to believe this was the only option because the government had failed at containing the virus already and “it could have managed better.” Based on the context of existing government mistrust in the area, the scarcity of this viewpoint may reflect that many participants started out with low expectations of government intervention and
5d. Prevention beliefs

Table 5. Codes related to participants’ beliefs about coronavirus prevention and solutions. Codes that appeared over 30 times are highlighted in yellow.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevention belief</td>
<td>mention that they believe prevention is important for coronavirus</td>
<td>49</td>
</tr>
<tr>
<td>Prevention disbelief</td>
<td>mention that they do not believe prevention is important for coronavirus</td>
<td>6</td>
</tr>
<tr>
<td>Friends/family agree</td>
<td>friends/family behave in similar way to participant</td>
<td>31</td>
</tr>
<tr>
<td>Friends/family disagree</td>
<td>friends/family do not behave in similar way to participant</td>
<td>21</td>
</tr>
<tr>
<td>Community concordance</td>
<td>feels their beliefs align with others in the community</td>
<td>2</td>
</tr>
<tr>
<td>Community discordance</td>
<td>feels their beliefs do not align with others in the community</td>
<td>19</td>
</tr>
<tr>
<td>Moderation</td>
<td>Any mention of following prevention strategies in moderation</td>
<td>22</td>
</tr>
<tr>
<td>Quarantine</td>
<td>any talk of staying home to prevent coronavirus transmission</td>
<td>6</td>
</tr>
<tr>
<td>Social distancing</td>
<td>any talk of social distancing</td>
<td>55</td>
</tr>
<tr>
<td>Stigma</td>
<td>mention of stigma related to coronavirus, or a prevention measure related to coronavirus</td>
<td>6</td>
</tr>
<tr>
<td>Lockdown</td>
<td>any mention of completely locking down the country/state/area to prevent coronavirus</td>
<td>24</td>
</tr>
<tr>
<td>Enforcement</td>
<td>Any mention of enforcement, particularly legal consequences, as a prevention method</td>
<td>45</td>
</tr>
<tr>
<td>Education</td>
<td>Any mention of education being important to combatting Coronavirus</td>
<td>36</td>
</tr>
<tr>
<td>Mask Behavior</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mask</td>
<td>any mention of wearing a mask to prevent coronavirus</td>
<td>85</td>
</tr>
<tr>
<td>No mask</td>
<td>any mention of not wearing masks</td>
<td>18</td>
</tr>
<tr>
<td>Avoids mask</td>
<td>mention that someone actively avoids using a mask</td>
<td>22</td>
</tr>
<tr>
<td>Disbelief in masks</td>
<td>any mention of the belief that masks do not help prevent coronavirus</td>
<td>14</td>
</tr>
<tr>
<td>Medicine/drug</td>
<td>any mention of hydroxychloroquine or any other drug in relation to coronavirus</td>
<td>1</td>
</tr>
<tr>
<td>Herd immunity</td>
<td>any mention of herd immunity in relation to solving coronavirus</td>
<td>10</td>
</tr>
<tr>
<td>Vaccine</td>
<td>any mention of a vaccine in relation to solving coronavirus</td>
<td>21</td>
</tr>
<tr>
<td>Antibodies</td>
<td>any mention of antibodies in relation to solving coronavirus</td>
<td>1</td>
</tr>
</tbody>
</table>

The majority of participants expressed the belief that various prevention measures, such as social distancing, hand-washing, mask-wearing, contact tracing and subsequent quarantine, worked and were important for containment of COVID-19. The belief in specific measures varied; social distancing was commonly mentioned, followed by an emphasis on adequate enforcement and education. Masks
were the most frequent prevention measure brought up overall, although specific attitudes on mask-

wearing varied. Masks were often brought up in the context of the polarized debate around the issue
and subsequent reactions within Shasta County. Some of these participants qualified this by explaining
that they did not “go overboard” or they “wear a mask only when [they] have to.”

Although the majority of participants believed in COVID-19 prevention measures, they reported
that often, their families and friends may not have followed these measures as strictly as the
participants. As shown in Table 5, these members of a participants’ surrounding circle were slightly
more likely to follow prevention measures than to not. However, many reflected that their inner circle
was “split half and half” between prevention beliefs and disbelief. In comparison, most participants
believed that members of the larger community generally did not share the same beliefs or practices
related to COVID-19 prevention. At the same time, people’s perceptions of others’ behavior did not
neatly fall into approval or disapproval. The following exchange demonstrates this complexity:

I: Do you agree with their behaviors related to Coronavirus?

P: It depends. I think that- I don’t think there’s anything wrong with someone being safer than most
people. I don’t know anyone related to near friends of mine, that wants the lockdown to end sooner
rather than later. Because I think that opinion is not seeing the big picture at all.

I: What do you mean by that?

P: As soon as you end the lockdown, we’re just going to have to get another lockdown. You’re just
elongating the problem and making it more evident that it needs to stay. It just doesn’t work. It’s not
These results demonstrate how participants tended to perceive themselves as remaining largely in the middle of the debate over prevention methods, surrounded by pockets of mostly like-minded individuals that were outnumbered in the larger community.

Many participants believed that community-wide compliance with COVID-19 recommendations was due to a lack of enforcement by local law enforcement, which preferred to educate others as opposed to issue citations. (Shulman 2020) Many acknowledged the complexity of their situations, explaining that local enforcement “are in a peculiar place because I don’t think that there’s enough law enforcement to enforce it with all of this stuff going on in Redding. But also because Redding is so conservative, like if they did decide that they were going to enforce it, that there would be a lot of commotion and chaos regarding that.” One participant attributed this lack of enforcement to the Black Lives Matter/George Floyd movement, explaining that, “Yeah, that is a flaw that like with the police, I think now. With all of the Black Lives Matter and everything, I think police are now afraid to hold people accountable for their actions, which is an understandable response to everything that is going on.” Others believed law enforcement would not enforce COVID-19 mitigation measures because they were “politically motivated” to avoid enforcing largely unpopular laws. Many participants contrasted local response in Shasta County to surrounding counties in the area, such as Yolo County and Humboldt County.

Some of these responses also called for community accountability in conjunction with law enforcement. They explained that “we need to, as a society, decide to not be afraid to hold each other accountable.” One participant believed that local police officers could encourage further compliance if they obeyed measures themselves, explaining that “cop culture is very strong up here” and many might follow if local officials set an example. Another participant corroborated this claim, explaining that
there was a “deli downtown that never shut down a single day and they never wear their masks in
there” where “local or state fire department folks” and “law enforcement” would frequent, elaborating
that “some wear masks and some don’t.” The same time, others noted that “peer pressure, like social
and moral ‘maybe you should do it’” attitudes did not ensure adequate compliance and led to a
situation where “a third of the population in Redding don’t choose to wear a mask.”

Several participants emphasized the importance of health education within the community as well.
One participant who worked with local Public Health explained that they had mainly reached out to
businesses and certain industries as reopening occurred across the county, but that “community
members were not necessarily on board.” At the time of interviews, they had begun reaching out to
certain community organizations in order to emphasize the importance of following prevention
measures. Many emphasized that communication was inadequate, calling for “more present” and
“visible” information available on several platforms. One participant explained that, “You listen to a lot
of radio stations, you wouldn’t know there was a pandemic, except for the commercials that are like
‘we’ll still help you. And we’ll have our guys clean your car before we give it back to you.’ But you don’t
hear the speeches from the governor on a lot of them. You don’t hear... I haven’t seen a whole lot of
television. Like I said, I listen to it on the radio. You get bits and pieces of what’s being mandated. It’s
not broadcast as widely as it should be, in my opinion. It should be on every radio station.” They felt
there was inadequate communication of new and existing information on national, state, and local
levels; the local level felt particularly inaccessible as most health information from Public Health was
found “on Facebook.” Some participants felt that existing messaging missed certain vulnerable groups,
such as migrant workers, because “the message doesn’t get down to that level very well.”

Many participants also spoke about lockdown as a prevention method. Their opinions on this
method were mixed; some spoke about how the previous strict lockdown may have engendered later
noncompliance as people were already frustrated. As such, they advocated for more “moderate”
policies that balances various risks (aligning with the “moderation” code as well). Others believed that “a complete and total shutdown, a lockdown” was necessary to prevent further spread of the virus as things had gone too far. These people referred to examples such as New Zealand’s COVID-19 response, which has been widely praised. Some acknowledged that quarantine might be best “in theory,” but this possibility might not be feasible for many in the long-term, considering the financial limitations and mental health effects many reported.

Some participants believed that achievement of “herd immunity” would be the only complete solution in order to return to normalcy. One participant explained that “I don’t think there’s anything anybody can do to stop this. They can think they can or try to, but if you hear what they’re saying, they always say “Slow the spread,” not stop it. They say, “flatten the curve,” not “the curve bottoms out.” This is going to go on for a couple years. Maybe this herd immunity thing is the best thing we’ve got going. Just the way I feel about it. I mean, what can you do? If this thing spreads as easy as they say it does. You can’t lock everybody up.” This reflects a sense hopelessness about the pandemic as well as confusion over certain widely used terms, such as “herd immunity.” As such, it emphasizes the importance of health education and communication.

