7 A LINGUISTIC ANALYSIS
Roles and Professional Identities in Defining Reality

Boyd Davis and Christin Wolf

Understanding Social Identity in Times of Crisis and Change, by Pilar Blitvich

In sociolinguistics, the concept of social identity has been used to explain how individuals' self-image derives from the social categories they belong to (Tajfel 1979), and it is related to the emotional and evaluative consequences of belonging to specific, recognizable groups (Tajfel 1982). Identities are intrinsically relational: who "we" are can only be fully grasped in relation to the "other." By understanding how individuals' thoughts, emotions, actions are impacted by real/imagined "others," we can evaluate their sense of belonging and how they think about themselves (Hogg and Vaughan 2009). However, this is not always straightforward. Discussing identity in a globalized world, Blommaert (2013) argued that the questions regarding who "we" and "they" are had become much harder to answer. In times of relative social stability, "we" have quite a clear sense of who "they" are and, therefore, of who "we'' ourselves are. Crises and world-scale changes destabilize "them," making it a category in constant flux, about whom very little can be presupposed. As a result, "we" also becomes a much more fluid and vastly more complex category.

It is not surprising that another global phenomenon, triggered by the COVID-19 pandemic, would have a major impact on how "we" think about ourselves in relation to "others." A virus, whose potential devastating effects for human life were difficult to gauge, spread throughout the world, also threatening to collapse financial and social structures. Crucially for this discussion, it was the "others" who embodied and transmitted it, and it was necessary to reposition them as "dangerous" and socially distance from them. As a consequence, in isolation, who "we" were, as sons, daughters, parents, club members, professionals, and so on, had to be rethought and recalibrated.

Very few professional practices were as affected by COVID-19 as health services; long-term care providers stood at the front lines of the battle against the virus, fighting it with limited knowledge and resources, overwhelmed by the number of cases and deaths. A critical situation in which what they knew of themselves as professionals and others as patients and colleagues was no longer on firm ground and often put to the test. The "other" had become a more fragmented unknown, a category about which very little could be presupposed, and so had the "we." This was especially true for those healthcare workers taking care of older adults, as the ones whose interviews are analyzed by Davis and Wolf. COVID-19 ravaged those older than sixty-five years old and went through nursing homes sparing few.

It is in this context, situated by and in the nine interviews referenced in this chapter and the narratives these elicited, that the fragmentation of the "we" and the "they" emerges as fundamental to the social identity co-construction of health service workers and how views about alterity had been significantly transformed by the perilous situation caused by COVID-19. The us/them dichotomy is present in all the interviews analyzed but not alluded to in a contentious manner, just to make sense of who both had become. The multiplicity of "they" is a reflection of how the "we" is in clear transition. Although there are different "theys," however, it is the "we" that is given more precedence, as "we" see ourselves as key to deal with the virus and restore the "other," and thus "we," to our previous selves, as much as feasible.

The analysis of "we/they," as deployed in the interviews under scrutiny, also points to the synergetic connection between the macro, the meso, and the micro level of social inquiry. Changing ideologies at the macro level tied to the COVID-19 pandemic and how these affected other/self perceptions of these workers, are mediated via the meso level, an interview, and instantiated at the micro (interactional) level by the use of distinct pronominal references, that reflect and also construct (affirming, questioning) those very macro-level ideologies. Hence, the need to carry out micro-level analysis but without forgetting to tie results to meso- and macro-level phenomena.

Now that, in many ways, the pandemic is behind us, it would certainly be interesting to see whether "we" and "they" are still fragmented similarly or have become gelled in ways that point to a different conceptualization of the social identity of long-term care service providers and those in their care.

