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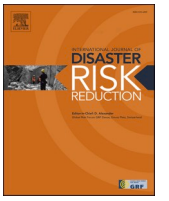

Older adult's experiences during the second year of the COVID-19 pandemic in Aotearoa New Zealand: Diversity and change in long term disaster situations

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ABSTRACT

The COVID-19 global pandemic has highlighted the morbidity and mortality risks of older adults as well as their heterogeneity and resilience. The immediate need to address psychosocial and health issues among this age group is driven by global concerns about the growing number of disaster occurrences, the growing ageing population, and widening inequalities. Using an inductive analysis of written comments about their experiences by 1,400 older people in the second year of the pandemic in Aotearoa New Zealand, we found that responses to the pandemic and government actions had fractured as different groups of older adults felt neglected or wronged by the centralised response. Negative themes of anxiety and fear describe aspects of vulnerability in older adult's lives and point to issues for repair and protection in pandemic situations. Positive themes describe the resources that people drew on to maintain their wellbeing in a lengthy disaster. Drawing on theorising around *conservation of resources* and *disaster communitas*, our analysis shows that across a long-term disaster situation, resilience may be best sustained by drawing on local support systems and enabling community volunteers. Institutional responses and planning must include and empower grass roots groups who are better placed to recognise and respond to the resource needs of their own communities.

1. Introduction

The COVID-19 global pandemic, as with any type of disaster such as the 2010-2011 Canterbury Earthquake Sequence and 2011 Great East Japan Earthquake and Tsunami, has highlighted the morbidity and mortality risks of older adults and the health and social inequalities among them [1,2]. The immediate need to address psychosocial and health issues among this age group is driven by global concerns about the growing number of disaster occurrences, the growing ageing population, and widening inequalities in many developed countries. This highlights the need to mitigate increasing disaster risks while there are growing numbers of older adults.

In the present study, we use qualitative data to explore older New Zealander's diverse experiences of the pandemic and government responses such as mandated lockdowns. We draw on theorising around resources [3] and disaster *communitas* [4] to understand the changing experiences of older adults during a long-term disaster situation which has been directly affecting lives for over two years and whose outcomes are difficult to predict.

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1.1. Study background

The present study was conducted in Aotearoa New Zealand (henceforth called Aotearoa). In March 2020, following the first COVID-19 cases, the Aotearoa borders were closed to all but citizens and permanent residents and the Aotearoa Government introduced an elimination strategy [5] with a 4-tiered alert level system (ranging from rules about reduction of contact to full lockdown) to combat COVID-19. Aotearoa moved to alert level 4 which included a national lockdown, self-isolation, and a state of national emergency. After one month, Aotearoa moved down through the alert levels to reach alert level 1 by June 2020. In August 2020, as new cases arose, the Auckland region (one third of the population) moved to level 3 while the rest of the country was at level 2. For the next few months there were several shifts in the degree of lockdown restrictions between regions. The whole country moved to alert level 4, the highest degree of restriction, in September 2021 following the Delta variant outbreak, followed by a period in which different regions were at different levels with Auckland and surrounding regions always at the higher levels. In December 2021, all Aotearoa moved to a new COVID-19 protection framework, which coincided with easing of restrictions by January 2022 and a dependence on mass vaccination for protecting public health. The borders were fully re-opened in July 2022, although the country remained at a low alert level with social distancing and mask wearing in public strongly endorsed.

1.2. Effects on the ageing population

While the pandemic has affected entire populations, it has not affected all groups equally. Older adults are understood to have disproportionately experienced negative outcomes from the COVID-19 pandemic worldwide, experiencing increased mental health, morbidity and mortality risks [e.g., 6–8]. Early studies on the impacts of the pandemic on health and wellbeing highlighted the increased risks for older adults [e.g., 9]. Of the total number of confirmed cases in Aotearoa by August 2021 (before the Delta outbreak in mid-August), 73.6 % were found among younger age groups (49 and under), although all deaths had occurred in older age groups (50+) [7,10]. Thus, older adults, who were considered vulnerable and at-risk from the coronavirus (those over the age of 70), and others with existing long-term health condition were urged to remain strictly isolated at higher alert levels.