Various participants focused on a vaccine as the only method that would truly “return things to normal.” Many expressed doubts about the idea of a vaccine as a “magic bullet,” however. Participants worried how many people would be amenable to taking new vaccines and expressed their own distrust in a government vaccine. Others felt that while vaccines would be part of the puzzle, they would not replace a lack of “effective treatment and leadership.” Some participants viewed the vaccines less in terms of the immunity they might confer and more in terms of the reassurance a vaccine would give to the general population. One participant explained that, “now that everyone’s so freaked out and probably overreacted to [COVID-19] the only long-term solution to this is vaccines. So until there’s a vaccine, it’ll continue to be a big struggle.” This participant also hoped that roll-out of a vaccine would
not cause everyone, including government officials, to forget about the lessons learned from the pandemic and “go back to square one.”

Masks were by far the most controversial topic throughout the summer of 2020, particularly as Governor Newsom had only recently instituted a state-wide mask mandate in mid-June (Romo 2020). Residents of Shasta County displayed a variety of mask-wearing behaviors in response to new regulations and according to previous information they had received. The vast majority of participants expressed the belief that masks were effective at preventing spread of the SARS-CoV-2 virus. Some followed the mask mandate because they had family that encouraged them to, because they were required to wear masks in some stores, or because their jobs enforce mask-wearing. Other participants might “have masks and take them where they go,” but “not necessarily wear them every time they go out in public.” One participant explained that they would not wear a mask “unless I feel like someone thinks I should,” adding that they had never had anyone tell them to wear a mask. Some participants admitted that they did not wear masks “as often as [they] should” because masks felt “uncomfortable,” in the “suffocating” heat of Redding during the summer. One participant joked that, “the people who are making these [laws] do not live in Redding. They do not know how hot it gets.” However, this joke belies much of the common sentiment of the area, that outsiders do not understand the difficulties of living in Shasta County. As such, masking also became a way that residents of Shasta County determined outsiders and insiders within their community as well. One participant explained that they “have asthma and [wearing a mask] makes it way too difficult to breathe for me.” Another participant who had cancer described that they had “a breathing problem which causes issues with masks.” One participant felt that “a lot of people don’t know how to wear masks” and thus minimized any benefit masking would confer. Others felt that mask-wearing was over-exaggerated and that other prevention methods, such as hand-washing and distancing, were adequate enough to reduce risk. Some doubted the efficacy of cloth masks as opposed to N95 masks, particularly as people tended to frequently touch
their faces to adjust masks. A minority opposed mask-wearing on principle because they believed “that our government is using this to see who will and who will not obey their dictates, whether they are legal or not.”

Residents in Shasta County held a range of beliefs towards COVID-19 prevention measures. These results demonstrate that despite national rhetoric, attitudes towards mask and other COVID-19 prevention methods were not as simple as “pro-mask” and “anti-mask.” Although the vast majority of participants held varying degrees of belief in social distancing, hand-washing, and mask-wearing behaviors in order to prevent COVID-19, many perceived that they were in the minority as opposed to the larger community. As such, the attitudes people took towards prevention methods also reflect intra-community dynamics as well as differing self-perceptions.

5e. Ideals

Table 6. Codes related to ideals that participants cited. Codes that appeared over 30 times are highlighted in yellow.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Freedom</td>
<td>any mention of freedom, individual/constitutional rights</td>
<td>28</td>
</tr>
<tr>
<td>Individualism</td>
<td>any mention of my choice, personal choice, my life, or that others should care about themselves and leave me be. “To each their own” philosophy.</td>
<td>34</td>
</tr>
<tr>
<td>Protecting Others</td>
<td>protecting others from coronavirus is a major concern</td>
<td>43</td>
</tr>
<tr>
<td>Community consideration</td>
<td>any mention of finding comfort in communal struggle - ‘we’re all in this together’ mentality</td>
<td>4</td>
</tr>
<tr>
<td>Loved ones</td>
<td>any mention of being concerned about coronavirus affecting loved ones</td>
<td>12</td>
</tr>
<tr>
<td>Personal responsibility</td>
<td>taking personal responsibility for prevention transmission is important</td>
<td>22</td>
</tr>
</tbody>
</table>

Participants often referred to sets of base beliefs and ideals they held to which informed their response to COVID-19. Many referred to “freedom” and “individualism” as informing their reactions. One participant concisely explained, “Before I would wear the mask when I wanted to do it, but now I’m told by the governor that I have to do it at certain times.” They felt that COVID-19 regulations infringed on their constitutional rights and that officials should “let people do what they need to do.” Several participants attributed this attitude to local culture, explaining that “most people in the North State are
very pro- ‘I’m going to do whatever I want, and it does not matter how it affects me or anyone else.’ So they tend to not follow the recommendations or expect anyone else to follow them.” This sense of freedom was slightly different from individualistic tendencies that also discouraged people from holding others accountable. One participant described their attitude as “to each their own. If people want to walk around in a hazmat suit, I don’t care [laughs] It’s up to them. But if people don’t want to wear masks, either, that’s not my area to judge them.” Many felt that although it might be safer to encourage everyone to wear masks, it was immoral to dictate their beliefs to others. This attitude demonstrates the strength of individualistic ideology in this area.

Some residents applied similar individualistic beliefs to promote COVID-19 prevention measures, citing an attitude of “personal responsibility. One participant compared their prevention behaviors to defensive driving, explaining that “my response in public when I see people doing that is more to take more precautions to protect myself. So if I see groups, I’ll move away or I will wear a mask wherever I go. It’s sort of like defensive driving, where you should assume everyone besides you is a bad driver. When I go out, I just assume everyone’s a carrier and I have to do everything necessary to keep me and my loved ones safe.” As such, they applied the same individualism towards a more collective mentality.

Participants frequently alluded that their compliance with COVID-19 prevention was out of a sense of protection for others. One participant explained that they followed prevention measures “out of respect” for others; “if someone’s feeling uncomfortable about something and it’s a valid reason, you need to respect that.” Echoing the sentiment of “personal responsibility,” one participant explained how they connected their morals to their practices

*It was important for me to still keep fulfilling my responsibility and to be a good person, you could describe it as a good citizen or whatever, but essentially, it’s just a good person and being kind and respectful to other people. So you know, it was still important to me to keep behaving in a way that would keep myself safe and other people safe.*
As many participants identified themselves as not at risk for severe complications from the virus, they rationalized prevention concerns in terms of those around them, particularly their loved ones. Others cited specific people they came in contact with, such as “89-year-old Dorothy next door,” “family that are severely immunocompromised,” or “3 kids to protect.” A minority alluded to a larger community. One participant explained that, “even if I’m not super concerned about myself because I know that I’m young and healthy and the likelihood of anything bad happening to me is pretty small, I think it’s important to be responsible for other people in your community that you might have contact with who may be compromised or elderly.”

5f. Political Aspects

Table 7. Codes related participants’ political beliefs. Codes that appeared over 30 times are highlighted in yellow.

<table>
<thead>
<tr>
<th>Code Type</th>
<th>Code Description</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Election influence</td>
<td>any mention that coronavirus will go away after the election or that the election has someone led to exaggeration of response</td>
<td>9</td>
</tr>
<tr>
<td>Election disappear</td>
<td>belief that coronavirus will disappear after the elections or was politically manufactured</td>
<td>5</td>
</tr>
<tr>
<td>Political self-interest</td>
<td>mention that politicians are looking to their voting base/constituent desire over public safety</td>
<td>18</td>
</tr>
<tr>
<td>Anti-science</td>
<td>mention that politics are not taking scientific advice seriously, that science and politics are currently at odds, etc.</td>
<td>10</td>
</tr>
<tr>
<td>Anti-vaxxers</td>
<td>any mention of anti-vaxxers</td>
<td>12</td>
</tr>
<tr>
<td>WHO negative</td>
<td>Any negative comment/reaction on the World Health Organization</td>
<td>1</td>
</tr>
<tr>
<td>WHO positive</td>
<td>Any positive reaction/comment on the World Health Conversation</td>
<td>1</td>
</tr>
<tr>
<td>Foreign countries</td>
<td>Any mention of foreign countries’ response</td>
<td>13</td>
</tr>
<tr>
<td>China negative</td>
<td>Any negative comment/reaction about China</td>
<td>8</td>
</tr>
<tr>
<td>Policy Response</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncertain</td>
<td>government response was uncertain, wishy-washy, confusing</td>
<td>37</td>
</tr>
<tr>
<td>Decisive</td>
<td>cohesive, decisive response</td>
<td>6</td>
</tr>
<tr>
<td>Too late</td>
<td>government response came too late</td>
<td>10</td>
</tr>
<tr>
<td>Too early</td>
<td>response/prevention was lifted too early</td>
<td>5</td>
</tr>
<tr>
<td>Caring</td>
<td>response showed genuine care for others</td>
<td>3</td>
</tr>
<tr>
<td>Blasé/uncaring</td>
<td>response/responders seemed uncaring</td>
<td>5</td>
</tr>
<tr>
<td>Polarized</td>
<td>response was polarized or extreme on opposite ends</td>
<td>57</td>
</tr>
<tr>
<td>Federal level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trump negative</td>
<td>Any negative reaction/comment on Trump</td>
<td>42</td>
</tr>
<tr>
<td>Trump positive</td>
<td>Any positive reaction/comment on Trump</td>
<td>18</td>
</tr>
<tr>
<td>CDC positive</td>
<td>Any positive reaction/comment on the CDC</td>
<td>12</td>
</tr>
</tbody>
</table>
Broadly speaking, participants tended to negatively view political actors and events during the COVID-19 pandemic. Many described policymakers’ response to the virus as “back-and-forth,” “wishy-washy,” and “inconsistent.” Many concentrated their frustration on the discrepancy between federal, state, and local levels’ messaging. One participant explained that “there’s been a lot of conflict between different levels of government, and I think that mixed messaging is also making people very frustrated.”