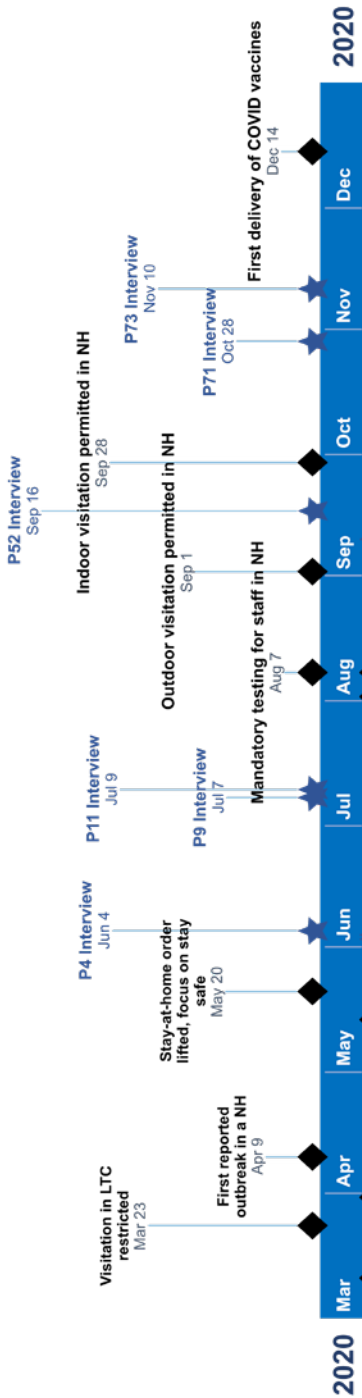

Figure 7.1. Timeline of Interviews Quoted in Chapter 7.

THIS CHAPTER IS A DEPARTURE from the others in the book as it provides a linguistic analysis by Dr. Boyd Davis with assistance from Christin Wolf. We focus on the language used in a subset of nine interviews selected by Shenk and Wolf to serve as representative of the three phases of the larger study. We used corpus-based analytic tools and techniques (*TextInspector.com* and *WMatrix.com*) to identify key discourse patterns as the interviewees talked about a situation that would not, and could not, stand still. In addition, our approach is from a sociopragmatic and interpersonal perspective to focus on language use in the discourse of the interviews themselves.

Three uses of language are of particular interest in our analysis, though these are in no order of preference. First is the use of interactive metadiscourse: words or phrases reflecting that the speaker or writer wants the hearer/reader to notice that they are using words to hedge and stall or to emphasize a particular word or phrase (we "might" . . . they "always"). Next is the use of quotative "like," often coupled with reported speech (and he's like "we should stop" . . . or they said that we should stop . . . instead of Geoff said "Stop!"). This combination is frequently used to justify or explain a choice of action or reaction (and they're like assuming that. . .). A third is the presence of multiple referents for the pronouns "we" and "they," whose range of senses helps us understand aspects of who the speakers are. We will focus most of our attention on this last usage.

As a preview of content, the subsample of participants from Phase 1 were confused and eager to understand the nature of the emerging pandemic and what its impact on their roles, rules and responsibilities might be. The residential long-term care community administrators and caregivers from Phase 2 spoke often of "knowing" in terms of what they knew they were doing for the older adults in their care while acknowledging that it wasn't enough. They were in the middle of a move from the unknown to dealing with the known as they faced the deaths of residents and personal losses associated with the ongoing nature of the pandemic. Phase 3 included caregivers working in senior centers, adult daycare programs, and home care agencies. They spoke of the little things they could do for clients and families even when they could not provide care in person because of closures and client isolation. Acknowledging the physical and mental decline—and even deaths—of the older, often cognitively impaired seniors they cared for, these caregivers continued to show up and do everything they could think of for those in their care.

Our discussion is keyed to transcripts of the selected interviews. All the interviewers and respondents in this subsample were female. Each interviewer began by asking the interviewee's role, title, and credentials, which in effect established the initial footings for the dyadic interactions: one person would ask questions focusing on the respondent's connection to older

adult and dementia health care during the pandemic, and the other was, in the next turn, expected to answer. The turn of the respondent in the interaction could, and usually did, include several large chunks giving context for their response. This typically included both factual accounts or chronicles of events and some notion of perceptions and interpretation; respondents occasionally went beyond the opening and complications of their particular narrative or their chronicle to give some sort of evaluation. The respondent was positioned as an expert in their area of work and as being knowledgeable about expectations from supervisors for their particular role.