While older adults were initially considered psychologically vulnerable, owing to the mortality risk and stresses of social isolation [e.g., 11], later meta-analysis of empirical work showed that older people were often less emotionally vulnerable than younger people [12] and a systematic review [13] found that older adults generally reported lower stress and less negative emotions under quarantine than younger adults. One explanation for these differences is that, despite declining health, older adults had developed higher resilience by previously experiencing and coping with disasters, life challenges, and adversities [14–16]. Such individually focussed explanations provide us with some idea of the importance of lifelong experience. However, explanations of individual resilience omit consideration of the role of current material, social, and cultural contexts.

1.3. Communitas as a theoretical explanation for social resilience

Further explanation of resilience is provided by theories of community altruism or "disaster *communitas*" which refers to the improvisational social bonds and acts of mutual help, collective feeling and utopian desires that typically emerge following disasters [4]. Such a strong sense of community emerged during the first 2020 lockdown in Aotearoa when community and Māori (Indigenous people of Aotearoa) tribal groups provided economic, health and social services [17,18]. Stephens and Breheny [19] found that older New Zealanders, rather than expressing anxiety, generally enjoyed this sense of community during the first lockdown. Most older adults who were retired or able to work from home, appreciated the support provided by family, friends, and neighbours, and home contact and support services provided by local authorities and NGOs including a university student-led volunteer group called Student Volunteer Army (SVA) [20]. They also enjoyed governmental support in terms of wage and heating subsidies and cohesive leadership, which included daily information updates and clear consistent messages. Government leadership was supported by Māori and Pasifika leaders and politicians of different political persuasion. Accordingly, at that time, people expressed a strong sense of unity, security, and social cohesion. The time in lockdown was often described as an idyllic period [21], representing a return to a better past or hopes for a reconfigured idealised future for society. Such responses have long been observed in a wide range of disaster situations [4].

1.4. Social inequalities among older people

Although the positive response was dominant in older New Zealanders' accounts, the privilege of enjoying lockdown did not apply to those who were more vulnerable: essential workers (who continued to work in difficult situations); those who lost their jobs (especially difficult for older adults); or those who were caring for another vulnerable person. Older adults are often overgeneralised as a homogeneous group of powerless vulnerable people [22,23], but the pandemic has not affected older adults equally. COVID-19 has had a disproportionate impact, by reinforcing existing inequalities in groups of older people defined by gender, class, ethnicity, race, ability, and sexuality [24]. Impacts of the global pandemic disaster on older adults' health and wellbeing are unevenly distributed due to the complex intersection of social determinants, circumstances and contextual factors that characterise any demographic group [25].

1.5. Summary and research question

Initial studies of older people's experiences have pointed to both sources of resilience for older adults, and to the effects of diverse circumstances. Studies following the early phase of COVID-19 highlighted positive responses to the unprecedented pandemic and early lockdown [19,26]. However, these were early studies of a novel situation and the ongoing effects of the pandemic and subsequent lockdowns have yet to be documented. Findings from Aotearoa and international research remain equivocal regarding the specific vulnerability, and resilience, of older adults during the pandemic [27]. The COVID-19 pandemic is a unique rolling disaster [28] which

has important implications for wellbeing in high stress conditions as waves of the disease and its variants affected different populations at different levels across time with no known endpoint.

Although there has been a proliferation of research during the COVID-19 pandemic, we have little in-depth understanding of the diverse experiences of older adults over the longer term. The present study aimed to consider the vulnerability and resilience of older adults during the second year of the ongoing COVID-19 global pandemic in regard to long-term disaster response.

2. Method

To explore older adult's experiences of the mid- and longer-term pandemic response in terms of vulnerability or resilience in the face of disaster, we employed an inductive qualitative analysis of free-text comments.