Participants felt that “it was frustrating and confusing for a lot of people” to “close and then reopen” businesses, referring to business policies instituted by Governor Gavin Newsom on the state level. One participant elaborated:

“Newsom has been very back and forth with opening restaurants and closing restaurants and opening and closing use. He’s been very wishy washy with the regulations. His statements have been very contradictory. And it’s very much a ‘please the people’ instead of ‘let’s do what we need for the people and let’s do what the people need.’”

Despite historic distrust of large government response, the majority of participants believed a more “centralized” and “united” response would have benefitted mitigation efforts. This may have referred to a more measured response to prevent closing, re-opening, and subsequent closing, or it may have referred to “coordinated,” “consistent” messaging on all levels of government.
Closely related to concerns with mixed messaging, several participants alluded to the polarized nature of debate over COVID-19 prevention methods. As previously discussed, political party vastly influenced how people perceived the threat of COVID-19 and responded to prevention measures (Cavillo et al. 2020). However, many felt that “every political party has a very very strong view” which were “all extreme.” Many believed there was “[no] middle ground. It is very politically driven.” Many participants pointed to the different views different individual actors espoused, particularly those of President Trump. Even self-identified Trump supporters criticized the president for his outspoken attitudes towards the virus; they believed he should be “supporting what the people are saying” rather than “talking about disease, because he’s not an epidemiologist or physician or anything like that.” Some participants felt that “something like this [polarization] happens before every big election.” One participant worried that “if they don’t get something, together, Democrats and Republicans, things are going to get worse in this country.”

Although participants were more likely to mention negative opinions of President Trump than Governor Newsom, they were still more likely to criticize Newsom’s actions than support them. As previously mentioned, many felt that Newsom’s business policy was uncertain and confusing. However, many took a more nuanced view of the governor’s actions. One participant explained that they were “really impressed with the governor's initial response,” but felt that “the reopening was chaotic and haphazard and perhaps a little too soon and not very well planned.” In contrast, many felt that “local leadership” did not “really [do] anything about the spread of COVID." One participant who worked closely with local leadership during the beginning of the pandemic felt that while local governments found themselves largely without the necessary resources to “deal with [the virus],” they simultaneously “didn’t want to stick their neck out” and siphoned blame for COVID-19 regulations up to the state level.
Many felt that elected officials chose certain actions in order to please their constituency and ensure re-election rather than to align with recommendations from local Public Health. As such, local government undermined itself and further dissuaded belief in its efficacy and power. One gun store owner described how they wrote a letter to Sheriff Magrini explaining that they themselves did not think gun stores should be considered essential during COVID-19; the Sheriff did not directly respond, but rather issued an announcement over Facebook the next day explicitly clarifying that "gun stores were essential businesses."

Residents of Shasta County may have experienced the brunt of this political “whiplash” as they heard inconsistent messaging from a Republican federal administration, Democratic state government, and largely Republican local government. In light of this confusion and perceived failings on multiple levels, many participants did not stick to mere party ideology and support their favorite candidates, but acknowledged their faults, analyzed their mistakes, and were willing to condemn certain actions. These results, in conjunction with demographic data that the majority self-identified as “moderate,” reflect how application of national political binaries did not adequately capture the realities of political discussion in Shasta County during this time period.

5g. Healthcare

Table 8. Codes related to participants’ beliefs about coronavirus prevention and solutions. Codes that appeared over 30 times are highlighted in yellow.

<table>
<thead>
<tr>
<th>Code</th>
<th>Definition</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local public health</td>
<td>Any negative reaction/comment about local public health response</td>
<td>6</td>
</tr>
<tr>
<td>negative</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local public health</td>
<td>Any positive reaction/comment about local public health response</td>
<td>10</td>
</tr>
<tr>
<td>positive</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical community</td>
<td>Any mention of the medical community</td>
<td>22</td>
</tr>
<tr>
<td>PPE</td>
<td>Any mention of supply of PPE available in hospitals, etc.</td>
<td>14</td>
</tr>
<tr>
<td>Adverse health effects</td>
<td>Any mention that COVID has negatively impacted other aspects of health</td>
<td>6</td>
</tr>
<tr>
<td>Asymptomatic cases</td>
<td>Any mention of asymptomatic cases</td>
<td>4</td>
</tr>
<tr>
<td>Testing</td>
<td>Any mention of COVID-19 testing</td>
<td>28</td>
</tr>
</tbody>
</table>
Overall, participants tended to view local healthcare professionals and the public health department well. Several participants felt that the local hospitals did what they could in the face of inadequate resources and resistant non-medical populations. They praised initial local coordination to mobilize resources as timely and effective. Although some believed that hospitals were “provided an incentive” to “inflate numbers” of COVID-19 deaths because they were “paid per death and paid per ventilator use and paid per case admitted,” even more critical perspectives did not explicitly blame the medical community. This perspective may be skewed due to the large number of healthcare workers in the interview sample. Additionally, healthcare workers were more likely to distinguish between the medical community, public health, and local government response. As such, discussion of the medical community and local public health department were largely internal commentary by local healthcare professionals.

Many participants discussed issues with testing and PPE in the area. Many felt that testing was “still not very well implemented” and “not accurate,” as well as largely inaccessible on the local level. Participants felt that local healthcare “could be putting more money or effort or emphasis into testing on the community level,” noting that many others they had spoken to “don’t even realize that we have free access to testing symptom-free over at Shasta College.” One participant described that, “People have yelled at me for saying I got tested. They were like, oh, you’re using up all the tests. And I was like, no. Like, they’re actually encouraging that people go because they’re trying to find asymptomatic carriers there.”

The following exchange demonstrates difficulties with testing in the area:

P: How do you know if the tests work? It takes 3 days to get the results back.

I: And that’s if you’re lucky right now.
P: You could leave the test site, go to the mall, get exposed, and be positive before your test results come back. So that... it’s a flawed system.

I: I also know right now in Shasta County, it’s taking a week to get results back.

P: They went to Red Bluff.

Participants often went to Red Bluff, located in adjacent Tehama County, in order to secure quicker testing because Shasta County testing systems were understaffed. Similar to the rest of the country, this underserved county experienced extreme difficulties with acquiring adequate personal protection equipment well into the summer. As someone who volunteered with Public Health’s testing department, I can testify to the limitations of the local testing throughout the pandemic. During my time there, a small division of three volunteers and five full-time employees was tasked with scheduling and managing all drive-thru testing for the county as well as fielding various questions through a helpline and delivering test results. Until recently, tests could take anywhere from 5-7 days to process on average; only one hospital possessed rapid testing capabilities, which they reserved for admitted ER patients due to a lack of available tests. I frequently had to tell patients seeking specialized care in hospitals in Sacramento or San Francisco, which asked for tests done within 72 hours of a visit, that we could not provide any tests that would fit these qualifications. Although many in Shasta County minimized the coronavirus epidemic or opted not to take tests as it would “contribute to falsely inflated rates,” testing resources were still over-stretched.

5h. Business and Economic Concerns

Table 9. Codes related to participants’ mentions of business and economic concerns caused by coronavirus. Codes that appeared over 30 times are highlighted in yellow.

<table>
<thead>
<tr>
<th>Definition</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Healthcare worker</td>
<td>any mention of being a healthcare worker, or having one in the household</td>
</tr>
<tr>
<td>Frontline worker</td>
<td>any mention of being a frontline worker, or having one in the household</td>
</tr>
<tr>
<td>Non-essential worker</td>
<td>any mention of being off their job during coronavirus, or having someone in the household who did not work</td>
</tr>
<tr>
<td>Businesses care</td>
<td>Any indication that businesses do care about coronavirus</td>
</tr>
<tr>
<td>Businesses don't care</td>
<td>Any indication that businesses don't care about coronavirus</td>
</tr>
<tr>
<td>Businesses afford</td>
<td>any mention that larger businesses can afford to take precautions</td>
</tr>
<tr>
<td>Employees prevent</td>
<td>any mention that employees wear masks, social distance, etc.</td>
</tr>
<tr>
<td>Employees don't prevent</td>
<td>any mention that employees don’t wear masks, social distance, etc.</td>
</tr>
<tr>
<td>Consumer power</td>
<td>any mention that the consumers are important in directing/influencing business response.</td>
</tr>
<tr>
<td>Shut down</td>
<td>any talk of shutting down the economy</td>
</tr>
<tr>
<td>Economy over health</td>
<td>any mention of the economy being prioritized over health</td>
</tr>
<tr>
<td>COVID Relief</td>
<td>any mention of federal relief stipends (PPP, CARES, stimulus checks)</td>
</tr>
<tr>
<td>Reopening Economy</td>
<td>Any mention of reopening the economy</td>
</tr>
<tr>
<td>Financial Struggle</td>
<td>any mention of COVID negatively affecting someone’s job/financial security</td>
</tr>
<tr>
<td>Financial Gain</td>
<td>any mention that COVID has increased someone’s business, positively affected job/financial security</td>
</tr>
</tbody>
</table>