To some extent, the interaction in the interviews could easily be characterized and framed as organizational discourse: according to Fairhurst and Cooren (2018: 2), qualitative analysis of organizational discourse is frequently conducted from the perspectives of "ethnomethodology-informed conversation analysis," narratology, or critical discourse analysis. By "critical discourse analysis" we mean the combination of discourse and ideology; by "narratology" we mean the study of story; and while "conversation analysis" is what looks like a transparent term, when combined with ethnographic techniques for study, the researcher can look more closely at everyday interactional competence in the context of particular situations (Arminen 2012). Each of these allows an interpreter to isolate and discern issues of or related to power. We will focus on professional identity that presumes some aspect of organizational discourse from an allied but different stance, that of professional discourse. It is worthwhile, however, briefly discussing—and oversimplifying—some of the layers of power and positioning identifiable in narratives in these interactions. As Deppermann (2013: 67) reminds us, narratives are "particularly powerful resources for positioning." For positioning we cite the way it is explained by Bjerre, basing his discussion on Davies and Harré (1990: 46), "'the process by which people attribute to others or to themselves a set of characteristics', which 'affect future interactions' . . . and may be studied by focusing on central speech acts and the use of 'images, metaphors, storylines and concepts'" (Bjerre 2021: 250).

Although the respondents in the interviews can position themselves as having ownership over whether they will furnish information, they are nonetheless under the power of the interviewer. While the respondent has agency, the interviewer is ultimately dictating the direction of the interview because they ask the questions. These questions can threaten the persona of the respondent, which on the part of administrators early in the pandemic is actually likely. Respondents are under the authority of whoever directly supervises them on the job in the residential long-term care community, adult daycare, or other program or agency. Each of those locales are likely to be overseen by owners and/or advisory boards, monitored by local, state, and federal agencies. All, however, are currently un-

der the power of a serious and mysterious illness about which none of the participants or their supervisors have confidence in their knowledge and all suffer some anxiety about a shared responsibility to care for others. Their individual, social, and professional identities have been shaken and their face—their standing as worthy in their own eyes, in the reflection from others, and in the eyes of the others—is threatened. If we were speaking of a master narrative that we apparently tell ourselves, it might be that staff at every level are plentiful, well trained, and take good care of older people in every kind of communities for pay or private homes; its counternarrative, which the pandemic exacerbated, revealed and extended the gaping crevasse in the system of care, in the sheltering buildings, and by extension the staff themselves (Hyvärinen, Hatavara, and Rautajoki 2021). We see both the master and the counternarrative in the answers, usually building to narratives or stories, by the respondents.

Narratives by respondents in interviews are going to be full of fits and starts, memory glitches, and fishing for words, phrases, and chunks of suddenly remembered data or cascading with a sudden spillover of information and interpretation. Narratives typically fall into five categories, and their content—or at least a typical introduction and initial complication—will frequently be probed to continue along lines chosen by the interviewer. The five typical types of narrative are as follows.

1. Stories in which the conversation partner (here the interviewer) provides minimal prompts (Mm-hmm; Ahhh; I see). These can be previously told or new but connected stories instigated by interviewer prompt.
2. Small stories that sound like everyday events and are very short stories told "in passing" (e.g., studies and examples of small stories with full examples by Georgakopoulou 2007).
3. Shadow stories that remain "hidden" behind hints (de Medeiros 2015) unless the conversation partner probes.
4. Chunks of a story, usually a high point or evaluation, but without any discernible context.
5. Chronicles or accounts that have no narrative structure (Davis and Maclagan 2021, 6).