2.1. Participants and procedures

Participants were respondents to the 2021 wave of the Health, Work and Retirement (HWR) study of older community dwelling adults who were initially randomly selected from the New Zealand Electoral Roll and had agreed to participate in the biennial longitudinal survey [29]. The 2021 cohort of N = 4075 was aged 55–93 years. The age range was chosen for this longitudinal cohort with the aim of following people into retirement and beyond; 55 is often chosen as the lower bound for older age in national samples [e.g., 30]. The questionnaire was specifically designed to capture quantitative information regarding the impacts of the COVID-19 pandemic and consequent restrictions on the social, mental, and physical health of older adults. The back page of the questionnaire was blank with an open-ended question: "We are interested in hearing about your thoughts and experiences on any of the topics in the survey. Please use this space to write any comments you may have, including any regarding the COVID-19 pandemic." Over 1400 respondents wrote comments related to the survey, and most commented on their pandemic and lockdown experiences. These 1462 respondents, who wrote their comments as they were experiencing the pandemic and subsequent lockdowns during 2021, were the participants in the present study. Some respondents wrote one or two sentences, while others wrote more lengthy commentaries (up to one page attached separately). The extracts chosen to illustrate the themes below were selected for brevity.

These participants were aged 56–93; 550 were males and 912 were females; 320 were in full time employment, 307 in part time employment, 10 unemployed and seeking work, 50 unable to work, and 579 were retired (4 full time students, 37 full time homemakers, 155 other or missing). There were 531 of Māori descent. There were 344 living alone. There were 356 living in rural areas.

2.2. Data analysis

The orientation was inductive. All written responses were coded to identify common patterns of explicitly stated experiences, perceptions, and feelings during year two of the pandemic. The codes were developed on the first 300 responses, and these codes were used to code the full dataset. Samples of the coded extracts were then checked, refined following discussion among the authors, and used as the basis for a thematic analysis.

The coded extracts were analysed to identify the major repetitive patterns found in the data in terms of shared perspectives and experiences [31]. First, there was a clear division between accounts with a positive or a negative orientation to experiences during the pandemic and the national response. We acknowledge that people may experience both positive and negative aspects of a disaster together; however, in these brief extracts, the focus of the experiences described could be coded as a positive aspect of the disaster situation or as a negative experience.

Due to the size of the dataset, there were many disparate aspects of the situation commented on by different respondents such as the vaccination rollout, information dissemination, lockdown experiences, work difficulties, personal fears, etc. By considering all these responses in terms of positive or negative responses to COVID-19 and the national response, we were able to bring these disparate responses into an interpretive framework [32] that allowed us to identify themes of vulnerability that underpinned the negative responses and resilience which bolstered the experience of the pandemic as positive, expressed by older adults during the second year of the COVID-19 pandemic. Thus, within each set of negative and positive accounts, themes regarding vulnerability and resilience, was identified. We also noted an additional theme highlighting perceptions of change, or erosion of resilience, across the two years.

Providing counts of the coded extracts is not a standard approach to qualitative data analysis. It is useful here because of the large N, and because of the diversity of topics covered in the responses. This quantification aids interpretation by allowing the reader to gain some sense of the relative importance of each topic across the whole sample and the preponderance of different kinds of negative and positive evaluations of the pandemic experience. Brief extracts from the data are used to illustrate each theme.

3. Results

From the 1354 responses in the final data set, 675 were coded as positive and 679 were coded as negative. The key themes associated with negative responses describe aspects of vulnerability in these older adult's lives and point to issues for repair and protection in pandemic situations. These are themes of anxiety or fear, difficulties caused by COVID-19, distrust of the Government and health services, and social divisions.

3.1. Negative themes

3.1.1. Individual anxiety or fear

Some participants described experiencing mental health issues, shock and fear, anxiety about keeping safe, and worry about self or family (N = 83).

> COVID-19 has made me think about going to places where there will be crowds, I do not go out as often and do not go where there will be lots of people. Kiwis are too complacent. I scan the QR code at supermarkets, doctors and anywhere else. I hate it when people do not keep a metre distance if waiting in line. I carry my own hand sanitiser and use it after touching anything outside of my home. I stock up essential items just in case of another lockdown. I do not travel out of town unless absolutely necessary (e.g. sick relative). I got the jab even though I was against it (not enough research) because every day COVID-19 is spreading all over the world … I never thought I would live to see a pandemic like this.