**Table 10. Job Characteristics**

<table>
<thead>
<tr>
<th>Category</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Government Designation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Essential</td>
<td>11</td>
<td>36.7%</td>
</tr>
<tr>
<td>Non-essential</td>
<td>14</td>
<td>46.7%</td>
</tr>
<tr>
<td>Unemployed (retired, student, etc.)</td>
<td>5</td>
<td>16.7%</td>
</tr>
<tr>
<td><strong>Management Responsibilities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-management</td>
<td>14</td>
<td>46.7%</td>
</tr>
<tr>
<td>Small business owner</td>
<td>9</td>
<td>30%</td>
</tr>
<tr>
<td>Supervision</td>
<td>7</td>
<td>23.3%</td>
</tr>
<tr>
<td><strong>Occupational Risk</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>13</td>
<td>43.3%</td>
</tr>
<tr>
<td>Moderate</td>
<td>13</td>
<td>43.3%</td>
</tr>
<tr>
<td>High</td>
<td>4</td>
<td>13.3%</td>
</tr>
<tr>
<td><strong>Healthcare Workers</strong></td>
<td>8</td>
<td>26.7%</td>
</tr>
</tbody>
</table>
Many participants mentioned being a healthcare worker or having one in their household. 8 participants (26.7%) identified themselves as working or having previously worked in the healthcare field. This partially reflects an intentional search for healthcare workers as well as personal connections within Shasta County’s healthcare system. Both frontline and essential workers were mentioned 21 times each, whereas participants were slightly more likely to identify themselves as non-essential workers as opposed essential workers. 16.7% of interviewees were broadly unemployed; they may have been searching for a job at the moment, retired, or a full-time student.

Occupational risk was determined based on the Occupational Safety and Health Administration’s guidelines and Occupational Risk Pyramid for COVID-19. Healthcare workers and any other workers who might be exposed to known or suspected COVID-19 cases were classified as “high risk.” Workers who had frequent, close contact with people who may be infected (but were not suspected or known cases) or whose jobs required travel were placed in the “medium risk” category. Those whose jobs did not require contact with others or who had minimal contact with the public and other coworkers were classified as “low risk.” Participants were most likely to work in moderate- or low-risk occupations. In comparison to the data on occupational risk, most participants perceived their risk to be low (53.4%), while much less perceived their risk to be moderate (26.7%) or high (20%). Additionally, many of the participants who placed themselves in the high-risk category cited medical conditions that might complicate COVID-19 infection. Comparison of the two groups clearly shows that many participants’ perceptions of their risk did not correspond with their occupational risk, not even considering various other factors such as age, health, or other potential sources of exposure. As such, participants may have been likely to underestimate their risk than to accurately estimate or overestimate it.

Participants tended to focus on the consequences of reopening the general economy throughout the summer. The majority of participants believed that businesses cared about prevention methods, but were unable to afford to take precautions, mainly due to financial concerns. Business owners
expressed distress over the way COVID regulations affected their business or frustration with how polarization affected consumers responses to their businesses. This distress was exacerbated by previous economic troubles due to the Carr Fire. One small business owner explained that “before coronavirus I hadn’t even been paying myself yet. I was only making enough to pay my business’ bills and my employees’ paychecks. And then after coronavirus started, I barely had enough to cover bills. And some months I don’t have enough to pay the bills, so I was actually looked into getting another job. So I’m starting a new job soon and hopefully that will keep my business open. But I wouldn’t have done it if the coronavirus hadn’t happened because I’m just so worried that I won’t be able to pay my bills...”

Several participants described the inadequacies of available federal aid, citing how “obtaining a PPP loan was “really hard... to qualify for and also just the money for ran out really, really fast.” One employee alluded to the seemingly random nature of obtaining a loan; although her employer received enough money to repaint their restaurant before it reopened, she was uncertain whether “some of these other local businesses were able to get one or not.” Another participant said they were “one of the very lucky ones” despite getting “laid off for two months when [they] shut down” because they “had no problem getting on unemployment quickly. In contrast, many of their coworkers “didn’t get unemployment the entire two months that they were off. They didn’t - they started getting in after they went back to work. It took a long time.” Some participants proposed more targeted solutions where “the people get laid off are the people getting the money, not the people who don’t actually need it as such, you know?” This individualized preference was in contrast with Coronavirus relief programs such as the $1,200 stimulus check the federal government announced would be distributed to most residents at the beginning of the pandemic.

Larger businesses experienced COVID-19 very differently from smaller businesses in the region. Many participants noted that larger businesses in town could afford to better adapt to new regulations and that stores such as “Lowe’s,” “Home Depot,” and “Wal-Mart” were not required to shut down. One
participant explained that “it seems like the corporate owned restaurants are following the guidelines quite a bit more closely than some of the smaller locally owned businesses” but that “in some ways you can't blame them. I mean, if they had some of these smaller places that they have to close down a second time, they may not reopen... I don't feel like I can make a judgment call exactly on that.” These anecdotes further reflect class divides within Shasta County. Small business owners acutely perceived their differences from larger businesses during the COVID-19 pandemic and recognized the privileges larger corporations and richer individuals’ experiences during this time.

Many small business owners additionally emphasized the ways larger polarization in the country affected their livelihoods as customers re-enacted the national debate on masks on the battleground of small businesses. These owners felt trapped in that, if they enforced mask mandates set by the state of California, they would alienate many of their customers. At the same time, if they did not enforce masking policies, they would still lose customers. One participant explained that, “it's hard to limit people on what they can or can’t do when they come in because I need customers or I'm going to lose that business.” As such, local businesses were less likely to enforce masking mandates because they more acutely felt the loss of disgruntled customers.

Many questioned how the government selected “essential” and “non-essential businesses. One participant expressed frustration that a state-designated label could determine whether “you're gonna go bankrupt or not.” Another participant explained that having “the casinos open but the churches aren't open” or having “Lowe's open but [not] my restaurant” was “not fair,” especially “if [Lowe's] is crowded... and my restaurant... I had a plan and everybody spaced out, yet I'm closed and they're open.” The selected businesses in these anecdotes often reflected participants’ personal and moral disapproval of institutions within the community.

The prevalence of codes within this section reflects the pressing financial concerns many felt during the summer of 2020, and how they felt those financial concerns came into conflict with their personal
health concerns. This data demonstrates how residents of Shasta County perceived both COVID-19 and financial preservation as risks and subsequently chose to prioritize these risks. Based on several occupational factors, individuals varied on a spectrum. Small business owners, especially those that perceived they had low risk and had more to lose from a business failure, tended to lean more towards opening up the economy and minimizing mitigation measures. While employees also considered the importance of continued work, they were more likely to pressure employers to follow mitigation and prevention measures. One participant described how “a number of employees... put their foot down when [they] came back” and emphasized the importance of strictly following guidelines to their employers. These internal dynamics of various managerial positions (non-managerial, small business owners, and supervisors for larger corporations) more specifically affected the positions businesses took in regard to reopening.

5j. Rural-Urban Divides: Why Being Rural Matters

Table 11. Codes related to specifically local concerns. Codes that appeared over 30 times are highlighted in yellow.

<table>
<thead>
<tr>
<th>Local Context</th>
<th>Description</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bethel Church</td>
<td>mention of Bethel, School of Supernatural Ministry, etc.</td>
<td>4</td>
</tr>
<tr>
<td>Sundial Gathering</td>
<td>mention of the gathering at the Sundial held in July</td>
<td>7</td>
</tr>
<tr>
<td>Cottonwood Rodeo</td>
<td>mention of the Mother's Day rodeo held in Cottonwood</td>
<td>6</td>
</tr>
<tr>
<td>State of Jefferson</td>
<td>any mention of Jefferson, the State of Jefferson, Don’t Tread on Me, etc.</td>
<td>9</td>
</tr>
<tr>
<td>Fires</td>
<td>Mention of local fires affecting peoples’ lives</td>
<td>11</td>
</tr>
<tr>
<td>BLM protests</td>
<td>any mention of BLM protests, George Floyd, Breonna Taylor, Ahmaud Arbery, protesting, etc.</td>
<td>28</td>
</tr>
<tr>
<td>Rural</td>
<td>any mention of Redding being a rural area, policy response differing</td>
<td>31</td>
</tr>
<tr>
<td>Underrepresented</td>
<td>any mention of feeling not represented, having no voice, or that the region is not represented</td>
<td>12</td>
</tr>
<tr>
<td>Unique/Isolated</td>
<td>mention of Redding as a unique area or having a “bubble” mentality</td>
<td>14</td>
</tr>
</tbody>
</table>

Participants often repeated the sentiment that “what works for San Francisco or L.A. (Los Angeles) does not work here.” The majority of participants described that they and others in the community felt current policies were ill-suited to rural areas. Many felt that state-wide policies did not accommodate
for the differences in rural and urban life. One participant explained that “a lot of people here don’t necessarily have a lot of remote work, because a lot of them are in agriculture, or in retail, or they’re a business owner, and they’re in work that requires a lot of moving supplies and things like that.” As such, policies that mainly focused on remote work may not have been as possible in rural areas due to limited internet connectivity, and particularly so during the PG&E power shutoffs of the summer. Some believed that the lower population density contributed to lower case rates and would continue to protect rural areas. One healthcare professional explained that “I don’t think it’s a matter of we’re safer. I think all it does is buy us time. Because we’re not all congregating and – have you been to NYC? The sidewalks are huge and they’re always full. It’s harder to social distance there, so if you’re going to get it, all you have to do is go outside and you’ll get it. Whereas here, you might not go out every day, houses are a little further apart. So I think it’ll buy time, but if people are going to get sick, they’re going to get sick.” Daily cases in the area seem to support this idea, as Shasta County began to experience dramatic surges later in the year (Figure 2).