Any of these types will often include code-switching between professional talk and conversational register to indicate that the respondent has greater or lesser familiarity with an issue or situation. As Holmes and Marra indicate: "In different workplace contexts, and even at different points within the same interaction, participants emphasize particular facets of their social identities and different dimensions of social meaning—institutional or

organizational affiliation, professional status, collegial solidarity, authority responsibilities, gender category, ethnic affiliation, and so on" (2005, 197).

Social Identity, Professional Identity, and Professional Discourse

Willetts and Clarke outline current discussions of "attributes" required of a profession such as nurses, which includes "a systematic body of theory . . . a regulative code of ethics . . . [and] professional bodies/associations that control and monitor conduct and performance within their profession" (2014: 165). Sarraf-Yazdi and colleagues review professional identity in medical students as "a multifactorial phenomenon, shaped by ways that clinical and non-clinical experiences, expectations and environmental factors merge with individual values, beliefs and obligations" (2021: 3511). Day (2020: 111) reviews distinctions in the UK between "professional occupations" such as doctors, and "associate professional and technical applications" such as medical technicians. De Fina reminds us that "situational identities may be seen as roles related to the specific context of interaction. . . . Who we are is often defined in terms of who we are not or who we are similar to" (2011: 270–71). She goes on to say that "social identity categories are related to situations, roles, characteristics, and ideologies that are often stereotypical, and that these associations become part of the shared knowledge and representations of groups which in turn feed into wider ideologies and beliefs" (278).

This explanation, keyed to categories (because identity is never singular) is congruent with Schiffrin's discussion of Gumperz, Goffman, and interactional sociolinguistics. "Both authors see language as indexical to the social world: Gumperz conceives of language as an index to the cultural background knowledge which provides information as to how to make inferences and what is meant through an utterance. Goffman views language as an index to the social identities and relationships which are constructed during interaction" (Schiffrin 2009, 87).

The work of each scholar helps disentangle the components of social identity that feed staff and caregiver affiliation with the rules, regulations, and responsibilities of the source of their original training for work in the governmental agency, community agency, care community, or homecare business to which they belong. Their original training, be it experience alone to advanced degrees or institutes, is designed to instill aspirations, expectations, and eventual affiliation. That affiliation in turn is consistently incorporated into each of the selected interviews that are professionally distinguished in table 7.1. We also include a summary of the focus for the participants in each of the three phases.

Table 7.1. Selected Interviews Analyzed in Chapter 7.

Phase 1: Regional agency staff or advocate	*Phase 2: Residential long-term care*	*Phase 3: Home and community-based services*
Bureaucratic repetitions from job-related materials	**Running a place and setting social distances**	**Hands-on with staff when the clients can't really be social**
#2 Nursing Home Ombudsman	#9 Nursing Home Administrator	#52 Senior Center Director
#3 Aging Program Coordinator (community-based programs)	#11 Memory Care Activities Director	# 71 RN working as CNA at Adult Day Healthcare
#4 Assisted Living Ombudsman	#46 Lead Housekeeper	#73 Home Care Agency Director

Focusing on #3, #9, and #73, all of whom held administrative positions, responsibilities are always on their minds. In the interview with the regional Aging Program Coordinator, "so" is typically used to explain a result and to hold the speaker's turn at the same time. Throughout the interaction, she continually quoted her agency or shared something from one of its reports:

> I could tell you, give me one second and I'll pull up last week's weekly report. So, we serve nine counties. . . Um, so, that's (name of county) is our biggest one and the surrounding eight counties, and I'll pull it up. Let's see here, and I can tell you too, it should have like how many, how many meals they've provided and then also how many people. . . . So, they're all set up a little differently. So, (name of) county, because they have such a large population, they always do frozen meals anyway. (P3)

On the other hand, the nursing home administrator focused on morale shifting when the residents could once again order food for themselves and their families could return to doing their laundry, presumably in accord with their personal preferences.