People also wrote about a sense of uncertainty about the future of the country or the world (N = 58) and personal concerns about limited time left to enjoy life because of the disruptions (N = 11) which revealed both present and future insecurity.

3.1.2. Difficulties caused by COVID-19

Overall, 616 participants described personal difficulties caused by COVID-19. Of these, 117 described problems accessing services, health care, or social contact because of the lockdown restrictions, difficulties travelling overseas, and time spent in quarantine, travel restrictions and financial problems caused by border closures, and major disruptions to life plans.

Several (N = 91) also wrote about missing contact with family or friends. These difficulties were felt keenly by those who missed being able to visit dying relatives, attend funerals and significant birthdays, or missed the birth and growing up of grandchildren. The needs of family also created difficulties for 52 participants who wrote about the exhausting problems of having children at home, caring for grandchildren during the pandemic, difficult adult children who had returned home to live, and worry about vulnerable family members. A further 41 wrote specifically about the problems of caregiving. These included the hardships of not being able to visit older relatives who were in nursing homes and hospitals, caring for parents living in the community, and caring at home for disabled children, spouses, or parents with health problems or high needs including dementia. Another 89 described what we coded as "minor difficulties" which included missing out on usual activities, and holiday and overseas trips cancelled.

Workers (N = 119) also reported issues caused by the pandemic. These included redundancy or reduced hours, early retirement, negative impact on businesses, pressures of staff management and care, and difficult work conditions including community support work or homeless housing, international air crew, health care in hospitals and clinics, and teaching. Some (N = 45) described economic hardship caused by job loss, business failure, or support for family and children. Older adults living on the government superannuation alone were particularly hard hit by cost-of-living increases which were often mentioned.

Finally, 61 participants also mentioned their awareness of others' difficulties. While describing their own difficulties or good fortune, these participants mentioned those who were lonely, sick, poorly off, or working under difficulties making comments such as: "My heart goes out to others who are struggling financially and emotionally". Another participant described his emotional struggles which reflect many of the fears, difficulties and contradictory emotions expressed by others:

> I am self-employed, and, on the surface, my days do not change when in lockdown. However, I have realised that absence of freedom has an undeniable impact on wellness. It is hard to explain–I guess it is empathy for those who contract COVID-19, empathy for the impact it is having on already poor families, fear of the potential impact on income, fear of contracting it and passing it on to others, disruption, fear of the unknown, and authorities taking over, conflict between personal freedom and wanting to do the right thing, and anger at those who have no consideration for others. I have to recheck myself frequently so this is not a burden and fall back on feeling that everything will be all right. The negative and positive impact will linger on for many years to come.

3.1.3. Distrust of the government and health services

Many (N = 192) were critical of the quality of information provided or suspicious of the government's intentions as in the following examples:

COVID-19, health and government, too much spin, information withheld at times truth comes out later. E.g., actual experiences of friends and family often at variance to the Official information being given.

> I am very confused and angry about the covid response in Auckland and NZ. The silencing of dissenting voices and opinion from international and local experts is very frightening.

Eleven participants detailed their concerns (sometimes at length) about government cover ups and lies, the vaccinations being used to control people, mask wearing as a form of control, the deliberate release or non-seriousness of the virus, and the pandemic as a global scam.

An additional group expressed negative opinions because they did not intend to get vaccinated, were not convinced about its efficacy, or were concerned about possible or unknown dangers. For example, one person wrote:

> The vaccine is known to not stop you getting covid nor to stop you transmitting it to others, despite this the govt and health authorities seem so desperate to inject everyone with this (watered) product. Where is the precautionary principle. There are many reported side effects and the possibility that more will be revealed in time.

Several people also commented negatively about the national health system (N = 217). Many of these concerns were about the Pfizer COVID-19 vaccination roll-out, and people commented on their negative experiences of being vaccinated:

> Vaccine rollout confusing and poorly done. I know people in group 3 who have not been contacted or vaccinated jumped the queue June 10 to get vaccinated as no notification.