Although the State of Jefferson positioned itself around the idea that Northern California was largely underrepresented in state politics, those non-affiliated with the organization tended to support this idea. Some did not resent this and rather accepted that “just in numbers, [Southern California and the Bay Area] take precedence over Northern California,” which led to the “Redding conservative viewpoint” being “somewhat underrepresented.” The following exchange demonstrates a more individualized example of this feeling of underrepresentation and political disenfranchisement:

P: Well, I didn’t vote for Trump. And I didn’t vote for Newsom. I’m not a real political person. I tell people that I have a 12-foot section of fence in my yard, just so I can straddle it. So I’m a fence-sitter, and it doesn’t take much to knock me off on one side or the other.... It doesn’t matter what I
think about what the government’s doing. It really doesn’t. I can like it or not like it, but the way I feel about it doesn’t matter one bit.

I: What do you mean?

P: It just doesn’t matter. There’s no causative relationship between what I think and what’s going on. It doesn’t matter what I feel.

In an attitude reminiscent of these perceptions, several participants felt “insulated” from the pandemic, explaining that “you’re in a bubble up here like you can’t believe.” The rural nature of the area protected many from firsthand experiencing the virus during the summer. As a result, this may have contributed to beliefs that rural areas could be “somewhat less strict” about COVID regulations than other areas.

Many participants may have focused on enforcement as a prevention measure because they witnessed consistent lack of enforcement within Shasta County. Participants often cited two events that occurred in Shasta County over the summer in order to explain community attitudes toward COVID-19. One event was the Mother’s Day Rodeo in Cottonwood, which many condemned and believed “should not have been allowed.” Many attendants “felt they had support from local law enforcement as the Shasta County Sheriff’s office had said they would not be enforcing the stay-at-home order.” (Chavez 2020) Others pointed to religious gatherings organized by Bethel leaders, such as the “Sundial Bridge Gathering” in mid-July (Gardner 2020). Even participants who adamantly called for opening up churches admitted these gatherings were “probably not the best idea,” reflecting how COVID-19 behaviors further opened up conflicts with Bethel and eroded their support.

At the same time, many Bethel affiliates and others continued their behaviors despite condemnation and local authorities’ promises of enforcement. More than 250 cases identified from
September 18th to October 1st were traced back to Bethel Church and its corresponding divinity school, Bethel School of Supernatural Ministry (Benda 2020). Bethel affiliates run a popular local coffee shop, Theory Coffee Roasters, and draw a large crowd of students (Benda 2020). I visited this establishment several times throughout the summer and fall. The store was packed with BSSM students well into November, many of whom still did not wear masks. When I worked at Public Health’s call center, one Bethelite called in with concerns that the community encouraged beliefs that “if you wear a mask, you are not faithful enough in God.” While this may be an exaggeration, this corresponds with the general beliefs in “faith healing” which are prominent within the church.
Figure 2. Number of confirmed COVID-19 cases in Shasta County by day, March-December 2020. Annotated to reflect relevant events. Retrieved from https://www.co.shasta.ca.us/ready/covid-19/data.

5j.1 Black Lives Matter/George Floyd Protests
Table 12. Breakdown of attitudes towards the June protests by race.

<table>
<thead>
<tr>
<th></th>
<th>Positive</th>
<th>Negative</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>White</td>
<td>2</td>
<td>6</td>
<td>8</td>
<td>26.7%</td>
</tr>
<tr>
<td>Native</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
The George Floyd protests and subsequent Black Lives Matter movement throughout the summer came up in various forms during interviews. Participants’ varying perceptions of this movement reflect racial tensions within Shasta County and how these perceptions played into response to COVID-19 regulations. Interestingly, word choice between “Black Lives Matter” and “George Floyd” or “Breonna Taylor” protests varied by race. White participants tended to discuss these protests as “Black Lives Matter” protests, whereas non-white participants recognized these protests were one part of an ongoing struggle. They instead referred to the protests by the specific names of the people whose deaths sparked the summer protests, Breonna Taylor and George Floyd. These differences reflect different levels of racial awareness.

Just as how participants expressed moral condemnation of certain “essential” businesses, some participants subtly expressed disapproval of the Black Lives Matter protests that erupted across the nation in June in response to the murder of George Floyd. One participant described COVID regulations as “ridiculous” because “they [the government] keep changing the rules. You know, if you, if you're protesting, you don't have to wear a mask, they tell you not to purchase a mask. And so then people get mad at that.” Participants predicted that recent surges were “due to the neglect of safety codes that occurred during all the protests and the riots.” Another conservative participant believed that both COVID-19 and the protests were being exploited to undermine President Trump’s administration:

I: [laughs] Okay, so from what I've gotten, you're basically saying... they're connected in that... both coronavirus and these protests are being used by... by liberals, like for their own party interests.

P: Yes.

I: But they're not necessarily... like coronavirus isn't influencing the protests and the protests aren't influencing coronavirus. Right?
While this was the predominant view taken by white participants who mentioned the protests, it was not the only one. In contrast to the predominant view of those who opposed these protests for spreading COVID, one participant explained that “the only time [they] had gone outside for something that's not ... grocery shopping is then to go to protests in Redding.” Both white and non-white participants expressed the belief these protests were a “silver lining” of the pandemic and viewed them positively. At the same time, one Black participant spoke about the mental health toll of dealing with a pandemic that disproportionately affected Black people at the same time as a civil rights movement. One white participant explicitly linked their support of Black Lives Matter to their COVID-19 prevention behaviors, explaining that they read an argument on social media explaining that “if you’re not following [COVID-19 prevention] to a T and that stuff, you’re disproportionately affecting people who might not get the same care as you.” One participant who supported the protests voiced the converse of this connection, stating that “the people who hate COVID are often the people who hate BLM.”

Participants did not necessarily voice explicitly positive or negative opinions about protests. Interestingly, no Asian participants mentioned BLM in their interviews. Personally, I know that most of them supported the movement. Speaking as an Asian person who grew up in the area, I hypothesize that this is because these groups are afraid of white backlash but are able to distance ourselves from racial protests due to such phenomena as the Model Minority Myth (Blackburn 2019). At the same time, we may recognize that racial justice has been an ongoing struggle and do not necessarily associate this movement with COVID-19. However, this hypothesis is extremely limited due to the small sample size of ethnic minorities who were interviewed.
6. Discussion

These results demonstrate various responses and underlying reasoning behind individuals’ responses to the COVID-19 pandemic in Shasta County. Many participants reported that they gathered information about the COVID-19 pandemic through social media and regional news, which contributed to their understandings of the risk of COVID-19, the efficacy of prevention measures, and often negatively impacted their mental health. As a result of this outside news as well as personal and economic impacts of the pandemic, many residents “burned out” of the conversation around COVID-19 and, protected by the delay in cases their rural setting conferred, chose to retreat further into the insulation of local communities. Participants perceived their immediate surroundings as drastically different from what they saw on the news, and as such felt they merited different policies that took into account low case numbers throughout the summer as well as rising financial concerns throughout the community. Influenced by certain mass gatherings, such as the Mother’s Day rodeo in Cottonwood, the Sundial Bridge gathering, and the George Floyd protests, many participants felt there was a lack of law enforcement and education within the region.

Participants generally reported disappointment with political actors on state, local, and federal levels. Although some continued to support him, the majority of participants criticized President Trump for his response to the COVID-19 pandemic. Residents contended with local conservative leadership, Democratic policies on the state level, and a largely Republican federal response. Both federal and local political actors also came into conflict with scientific and healthcare authorities, further complicating the situation. Overall, participants felt that leadership was uncoordinated, uncertain, and confusing, particularly as polarization of the virus led to vastly partisan responses to the pandemic. Tying in with the financial insecurity of many residents in the region, many criticized inadequate COVID-19 relief funding, such as stimulus payments, PPP loans, and unemployment wages. Additionally, participants spoke to local business owners’ genuine concern for safety during the pandemic along with their limited
options due to inadequate financial aid. As such, these results shine light onto the complex risks and concerns that many individuals had to juggle during this pandemic.

6a. Deconstructing Rugged Individualism

Rugged individualism refers to a collection of individualistic behaviors that many rural “frontier” areas throughout the United States have traditionally promoted (Bazzi et al. 2020). This behavior is closely aligned with the “frontier” culture many rural Americans have constructed, which focuses on individual responsibility and independence (Fraser et al. 2017). Bazzi et al. (2020) posit that rugged individualistic opposition to hierarchies may have also rendered a distrust in scientific and government officials during the COVID-19 pandemic, hindering an effective and coordinated public health response. These cultures have tended to align with more conservative political orientations, resulting in largely rural support for Donald Trump, including through the COVID-19 pandemic.