> Yeah, there was no delivery of any food for them. We got our food trucks delivered, like Cisco and US Foods and supplies, but they [administration] were not letting food come in from the community. So, when that was lifted, I noticed a huge uptick in the morale because the residents could order pizza if they're feeling bad. They could order Chinese, DoorDash, but we had to wait for CDC guidance and the state to tell us that was okay 'cause everything got shut down. And a lot of families do their own laundry. We had to start doing their laundry. . . . I mean, it was bad. So slowly but surely, we're getting

> back there. They can do laundry now, they can get deliveries, everything but homemade food, 'cause we can't control homemade sanitation. (P9)

Even when some residential long-term care communities and home and community-based programs could reopen, residents and clients were still confused about what to do. The home care agency director described:

> Again, specifically with the facility or a community, they shut down. So we couldn't go in. And we had a number. . . we had a couple of client families where they were trying to get us in as essential workers to try to come in and help, but again, not knowing what they knew, I do think they did the right thing, but that doesn't help. . . . An overworked staff at a community or a facility is not going to have. . . They're gonna have even less time for a client. . . . We had clients that didn't understand that they couldn't go out. (P73)

It was difficult for residents and day-services clients as well as caregivers to adjust to lockdowns and their relevance to the rising death toll for older and vulnerable people, especially those with dementia and other cognitive impairments. A glimpse can be seen in the small story remark by #73 in October 2020: "Initially, none of us could've thought (chuckle) that we'd be here, at, what? Eight months now. And I would say from, in those four weeks, in the first two weeks of March, in the last two weeks of March, really, I lost half my business. It wasn't so much clients, but it was also caregivers." This finding is echoed by #46, who is a housekeeper in a well-supported residential care community and is discussing losses of staff as well as the deaths of residents: "Oh, man. Ooh. I'm gonna say. . . Oh, gosh. Off the top of my head, I'm gonna say maybe fifty, maybe fifty. It may have been more than that, but we lost I think it was twenty-one to twenty-four residents."

Us vs. Them or We vs. They or Everyone vs. COVID

Kenneth Kong draws on a number of definitions to pin down professional discourse, which is, by and large, the discourse used in the interviews. He explains that "any profession or company represents a 'discourse system' (Scollon and Scollon 2001), which links members through a shared ideology, socialization, face systems and discourse forms" (2014: 2). Prominent in all nine of the interviews are the frequent uses of "we" and "they" which on the surface might appear to be a variation of the "Us/Them" distinction familiar in political discussions and rhetorical arguments of any kind.

In her dissertation about media interviews with Australian politicians, Bramley claims that "pronouns are used to construct politicians' multi-

ple 'selves' and 'others' and . . . as they occur in sequence, the changing 'selves' of politicians and different 'others' are created" (2001: v). For example, Bramley's "we" [us, our] is discussed as representing "'institutional identity' (Sacks 1992), 'us and them' dichotomy; 'we' as a means of coimplicating people; 'we' to indicate that it is not just the IE [interviewee] who is involved in the issue; and 'we' to invoke a general collective response" (2001: 86). Bramley adds that "they" can represent that which is oppositional, affiliative, neutral, or generic.

It is not just Australian politicians on social media who shift identities. Respondents in the North Carolina COVID-19 interviews do so as well, although they are not focused on the same identities as politicians and are seldom combative or oppositional. For a more detailed analysis, we focus on four women in a variety of positions. Table 7.2 displays the uses of "we" and "they" in the interviews with #3, #9, #73, and #46. There were a total of 251 "we" tokens and 181 "they" tokens, for a total of 432 tokens analyzed.