3.1.4. Social divisions caused by the pandemic response

A few (N = 44) participants described social divisions caused by COVID-19 experiences and particularly by the vaccination programme. As one put it succinctly: "COVID-19 had impact on who and who doesn't believe in injections". Several others mentioned their concern about anti-vaxxers or conspiracy theorists and a general concern about refusals to help remove this virus from our community. Some mentioned divisions within families, or between friends causing rifts. In addition, 40 participants expressed their broader concerns with rule breakers. People who flaunted stay at home rules, did not wear masks in public spaces, did not maintain social distancing, people coughing in public, or failing to use the tracer app were topics of approbation. Participants were also concerned about the number of people in the country pressuring the government to open the borders; these were described as selfish. One participant wrote about their confusion amid these divisions:

> There is a lot of negative media regarding the pandemic. I am not sure what to believe. I have had concerns about getting the vaccination because of negative comments on social media. COVID-19 has made me anxious for my family who live in Queensland, Australia and B.C., Canada.

3.2. Positive themes

The themes identified within the positive responses point to the supportive resources that are drawn upon in disasters to enable resilience. These resources provide indicators of individual, environmental and social resources and government roles, that enabled people to navigate the two years positively.

3.2.1. Individual resources

Participants described a variety of individual practices to maintain wellbeing during adversity including exercise, maintaining a positive attitude to life, and reliance on religious faith. The most commonly mentioned practice for maintaining wellbeing was health related behaviours (N = 126); most of these comments described the importance of exercise, particularly walking or bicycling, as a favourite activity during lockdowns. People reported that the increased time available and decreased traffic allowed them to focus on and enjoy these pastimes. Those who did not have access to the outdoors walked around a courtyard or followed exercise sessions on television. Other health related behaviours mentioned were healthier eating, sleep, and improved hygiene behaviours such as hand washing and mask wearing.

Some older adults (N = 46) also mentioned the importance of a positive attitude to challenging circumstances including acceptance. Others mentioned the positive aspects of the pandemic itself, such as realising the importance of family. Five of these mentioned the experiences of past disasters (earthquakes or World War II) as supporting a sense of resilience. Additionally, 26 participants saw their religious faith and confidence in divine care as a resource to maintain a positive outlook on the events. One participant summed up many of these ideas succinctly by saying:

> At this stage of the pandemic, I believe we just need to accept it is going to be with us for a while. Try and eat healthy and exercise. Keeping active will also help mentally, socialising with friends will help tremendously. Lockdown was the worst aspect of this COVID-19. Not seeing family and friends you really missed them. I think it is a realisation how much more families appreciate each other. A big wake up call to us all.

Such accounts of individual practices can be understood in terms of access to resources which support health promoting behaviours. Although participants attributed their positive experiences of the pandemic to such practices, good sleep, space for exercise and access to healthy food were not separate from environmental and social resources.

3.2.2. Environmental resources

Support for wellbeing from the environment was found in the benefits of lockdown time, the use of technology, and living in a rural location.

Many people (N = 188) reported enjoying the lockdowns over time. For those who were retired or could work at home, lockdowns provided a much valued slower-paced life, with fewer social and work-related responsibilities, peaceful streets, and time to pursue hobbies and reprioritise the important things in life. Several (N = 105) commented on the importance of various forms of communication technology (including television, radio, Zoom, social media, phone, texting and emails) to keep informed and in contact with friends and family, as in the following example:

> I spent initial lockdown over Mar/April with my mother. Isolation from family members and partner was difficult, but contact through phone, zoom and other digital platforms helped. It would have been a struggle on my own without communication access. I consider myself extremely fortunate. Daily exercise around my community also provided a stress release valve when feeling under pressure from the stress of lockdown.

People who lived rurally often commented (N = 19) on the advantages of living in the country during lockdowns which generally included little change to their lifestyle, a sense of community and security. An example of these resources for resilience was:

> I live rurally [in area] on a small lifestyle block. The pandemic did not affect me as I was able to continue to do most days what I normally do work on growing all my own fruit and vegetables. I was able to share these with some of my elderly neighbours so had two buddies I would frequently visit to leave food on their doorsteps and chat from a distance.