As a rural, largely white, Republican, and lower-income area with low college education rates, Shasta County residents displayed elements of this attitude of rugged individualism. Participants testified to a strongly individualistic culture that emphasized personal responsibility. Regional history and contemporary trends display cycles of economic booms and busts, with majority of income generated from natural resources having been siphoned off the other areas of the state of California. As such, local residents harbored an attitude of mistrust of state officials that was encouraged by local officials’ attitudes. Shasta County residents, such as those within the State of Jefferson, actively pushed against state actors, such as Gavin Newsom, that they felt were corrupt and unwilling to treat their region fairly. However, participants also concentrated their frustration on other actors – Sheriff Magrini and President Trump were also often criticized.

This tendency to focus on individuals may reflect participants’ largely individualistic mentalities, which affected how they perceived response efforts. At the same time, this tendency may be more
influenced by the increasing personalization of politics, which has been especially accelerated by social media (Bennett 2012). Additionally, this focus may reflect low education levels in the county - Thorson (2012) found that participants without a college education were “much more likely to talk about citizenship in individualistic, hyperlocal terms.” (p. 81) In 2014, only 19.1% of Shasta County residents reported that they had obtained a bachelor’s degree or higher (Health and Human Services 2014).

However, within the sample, residents displayed a variety of views that were not always explained by mistrust of government and scientific officials. Although many residents had both historic and cultural justification to mistrust COVID-19 regulations and science, the vast majority of the sample stated that they believed the existence of the COVID-19 virus and the efficacy of various prevention methods, including face masks. Many called for further enforcement of existing COVID-19 mitigation measures. Others bristled at perceived unnecessary regulations that did not correspond with local contemporary statistics and concerns.

Despite a largely individualistic culture, participants reported that they followed COVID-19 prevention measures often due to a sense of respect for loved ones. In this way, individualism was not divorced from compassion and care for others. Participants from various perspectives on the COVID-19 debate framed their behaviors in terms of a culture of personal responsibility to encourage safer behavior. At the same time, these participants who followed COVID-19 prevention measures called for measures that were not centrally controlled by a government. While top-down approaches to public health and COVID-19 prevention have proven largely effective, attempts to institute such regulations in the North State largely backfired and engendered further ire towards public officials. As such, these events demonstrate the necessity of working with local cultures instead of against them.
6b. Neoliberalism and the “Shame and Blame” Response

Previous research has already emphasized how the COVID-19 pandemic response was significantly weakened by global neoliberalism (Navarro 2020). Neoliberal policies, particularly those of austerity, encouraged increasingly inaccessible privatized health services and weakened public health departments capacity to respond and disseminate information and resources. President Trump’s policy which advocated that each individual state within the United States should compete for available PPE and testing supplies further demonstrates how neoliberal ideologies weakened COVID-19 response and incapacitated many (Navarro 2020). Throughout these interviews, participants familiar with local healthcare testified to the inadequacy of available resources due to this trend.

One participant who worked in public health additionally traced the “launch of neoliberalism and the market” and condemnation of government regulations to subsequent response to COVID-19 in the area. As much of local culture had already attributed responsibility for such issues as water loss, gun ownership, the bust of the lumber industry, and more to “environmentalists” and “the government,” they easily adapted these narratives to COVID-19. Although many were criticized for their decision to prioritize economic concerns over health ones, the drastic response in Shasta County is only symptomatic of a national problem. Even Governor Newsom, whose response to the virus was generally described as caring (even by those who disapproved of his response), did “his press conferences and he’s in a flower shop before Mother’s Day and talking about how he supports these businesses, and he talks about ‘don’t do things you don’t need to do, but go to your local florist!’” This anecdote demonstrates how even the most cautious responses tended to prioritize the economy as part of a neoliberal, consumerist ideology that emphasized the importance of commerce. Although political debate over the pandemic was deeply polarized, both major parties in the United States emphasized profit and the free market above all.
At the same time, the general population tended to concentrate their frustrations with a system in a highly polarized fashion. The oversimplified perception of issues was that Republicans blamed Democrats for their (perceived) overly cautious attitude towards the pandemic, whereas Democrats blamed Republicans for their (perceived) carelessness. Although many participants reported that they felt uncomfortable and often caught in the middle of these two sides, in light of these divisions, many did “pick” a side – at least in terms of COVID-19 response. However, almost all participants expressed frustrations with individuals in their lives who they felt did not follow the “correct” procedure for COVID-19 prevention. This “shame and blame” response that focused on individual actions as opposed to systemic failures which did not only allow these varied responses, but amplified them, further demonstrates the deep roots of neoliberalism and individualism within the United States.

6c. Risk Perception and Prioritization

Participants alluded to several simultaneous risks which they experienced during the COVID-19 pandemic, mainly financial ruin, fires, law enforcement, and the disease itself. Many explained how the COVID-19 pandemic made them feel as if they had to choose between the multiple risks they faced. After assessing local statistics during the summer of 2020, many participants felt that they had no choice but to keep businesses open, occasionally leading to noncompliance with basic COVID-19 regulations. As such, these choices show the short-term and long-term priorities that many perceived; financial stressors seemed to be the most urgent and pressing, whereas concerns over disease spread might have become more long-term as cases spiked in the fall. After assessing law enforcement’s vow to not issue citations for compliance, many felt reassured that they could continue to operate.

These risks also influenced each other; past experiences with frequent wildfires had further destabilized the financial security of many residents and influenced their perceptions of emergency management. One participant conceptualized both fire and COVID-19 preparedness as
complementary, rather than opposing. They explained that “people think of emergency-preparedness, as
we... had an example of the Carr Fire. They had no idea that it was gonna spread like that from a travel
trailer having a flat tire. I've got friends that lost their home. And so emergency preparedness in COVID...
It's just as bad, but worse, a hundred times worse. I mean, what are we up to? 150 thousand deaths.” It is
possible that many participants did not see a longer-term threat like COVID-19 to be as visible as the
fires many witnessed creeping up hills or the dilapidated buildings present throughout Redding.

Previous studies have analyzed multiple factors which affect risk perception. Mullins and Soetanto
(2013) analyzed how Black, Asian, and white communities differently perceived and responded to the
threat of a flood warning in the UK. Although each group perceived these threats differently, overall “all
three ethnic groups displayed a tendency to rely upon policy makers to deal with flooding and be
responsible for their welfare.” (p. 127) This indicates that policy responses for these emergency threats,
such as floods and fires, can be generally applied. However, in the case of COVID-19, ethnicity has been
proven to influence certain populations’ risk as well as their perception of that risk (Sze et al. 2020, Nino
et al. 2020). As such, these results may vary based on the type of risk that is in place – whether the
perceived threat is longer term or not, whether inequities are emphasized or not, and so on.

Based on this study’s previous comparison of occupational and perceived risk, healthcare workers
also tended to underestimate their risk. This further reflects how people do not necessarily base their
perception of risk in their professional knowledge, but rather respond to risks based on other, more
internalized and emotional factors (Peres et al. 2020). Participants spoke to a similar fracturing within
the medical community during the pandemic, where even trained healthcare professionals promoted
the belief that COVID-19 would be harmless if people merely “ate right.”
6d. Fear, Panic, and Neglect

In normal circumstances, scientific knowledge offers defense in that people can prepare for future risks. The COVID-19 pandemic fostered further fear and uncertainty because the scientific community itself could not offer all the answers about the pandemic. At the same time, seemingly innocuous, every-day activities suddenly became dangerous. Additionally, official recommendations to stay home caused many to worry about their financial security. As such, COVID-19 engendered an unprecedented level of fear and uncertainty. In response, many individuals turned to “magical thinking” in the form of various conspiracy theories, rumors, pseudoscience, and “old wives’ tales” (Gusterson 2020).

Furthermore, the COVID-19 crisis has mostly “intensified” people’s faith (Ibid). Especially in the face of incompetent leadership and inadequate resources, many felt that “magic may seem our best hope” for COVID-19 (Ibid, p.7). Although few participants echoed “magical thinking” in the sense of certain cures, herd immunity, or other scientific myths, many focused on their religious communities and the support they offered. This intensification of faith may have also contributed to the outrage that many expressed at restrictions on church gatherings. One participant who ran a gun store reported that after the announcement of the virus, gun sales “skyrocketed” to the point where they could no longer find supplies anywhere in the country. This anecdote corresponds with Gusterson’s assertion that Americans view guns “in an almost mystical way.” As such, gun sales within Shasta County during the pandemic reflect another form of this “magical thinking” at work.

Health security experts conceptualized the fear that COVID-19 engendered in a different way – as “the cycle of panic and neglect” (International Working Group on Financial Preparedness 2020). The initial fear that the COVID-19 crisis elicited was unsustainable over the long-term, and as weeks turned to months, many began to burn out. Even in Shasta County, where people recognized that they were overall protected from the initial wave of COVID-19, by the summer, many participants reported a sense of “burnout” from the constant doom and gloom they witnessed on the news and within their
communities. In response, many actively chose to disengage from the reality of COVID-19 and attempted to return to a sense of normalcy, often eschewing COVID-19 guidelines. This burnout may have also contributed to participants’ potential underestimation of their personal risk as well as their neglect of safety precautions. Additionally, the same “magical thinking” that facilitated the spread of many conspiracy theories at the beginning of the pandemic may have morphed into the belief that people could continue their lives without the risk of COVID-19, particularly in rural settings. This idea may only have been amplified by economic reopening and attempted “adaptations” that often did not decrease risk, such as the institution of nightly curfews, curbside restaurant services, and more.