First, the "we" tokens. Only the nursing home administrator (P9) discusses a doctor's visits to their residential long-term care community, and only two identify themselves as dealing with licensed and/or elected officials. In terms of self-identification as representing or belonging to a company, organization, or agency, the home care agency director (P73) mentions only her own. The aging program coordinator (P3) offers statements to quote and discuss from her supervisor and agency team of coworkers: her work links her with places where programs are offered, but there are many regulations to follow, particularly when she cannot actually see people receiving those services due to the lockdown. She punctuates a series of phrases with "so" to hold her turn while she thinks of the next part; after she has outlined what she was supposed to do, which is quite a lot, her answers smooth themselves and the "so" edges away:

> *So*, for example a program that we actually offer in house and deliver would be our evidence-based health programs. *So*, these are programs that we offer the community at no cost to older adults to help them manage chronic conditions, to help them prevent falls, to help them [take] care of themselves if they're caregivers, all kinds of programs like that. *So*, that would be an example of a direct service. Um, some of the programs that I work with indirectly would be some of the in-home and community-based services like the senior nutrition program. *So*, that includes the congregate nutrition program. *So*, where people come together at one site to have meals and socialize. Also, the home delivered meal program, transportation programs, as well as senior centers. *So*, those would be the ones I work with most commonly. (P3)

The housekeeper, on the other hand, is eager to explain not only the inventive ways her well-endowed residential community has created to stem

Table 7.2. We/They Senses from Selected Interviewees.

	P3	P9	P73	P46
	Aging Program Coordinator (Administrator)	**Nursing Home Administrator**	**Home Care Agency Director (Administrator)**	**Lead Housekeeper (Direct Care)**
We-doctors	0	2	0	0
We-officials	1	1	0	0
We-my organization/ agency/ies	30	20	1	30
We-our staff	35	16	18	13
We-me and my close peer staff at work	12	7	29	24
We-generic all healthcare	2	7	2	0
We-my family	0	0	0	1
Totals	**80**	**53**	**50**	**68**
They-residents	0	14	12	6
They-staff	5	5	16	20
They-official	8	11	1	0
They-peer staff with me	5	0	16	0
They-outside clients	15	5	4	0
They-other staff (outside agency)	5	4	2	0
They-outside community	7	7	2	0
They-all people	1	2	2	0
They-family members	1	1	4	0
Totals	**47**	**49**	**59**	**26**
Grand totals	**127**	**102**	**109**	**94**

the tide of infection, including moving rooms and even floors of people, but also its generosity to its hands-on and frontline care staff during lockdowns, giving them extra money and frozen and canned food to take home on a weekly basis:

> And since the pandemic started, I don't know about other companies out there, but they have helped us so much, so much, in any way that they can.

> Far as. . . When we was having problem with the tissue, they gave us. . . Man, they ordered so many cases of tissue. Thirty cases of tissue with ninety-six rolls in each box, to make sure that the residents and their staff will have tissue. They gave us food. They gave us food, they gave us chickens, they gave us pies, they gave us hamburgers, they gave us a lot of stuff, wipes, everything. (P46)

Throughout the interviews, staff as a topic falls into two categories. "Staff" can mean "other staff at our site" with whom I work closely, or else "staff" can be cited as a generic group in a residential long-term care community or program who perform care ("Oh, our staff will take care of that"). The way either category is discussed is keyed to the speaker's professional rank and job description that determines whether staff work under her or beside her.

The aging program coordinator (P3) most frequently mentions duties or responsibilities of "we staff-in-general," as there are a number of community-based programs (such as those mentioned in this chapter) that staff from her areawide agency must oversee in addition to nursing homes and assisted living communities, across nine counties. She works most closely with a set of peers who are staff as well; they each focus on one county. The administrator (P9) runs a nursing home: she mentions "we staff-in-general" in terms of the duties that change from day to day, although she has several peers and managers at her site with whom she shares ideas and comes up with solutions to the day's particular crises. The home care agency director (P73) works frequently with her closest staff; for her, "we staff-in-general" does not carry the load as much as the staff connected with caring for various clients in their own homes and residential long-term care communities. The housekeeper's (P46) emphasis is on expectations for general hands-on staff, and the daily shifting of duties for those peers who, like her, are working all over the building as COVID patients change rooms, wings, and floors. Everything changes all the time for a frontline worker during a pandemic. In general, people talk about what they would like to do, what makes them most afraid, and how essential their colleagues and peer workers are when they are on the job together. This is no doubt why health care as a topic for discussion has but a few mentions, primarily from the nursing home administrator who is quite naturally concerned with government pronouncements as she tries to keep the staff and residents safe. Personal family relationships are mentioned only by the housekeeper, who fears bringing disease home to the other five people (including a new baby) who live with her in her apartment.