> I actually enjoyed the peace and quiet of lockdown especially the lack of traffic on the road. I had continual contact with family overseas and friends around NZ by using Whatsapp, Facetime, phone, texts and emails. I felt fully informed listening to news on TV, radio and online.

3.2.3. Social and community resources

Social sources of resilience reported included family support, community support, government support, and employer and government support for workers. Many participants (N = 126) were moved to comment on the support that they received from family members and often reported increased recognition of the importance of family or renewed closeness to family. Owing to the increased danger of infection for older adults, children moved in with their parents or parents moved to stay with children or other family members. In general, these participants received assistance with shopping and health care essentials, as well as increased contact from wider family members in various ways.

People (N = 122) found various broader forms of *community support* noteworthy during the pandemic. General contact and emotional support from friends in various ways such as telephone or socially distanced chats were valued. Help from neighbours with chores like shopping for older adults was often mentioned and appreciated. Community-based support for older people that was described included iwi (tribal) groups, church groups, or local organisations that organised the delivery of food or help with shopping. As an example:

> Our community formed a group to support all the whānau [families] in our coastal bay. We had food, health products all delivered to each whānau [family]. The key to our success was good open and honest communication. Everyone felt valued and most felt that they had been given the opportunity to reset and re-evaluate their lives and priorities. WE DID.

Neighbours, family members, and community groups continued to recognise older adults' particular vulnerability to the pandemic and fill the gaps in economic, human, and social services, for example, by doing grocery shopping during lockdowns. Survey respondents acknowledged such kind acts and friendliness; however, this was no longer a dominant theme, and some felt neglected by these acts of communal support.

3.2.4. Government roles

A major focus of these responses to the pandemic was the central role of the government. Some participants were clear about their support for the government actions (N = 186) in response to the pandemic in statements such as:

> I think the government has done an excellent job in keeping us informed and safe. The help for small businesses has been outstanding.

Many of these participants commented on the information provided by the government, often in terms of media messages:

> Like many older people, I listen to national radio rather than the talk back type of broadcasts and think that is a reason why I think we were well-informed during the pandemic. Good information contributed a lot to reducing the degree of anxiety experienced. Less misinformation or conspiracy theories!

There were 126 comments specifically supportive of the health system such as:

> I have managed well with COVID-19. I kept informed on TV and had no problem with receiving vaccine at local marae [community meeting place]–they were very caring and cheerful. My GP [general practitioner] and MMH [Ministry of Health sponsored data programme] have phoned on several occasions on my welfare.

In terms of the vaccine rollout, many of those who experienced the pandemic positively simply reported that they had been vaccinated while several commented on the ease of the process. Workers who retained their jobs as essential workers, stayed home with subsidised wages, worked at home, or returned to work as nurses, were often very positive about their experiences and the government support for workers and businesses during the pandemic (N = 96). Of these, direct support from employers was also noted by 11 respondents in terms of general support to remain working, extra training, provision of full health and safety conditions, leave on full pay, or payments to cover costs of working at home.

3.3. Resources depleted over time

The positive themes describe the resources that people drew on to maintain their wellbeing in a lengthy disaster. This comment from a participant exemplifies the depletion of these resources experienced by some, and changes towards more negative experiences and a growing sense of frustration across the two years of the pandemic:

> In 2020, COVID-19 was a novelty–everyone got involved around us, neighbours by willingness, walkers chatting over hedge, creating bubbles with others with welfare concerns, pantry planning. Phone calls to vulnerable. Nationwide internet entertainment positive feelings for a lot of folks, desperate feelings for others. Weather was extremely good to us–happy. In 2021–Aug 17–my 75th birthday, no cake, no flowers, a few visitors, and no celebration! Feelings of annoyance, resignation, fear. Weather not so kind, feelings of SAD. Recreating bubble, irritation with suddenness. Doctor appointments delayed again.