6e. Rural Minorities

The mythology of rural life that is characterized as entirely white, Republican, poor, and uneducated obscures the reality of life for many rural minorities. Many participants drew attention to the realities of several disenfranchised groups within Shasta County, especially homeless, incarcerated, and migrant populations. These groups were especially vulnerable to COVID-19, often due to cramped settings and inadequate resources. One participant noted that the Carr Fire most likely “increased homelessness to a certain degree” within the county, which traditionally has hosted a large homeless population that has often come into friction with housed residents. The larger community’s stigmatization of homeless people only further compromised their security. Similarly, many pointed to migrant communities’ particular vulnerabilities, partially due to the lack of Spanish-language health communication as well as financial insecurity that forced many to continue working in unsafe conditions throughout the pandemic. One participant drew attention to how “inmates [within California] were forced to shelter with people who tested positive for the virus.” During my time at the local public health department’s call center, I received a call from a frantic family member who
explained that local prison guards not only refused to buy face masks and other protective equipment for inmates, but also refused to let the caller buy masks for the prisoners.

These marginalized population’s experiences reflect the Foucauldian conception of “biopolitical societies [which] work through the abandonment of people whose lives are valueless to them where the idea of killing happens with ‘political death, expulsion, rejection, and so on’” (Hossain 2020). COVID-19 policies that viewed rural areas as homogenous societies enacted biopolitical rhetoric which actively chose to compromise the health of certain sectors of the population in order to save others. The lack of adequate federal aid and the subsequent push to reopen the American economy demonstrates a subtler form of these biopolitics. Policymakers generally chose to eschew aid in favor of reopening policies which overwhelmingly placed service workers, especially those in jobs generally considered to be “menial labor” (such as retail workers, waiters, bartenders, fast food workers, etc.) at much higher risk. As such, some lives were weighed against others and found to be less deserving; these decisions were then justified by neoliberal rhetoric.

Rural ethnic minorities’ experiences and vulnerabilities were particularly obscured by the narrative of a racially homogenous rural society. Certain ethnic groups in the area, such as the Mien, Hispanic, and Black communities, were even more likely to mistrust government information, in part based on their past relationships with authorities who often treated them unfairly. As such, although in general, ethnic minorities in the United States tended to perceive COVID-19 as a higher threat, Latino and Black communities were actually less likely to perceive COVID-19 as a significant threat, even in comparison with white groups (Nino et al. 2020) Due to several elements of structural racism, such as higher rates of chronic disease, access to less resources and quality care, increased occupational risk, and poorer-quality housing, ethnic minorities were additionally predisposed towards contraction of and complications from the disease (Nino et al. 2020). Figure 3 further confirms the disproportionate burden of COVID-19 on Black, Latino, Asian, and Native populations.
Sou Saechao, who is of Mien descent and is diabetic, suffered one of the most severe cases in the area over the summer; he was hospitalized for over two weeks in the ICU after both him and his mother contracted COVID-19 (Mangas and Newboles 2020). One participant who personally knew Saechao hoped that Saechao’s public testimony about his experiences would convince others in the Mien community, as well as the larger population of Shasta County, would “be life changing” by convincing people to “take [the virus] seriously.” Saechao’s case demonstrates how these structural factors of racism played into individual experiences of Coronavirus, as well as the importance of having trusted members of ethnic minority communities speak to their experiences.

Even white patients with chronic illnesses or other health concerns also testified to the way the COVID-19 pandemic complicated their lives. Patients had difficulties getting booked for necessary surgeries, as many prominent facilities in larger cities required testing that was not available in Shasta County. Previous studies have hypothesized that living with chronic conditions would become “more difficult and perilous” as healthcare resources were redirected towards COVID-19 response and vulnerable individuals remained especially isolated in their homes (Manderson and Wahlberg 2020). As COVID-19 preoccupied lawmakers, the prices of certain necessary drugs that help manage high cholesterol, asthma, pain, and smoking cessation continued to dramatically rise (Pradhan 2020). Hospital workers noted that patients delayed going to hospitals because they “were afraid of getting
the virus from the hospital.” When patients did finally decide to go to the hospital, they “were sicker than they would have been.” At the same time, one doctor reported hospital staff was also more reluctant to work because they feared for themselves. Another doctor in town had noticed a substantial “uptick in domestic violence” in an area that has already experienced disproportionately high rates of domestic abuse and child maltreatment (as compared to the state of California) for years (Health and Human Services 2014). As such, the mental health problems elicited by the pandemic translated into tangible adverse effects for the hospital system.

The sample of the population that was interviewed for this study further demonstrates these disparities, as well as who was able to create certain narratives about the COVID-19 pandemic in the area. The majority of participants in the interview sample were white. Although I reached out to Mien and Hispanic business owners and community members, many declined to comment. When I attempted to contact Chinese restaurant owners in the area, many hung up and said they could not deal with these issues right now. The response of Chinese community members, in combination with the prevalence of negative views about China and Chinese people within the interviews, may also hint towards fears of white retaliation against Chinese populations. Furthermore, no homeless or incarcerated people, nor migrant workers participated in these interviews. These perspectives are notably missing, potentially due to more personal interactions with the virus, fear of the others’ in the communities’ response, the lack of time and resources to take the time for a 30-minute interview, or other factors.

6f. Vaccine Hesitancy and “Anti-vaxxer” Sentiments

As previously mentioned, Shasta County hosts a relatively large population of “anti-vaxxers.” In the following exchange, a local doctor who worked with mainly low-income or underserved populations
explained how anti-vaxxer rhetoric affected her practice:

I: Do you think – especially in terms of vaccinations – I know you already said they don’t really listen, but…

P: People are stupid. I’m sorry, and that’s a terrible thing to say but they do not listen. The vaccination rates in this area are horrifically low. Which is part of why we had the measles epidemic of 2019. And they have these crazy ideas, right? They have no idea how science advances or what the immune system is or anything like that. So they have these crazy ideas that somehow, their way is better. Raising their child completely, ‘natural’ ha-ha, is going to protect them

I: Yeah, I think even the fact that our elected assemblyman is openly anti-vaxx is...

P: Well, don’t even get my started on those two.

I: Do you think with coronavirus, people have even been slightly more receptive to getting vaccination or anything?

P: A couple, but not… people are – it’s ideology. It’s like supporting Trump. You have to actually disregard every bit of reality known to humanity and still say, “oh, he’s great.” And it’s like, there is nothing great about this human, and yet people who support him are so invested that they don’t – they can’t come around. So it’s that kind of thing. Or this whole notion that somehow, someone’s personal freedom is being infringed upon because of a requirement to wear a mask and protect other people. It’s just like… it’s crazy. People misinterpret. They just misinterpret the facts to suit
ideology. So it has nothing to do with what they perceive, it has to do with what they’ve already decided.

One participant doubted vaccines because they felt it would be used as a tool of the government, explaining that “They want the new normal. It’s going to be difficult, because a lot of the CDC and Who do not want the normal back. They want the new normal. They want mandated things. Which... Fauci has said a vaccine is only good for six months. So why are you mandating them? You never wanted to mandate vaccines. If you want to go to work, this is what they’re wanting to do. It's underneath the table here. It hasn't happened.”

Even if they did not express explicitly anti-vaxxer beliefs, many were nervous about promises of a vaccine. One participant worried, “What are we going to do between now and the vaccine, number one, and number two – are you going to be the first person to get in line for the vaccine? Because let me tell you, I’m not going to be. And I’m not against vaccines, I’m very pro-vaccines.” Other participants expressed concerns that a COVID-19 vaccine would be “rushed” or that it would otherwise be ineffective due to rapid evolution of the COVID-19 virus. Many compared a potential COVID-19 vaccine to an annual flu shot, stating that even if they were overall vaccinated, they might elect to not receive the flu vaccine.

The beginning stages of the United States’ COVID-19 vaccine rollout have already demonstrated the relevance of vaccine hesitancy and anti-vaxxer ideologies. Even for healthcare workers who were prioritized for the vaccine, less than 50% of eligible workers were willing to receive the COVID-19 vaccine in St Elizabeth Community Hospital in neighboring Tehama County (Shalby et al. 2020). After speaking with my own contacts, they estimated that only 30% of eligible workers agreed to receive the vaccine at St. Elizabeth.

Similarly, as of April 2021, approximately 35% of Shasta County residents over 65 were fully vaccinated, far below the national average of 62% (Shasta County Health and Human Services, 2021).
As vaccinations recently opened up to any resident over 16 years of age, it seems unlikely that this discrepancy is due to a lack of supply. Rather, it is more likely due to vaccine hesitancy within this community. Within my sample, older residents were far more likely than other age groups to disapprove of local public health and speak negatively of the CDC, while they were less likely to express hope of a vaccine as a potential solution to the COVID-19 pandemic. One older participant explained that, “I’m not going to run out and get a proper virus vaccine just because. And I’m not going to get tested for coronavirus. I don’t have symptoms. I go there. I go to the doctors. They check my temperatures. Never had a temperature. I don’t have a cough really like that. And I’m certainly not going to give them a reason or a right to turn around and say, “ope, another Coronavirus victim.” Figure 4 shows a noticeable dip in COVID-19 rates for age groups 55-69 and 70-84. In conjunction with my data and Shasta County HHSA’s statistics on vaccination rates on COVID-19, these statistics may further speak to a hesitancy in these age groups to test for COVID-19 as well as to receive a vaccine.