"We" are much more important than "they," with only a few exceptions. Residents of residential long-term care communities are discussed by the

nursing home administrator (P9) because she is concerned about keeping them COVID free; the home care agency director (P73) is worried about who in which agencies can handle "them," and the housekeeper (P46), who is the voice for the hands-on care, finds "them" to be problems to be solved as well as people to be helped, which is probably why she talks about staff in general and how they are being shifted around the building, just like her. The home care agency director (P73) is concerned for staff welfare as well as how her staff—individually and as a whole—can move to handle different assignments with clients here, there, and elsewhere. Visits from officials to monitor or investigate or chastise administrators are a concern, particularly to those who coordinate community programs or run a nursing home, but peer staff are especially helpful to the home care agency director as they move through programs, changing how they might be delivered. Clients at various programs are crucial to program coordinators, and staff and residential long-term care communities not normally supervised can have activities or actions that could be useful. Of interest, though it should not be surprising, is the lack of discussion of anybody or anywhere outside her current worksite for the housekeeper: while other staff at her site are an important "they" working with her, particularly as residents, rooms, and units are shuffled, nobody else is.

Discussion

The people whose discourse is the focus of this chapter were charged with reaching out and overseeing or providing services to older persons and educating their family members, or providing activities for them, or housing and feeding them and keeping them from harm. All but the direct care workers, the frontline, hands-on staff, had received advanced academic degrees as well as extensive training in the professions to which they now belonged. And they were afraid during 2020 and the first major surges of COVID-19—all the time. They even said it. Early in the pandemic, P9 commented:

> Nurses are very afraid to give morphine and they're just afraid, because the end goal is comfort, but sometimes it reduces your respiratory response so much that you just pass and they feel guilty. And so hospice nurses are over there pushing it, putting them on a drip. If they go, they go. (P9)

P2 remarked on why residential long-term care communities are afraid of baseline testing, although it could be useful if it were truly available: "I think facilities on the front end are very afraid to say, 'Yes, give me base-

line testing,' because they're afraid to be on the news, and they're afraid it'll look negative." Halfway through the data collection, the housekeeper, reported:

> My patients, they were afraid, and I was afraid for them, but for some reason, I would go in their rooms and stuff. . . . I cleaned, I kept things purified, I went over and beyond. I made their beds clean. I went in there and I was like, "No. This could be my mother, my sister, my. . ." I forgot about myself, and I lost myself in those people, and it meant everything to me because now that we have come out and we are looking on the other side, some of those people came out with me. (P46)

Toward the end of the data collection, once the initial surge had eased, P71 said about the adult day healthcare clients: "They're afraid to come back, their families are afraid for them to come back."

The interviewees were each afraid their roles were going to change even further and that they could not meet expectations or even regulations. They were afraid that they themselves would catch COVID-19 and that programs and residential long-term care communities would lose so many clients or residents that they would have to close, taking their jobs with them. Small wonder they took refuge in organizational discourse and their own professional ways of talking about their profession. And they were still nervous, even though they had developed ways to begin to handle and readjust and reframe every aspect of their work.

They were right to be afraid. On 5 July 2022, the National Institutes of Health reported that for people eighty-five and above, COVID-19 "was the second leading cause of death in 2020, but dropped to third in 2021, likely because of targeted vaccination efforts in this age group" (www.nih.gov/news-events/). In the United States, we have not yet, as in Singapore, resorted to commodification of potentially related products such as this thinly disguised advertisement, "Keep calm, stay safe, and drink bubble tea" (Starr, Go, and Pak 2022). In times of pandemic when we are all afraid, "we" has become more important than ever.

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