Some participants (N = 31) commented on the changing experiences of the pandemic across the two years in this way, mentioning additional hardships as time went on, and growing anxiety and concerns about the future. The following extract, exemplifies this recognition of changes in family and community support as the novelty of a short-term crisis dissipates and difficulties across time

erode resilience:

> I found the first level 4 lockdown easier to experience. We made the most of the time and my daughter and her partner were living with us which was good. My husband was working fulltime as a GP and was quarantined to a separate part of the house. We made fun games and interactions to play at a distance with him. We picked wild mushrooms and shared with neighbours (at a distance). Everyone was aware of everyone else in the neighbourhood. We looked out for each other and phoned each other. This level 4 lockdown in August/September 2021 was very different. My husband is still working fulltime, and I am home alone. The feeling is very flat. No one is keeping in touch in the neighbourhood, we are all just hunkering down and perhaps aware that this could be a long-term thing. I worry for those in business, our children with mortgages, and for our children and grandchildren's futures.

4. Discussion

The views of a large sample of older adults during a long-drawn-out disaster situation were unprompted. This has provided a broad range of topics and highlighted some clear themes of interest to older adults. Although some of these may be context specific, a recent study involving 825 older adults in the U.S found similar themes across qualitative responses to an online survey [33]. Of 21 negative categories, the most commonly reported stressors were confinement/restrictions, concern for others, and isolation/loneliness; while the most commonly reported of 20 positive categories were family/friend relationships, digital social contact, and hobbies.

The first noteworthy finding in the present study was simply the split between those expressing positive experiences in response to the pandemic and those detailing negative experiences. This split highlights the changes across time in a pandemic whose effects continue after two years. In contrast to the findings from a survey of the same cohort following the first lockdown in 2020 when the responses to government and health system responses were overwhelmingly positive [19], the strong sense of community and fellow feeling that characterised the 2020 responses was less common.

In the second year, when the present data was collected, the responses were far more divergent. Rather than a strong sense of communitas expressed in talk of the "team of 5 million" and "be kind" as dominant themes, a clear split between experiences interpreted as positive and the more negative views was evident. The "honeymoon" disaster phase does not typically last an extended period of time (usually 1–6 months); as the "disillusionment" disaster phase begins, the sense of disaster communitas usually fades out [e.g., 4, 34,35]. During this phase, neighbours, family members, and community groups continued to recognise older adults' particular vulnerability to the pandemic and fill the gaps in economic, human, and social services, yet this was no longer a dominant theme. Among the positive responses, there was more awareness of different types of behaviour in the population. Negative responses described distrust of central government actions, and altogether there was very little mention of the government subsidies for employment and winter energy payments for superannuitants, although these forms of support remained available. Thus, resilience may be seen as contextual and resource-dependent, and gradually decreasing as time passes [36].

4.1. Conservation of resources

The resources participants in our study reported using to cope positively with the pandemic were similar to those reported by 5,180 adults in the U.S. including exercising and going outdoors, modifying routines, following public health guidelines, adjusting attitudes, and staying socially connected [37]. However, not all older adults had access to these resources. For instance, some of our participants found information about public health guidelines problematic or difficult to access. Difficulties with staying socially connected or stressful work conditions contributed to negative experiences. Verhage et al [38] found that, among older adults in the Netherlands, the length of time of the disaster disrupted known coping strategies, such as daily activities, to leave many feeling vulnerable and insecure. These authors emphasised the importance of acknowledging the heterogeneity of resources available to older adults, particularly social resources.

Conservation of resources (COR) theory [3] provides a framework for considering the actual needs of diverse groups of older adults in a pandemic situation. COR theory, as with the general theory of social vulnerability to disaster, suggests that loss of resources is disproportionately weighted so that those with fewer resources in society are much less able to cope with disasters and require the investment of additional resources to be resilient as much and for as long as their affluent counterparts [36,39,40]. Thus, in the present study, the split between positive and negative experiences of the pandemic may also reflect differences in access to resources that support older adult's resilience or expose them to higher risk. For example, those who were capable internet users could maintain social contact to leverage social capital, those who lived rurally were much less affected by lockdowns, or those who were retired or working from home did not feel the worst stresses of dealing with lockdowns and uncertainty about the future. Those who felt disenfranchised by government actions, those who suffered economic hardship, those separated from family and social supports by the centralised response measures, or those who are generally socially marginalised were more vulnerable to feelings of stress and mental health issues. Rather than seeing older adults as one group, it is important to pay attention to the broader communities to which they belong.