Figure 4. COVID-19 Cases by Age alongside Rates by Age Group per 100,00. Retrieved from https://www.co.shasta.ca.us/ready/covid-19/data.
Unfortunately, this study was unable to amass much data on explicitly anti-vaxxer views and how they were influenced by COVID-19. This paucity may be in part due to mistrust of scientific authorities—including me, as a public health student. As such, it is incredibly important to devote further research on the influences of these behaviors and the degree of vaccine hesitancy and denial. This future research will contribute to policy solutions that accommodate and/or educate these anti-vaxxer populations without compromising overall population health.

7. Conclusion

This study demonstrates the various responses and underlying reasoning behind individuals’ responses to the COVID-19 pandemic in Shasta County. While much of this data may not seem generalizable due the unique background and context of the region as well as the small sample size and limited recruitment methods, careful analysis can pull apart some lessons that can be applied to future research and policy. These results highlighted how the mythology of rural independence was constructed in order to justify neoliberal policies, which subsequently created a biopolitical understanding of citizenship during the COVID-19 pandemic. These biopolitical understands led policymakers to sacrifice certain vulnerable populations’ health during the pandemic in favor of a more vocal majority. Furthermore, this study highlights the process of risk prioritization during the COVID-19 pandemic, where a lack of relief funding forced many Americans to prioritize the more pressing concerns of their financial needs against the very real risk of the contracting the virus. As such, popular rhetoric blaming the general populace for their COVID-19 behavior only serves to siphon blame away from policymakers on all levels whose indecision, internal fighting, and manufactured polarization jeopardized the safety of their constituents. As a result, I provide several policy recommendations for future policymakers in order to ensure political stability and health security in the United States in the face of future threats to public health.

Although this study illuminated several important themes and topics for further discussion,
there were certain limitations that future research would benefit from exploring. As the previous
section highlighted, several marginalized voices, particularly those that were most impacted by the
pandemic, were missing from the interview samples. Additionally, as the majority of participants were
recruited through personal connections, this sample may not be entirely representative of the larger
community. Future research should focus on various recruitment methods, such as advertisements,
flyers, and more, in order to recruit various segments of the population of Shasta County. Furthermore,
research was concentrated within the largest city in the county, Redding. However, residents in more
isolated areas, such as those in the Intermountain Region (which, as the introduction explained, has a
vastly different history and geography, which may influence local culture), may have had different
perceptions and experiences or might further highlight certain themes.

Above all, this study highlighted the importance of regional history and context that influenced
responses on the local level. As such, although certain elements can be extrapolated from this
ethnographic research, further studies in various other regions of the United States would further
contribute to this body of work and create a more robust understanding of how culture influenced risk
perception and experiences during COVID-19. Additionally, expansion of the sample size would allow
for more generalizable data and could reveal other trends.

Further research might also benefit from a continuation of this study throughout the winter of 2020
(including in other regions of the United States) as the context of the COVID-19 pandemic rapidly
changed. Across the nation, cases have dramatically risen - many may have changed their opinions of
reopening policies in response. Furthermore, recent announcements about the distribution of the Pfizer
and Moderna vaccines may have influenced people’s perceptions in a different way. Studies into this
winter period may also be beneficial in providing a comparison study for the summer. A combination of
both a summer study and a winter study might reveal further patterns of seasonality in opinions about
the virus, in part since many rumors initially spread that as the SARS-CoV-2 virus dies in heat, it would not be a serious threat over the summer for many countries.

This research elicits further specific questions: What does this tell us about how rural America feels left behind? How does race play into it? Where does it leave us with mistrust in government? What happens as President Biden takes office? Will people believe in his leadership? What about individualism over collectivism? Is that a driving force for public health failures in the future? Does public health have a future in America? How do we rebuild trust in science?

Rural America feels left behind in policies as well as in modern culture. Rural white folks who have long seen themselves represented as the only inhabitants of rural areas and of America as a whole suddenly face new representation of various minorities as political movements such as Black Lives Matter advocate for these groups, and yet no visible advancements in terms of rural white peoples’ material reality. Instead, many independent workers in the area have seen further erosion of their economic security. As such, they have leaned further onto the mythological pioneer past which popular American culture has immortalized. They listen to the nostalgia-tinged memories of their forefathers and believe that once, they were not so beat down. At the same time, much of the blame for this backwards slide is pinned on minority groups. In this way, rural minorities’ lives have become progressively more endangered as they are left with the frustration of rural majority groups and abandoned by policymakers which increasingly focus on urban areas.

Coronavirus policies amplified these trends as many rural areas experienced a belated surge in Coronavirus cases. Many rural residents perceived prevention methods as infringing upon their individual and economic freedoms without protecting or benefitting them. At the same time, they encountered a resurgence of support for ethnic minority groups in the form of Black Lives Matter protests over the summer. As such, the two trends became intertwined to many rural majority
populations’ perceptions and signaled a fundamental change from the policies which they perceived their ancestors thrived on.

This mistrust played into Trump’s success within rural areas such as Shasta County during his presidential campaign. Although many perceived him as inefficient or rude, they hoped that a “political outsider” like Donald Trump could change politics in their favor. On the other hand, Joe Biden is perceived as a political insider. As such, the majority of Shasta County and other areas with a culture of rugged individualism are predisposed to mistrust him as well. If he is to successfully win over this population, he must understand their demands, acknowledge why they mistrust government (i.e., the history behind how recent regulations have damaged their enterprises) and vocally work to dismantle political trends which have contributed to this alienation. A Biden administration that otherwise seeks to return to pre-Trump norms will only further alienate without these changes, impacting long-term trajectories.

Similarly, scientific institutions must acknowledge past wrongs done to specific groups and highlight how innovations by scientific establishments have benefitted several populations. For example, anti-vaxxer populations are free of various infectious diseases despite not obtaining vaccines precisely because of the success of mass vaccination programs. At the same time, institutions could acknowledge that some of these past programs, such as smallpox initiatives in the Global South, denied autonomy and consent from certain recipients. Most importantly, personal outreach both from government and scientific establishments could go a long way in rural cultures which value the importance of interpersonal connection.

As many other scholars have pointed out, part of America’s problem in dealing with Coronavirus is due to our individualistic culture. Areas with the extremes of this tendency, such as Shasta County and its culture of rugged individualism, have demonstrated specifically how individualistic beliefs and tendencies compromised COVID-19 response. This is not to say that this response was inevitable and
immutable. We can encourage public health successes in the future by investing in our infrastructure and giving experts the tools to craft an effective, autonomous public health system. Americans strongly believe in certain inalienable rights, as demonstrated by the ideals to which participants throughout the political spectrum and on either side of the COVID debate held. The results of this research demonstrate a steadfast belief in protecting each other while maintaining personal responsibility. If we reframe public health interventions in terms of protecting each other while maintaining a sense of personal responsibility - even in terms of our personal responsibility to protect others - we can shape rugged individualism to the benefit of public health interventions.

7a. Policy Recommendations

Despite certain limitations, this research provides data to support several policy recommendations. Overall, it proves that policy, even in crisis situations, must begin to consider cultural factors and nuances when creating regulations and orders. Unfortunately, this has not been the norm in policymaking. On the state level, future policymakers must understand local rural culture and develop policy solutions that work with this local culture rather than issuing policy recommendations that may be better suited for more urban areas. Additionally, local rural groups cannot pass blame up the chain of command; this response only serves to weaken both confidence in local authorities as well as undermines trust in state authorities. Rather, a coordinated response on all levels (including federal) that supports each other and promotes a united government response is essential, especially in crisis situations such as the COVID-19 pandemic.

This study also demonstrated that policy response to a pandemic must be measured and demonstrate a continuous trend while also respecting the epidemiology and evolving understandings of the disease. As many participants testified, it was much more difficult to close businesses down quickly after re-opening, as many felt they had received minimal warning. This also demonstrates the
importance of adequate health communications with the public on all levels of government, particularly from public health departments. However, these departments need support and funding from other areas of government in order to effectively communicate with the general populace. Shasta County actively worked to debunk certain common myths about the Coronavirus throughout the pandemic; while this was extremely beneficial, these communications must be more widely broadcast, potentially through public-private partnerships with local news networks and businesses. These partnerships require larger, more continuous funding from higher levels of government, particularly the federal level.

These results also demonstrate the diversity of thoughts and experiences within Shasta County and highlight the vulnerability of rural minorities. As such, state and federal policymakers must not sideline these areas because they perceive a general attitude of mistrust. Instead, they must actively work to protect marginalized groups and promote more equitable policies. Although rural areas may contain comparatively less people, this minority is still relevant and deserving of equal access to testing, PPE, and other necessary resources in order to combat the COVID-19 virus and other future public health concerns.

Perhaps the most important lesson from this study is the necessity of federal relief funding and directives. The majority of participants spoke to a level of financial insecurity where they felt forced to disobey COVID-19 regulations in order to preserve themselves and their families. These participants recognized the risk of their actions, but when faced with the equally relevant risk of financial destitution, many chose to prioritize their finances. If adequate federal aid had been provided rather than a one-time payment of $1200 that was distributed to all citizens and focused more on stimulating the economy rather than helping relieve those most affected by the pandemic, case rates across the United States might have been lower, as many people would comply with COVID-19 regulations.
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