4.2. Communitas

The change across two years of the pandemic speaks to the short-lived sense of universal *communitas* evident in centralised disaster responses enacted over a longer time frame. Matthewman and Uekusa [4] describe five reasons for the emergence of *communitas*: a sense of suffering together; collective action to provide immediate aid to those affected; a sense of agency in adjusting to circumstances; the uncontrollable nature of disasters promotes a sense of togetherness; and the social nature of human beings. However, these

authors also note that, according to research to date, *communitas* is a temporary phenomenon. How can institutional responses enhance and prolong this important form of social support in a disaster situation?

Across a long-term disaster situation, some sense of *communitas* may be sustained by drawing on local and grassroots support systems and volunteerism. For example, Zollet et al. [41] described how local grassroots action in Italy was important in ensuring food access, provisioning, and distribution, when mainstream provisions were failing during the pandemic. Centralised government approaches have been often criticised for exacerbating pre-existing inequities and system failures and for outsourcing these human and social services to volunteer and community groups. Morgan et al. [42] described how grassroots community leaders mitigated these effects in Canada and suggest that community action is important for creating supportive environments. In Aotearoa, where the government was strongly criticised in the second phase of the COVID 19 response for failing to include equity for Māori [43], a review of recent literature [44] shows the importance of recognising local leadership, social networks, and resources to provide the sense of trust and care among older Māori needed in a disaster. Cram [45] states that "it is … important to learn from Māori responses to Covid-19 in order to celebrate the ways in which people looked after one another and also help ensure our capacity to do so again …" (p.4).

However, disaster researchers have already noted the problems of relying on community-based responses (i.e., responsibilisation of communities and individuals) and the neoliberalisation of resilience [36,46–48]. For example, Gray [49] cautions that "the optics of disaster utopia may serve to further exacerbate injustice" (p.15). Popular representations of community cohesion may (un)intentionally promote a false sense of equality and security by prioritising the needs of the privileged over those of people who remain marginalised. She has shown how community-based interventions in the U.S. can reflect existing inequalities and power relationships and suggests a "justice-oriented politics of disaster recovery" (p.1) [49]. Tran et al. [50] also caution against the total reliance on grass-roots systems citing the example of Vietnam, where the vulnerability of a grass-roots health system was revealed by the pandemic, and the importance of central support, including preparation, training and provision of resources was highlighted. Matthewman and Uekusa [4] also note the importance of institutional systems to support community organisations. This need has been highlighted in Aotearoa with the government making rapid moves following an inquiry, to provide greater engagement with Māori leaders and provision of relevant resources to local organisations; although this has been condemned as "far too little, far too late" (p.2) [43].

The advance preparation and provision of resources to empower community groups to respond to community needs will provide targeted approaches to disaster response and enable groups of people to avoid destructive social divisions in pandemics.

5. Conclusion

A pandemic is an ongoing disaster that engenders fear and anxiety about an unknown point of recovery and resumption of normal life. Older adults have been shown to be resilient in the face of the current pandemic, but older adults also belong to heterogeneous communities with different levels of access to supportive resources. Aotearoa has been recognised for the initial immediate strong public health response to initially eliminate and then vaccinate the population against the spread of COVID 19, especially among older adults. As a very small country, this initial response engendered a sense of communitas. However, only two years later, this sense of working together had fractured as different groups of older adults felt neglected or injured by the centralised response. Changing health information communications were delivered to the public creating a sense of insecurity and concern around issues such as safety, financial stability, vaccination mandates, and border restrictions.

Drawing on theories of communitas and COP theories, our analysis has shown that access to beneficial individual, environmental and community resources enabled the maintenance of a sense of communitas and resilience in the face of an ongoing disaster situation. Across a long-term disaster situation, a sense of communitas may be sustained by drawing on local support systems and enabling community volunteers. To work towards maintaining a sense of resilience for all across a diverse population, institutional responses and planning must include and empower grass roots groups who are better placed to recognise and respond to the resource needs of their own communities.

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Declaration of competing interest

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

Data availability

Data will be made available on request.

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