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**Experiences of older adults with anxiety and depression of the COVID-19 lockdown
restrictions**

Study 1: Factors associated with psychological distress in older adults during the COVID-19
pandemic: A Systematic Review and Narrative Synthesis

Study 2: A cocoon or a prison: Older adults with mental health difficulties and the COVID-19
lockdown restrictions- An Interpretative Phenomenological Analysis

Thesis presented by Alice Cashman for the degree of Doctor of Clinical Psychology

University College Cork

School of Applied Psychology

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Supervisor(s): Dr Mike Murphy and Ms Judy Wall

May 2022

Declaration

This is to certify that the work I am submitting is my own and has not been submitted for another degree, either at University College Cork or elsewhere. All external references and sources are clearly acknowledged and identified within the contents. I have read and understood the regulations of University College Cork concerning plagiarism and intellectual property.

Alice Cashman

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Chapter One: Introduction

Context and Overview

In January 2020, the World Health Organisation (2020) announced a global pandemic of the coronavirus disease 2019 (COVID-19), caused by the severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2). This pandemic has been a major international health crisis, with over 500 million cases and over 6 million confirmed deaths reported by May 2022 (Worldometers.info, 2022). In attempts to slow the spread of the virus, social distancing restrictions were introduced to minimise close contact between individuals. These social distancing measures included quarantines, travel restrictions, and the closure of schools, workplaces, shops, restaurants, and bars (Stawicki et al., 2020). Such disruption to education, employment, and social activities were referred to colloquially as ‘lockdowns’ and have been associated with job losses, financial insecurity (International Labour Organisation, 2021) and increased psychological distress (Ahmed et al., 2020; Alzueta et al., 2021; Di Blasi et al., 2021; González-Sanguino et al., 2020; Özdin et al. 2020; Rossi et al., 2020; Taquet et al., 2021).

At particular risk during the COVID-19 pandemic, were older adults who incurred an increased risk of developing serious illness due to the virus (Centers for Disease Control and Prevention, 2022). They were also particularly vulnerable to suffering psychological distress associated with the COVID-19 pandemic and its related restrictions (De Pue et al., 2021; Giebel et al., 2021; Kotwal et al., 2021; Krendl & Perry, 2020; Mishra et al., 2021; Lee et al., 2022; Trabelsi et al., 2021; van Tilburg et al., 2020).

This thesis explored the experiences of older adults during the lockdown restrictions of the COVID-19 pandemic and comprises two research papers. The first research paper is a systematic review synthesising the quantitative research on the factors associated with psychological distress in older adults during the COVID-19 pandemic. The second research paper uses a qualitative framework to investigate how older adults with pre-existing anxiety and depression experienced and understood the COVID-19 lockdown restrictions.

Outline of Chapters

Chapter Two: Systematic Review

This chapter presents a systematic review of quantitative research on the factors associated with psychological distress in older adults during the COVID-19 pandemic. The results of a narrative synthesis are presented.

Chapter Three: Major Research Project Literature Review

This chapter presents a review of the literature relevant to the lockdown experiences of older adults with mental health difficulties. Included here is a rationale for the major research project, as well as the major research project's aims.

Chapter Four: Major Research Project

This chapter comprises the major research project which explored the lockdown experiences of older adults with pre-existing anxiety and depression.

Chapter Five: Major Research Project Extended Methodology

Included in this chapter is additional information relating to the methodology of the major research project. It provides additional information about the research design, sampling and recruitment, data collection and analysis, ethical considerations, and quality assurance. It also offers reflections on the process of conducting the research.

Chapter Six: Discussion and Conclusion

Chapter six offers a summary of the findings of both research papers and of the clinical implications and limitations of the thesis.

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Chapter Two: Systematic Review

Factors associated with psychological distress in older adults during the COVID-19 pandemic: A Systematic Review and Narrative Synthesis

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Abstract

Objectives

Emerging epidemiological data suggest that the COVID-19 pandemic has been associated with widespread emotional distress. Older adults appear to have been disproportionately affected by the pandemic and the resulting social distancing restrictions and there now an emerging body of research investigating its associated psychological effects. The purpose of this review was to identify and assess the peer-reviewed scientific literature on the factors associated with mental health and psychological distress in older adults during the COVID-19 pandemic.

Method

PubMed, Embase, PsycINFO and Web of Science were systematically searched to identify prospective observational/cohort and cross-sectional studies concerning the relation between behavioural, contextual, and psychological factors and mental health and psychological distress in adults aged 65+.

Results

Twenty-three studies met the inclusion criteria and were included in this review. There is evidence of associations between governmental responses to the pandemic and increased depression and anxiety among older adults, potentially due to isolation, loss of social support and loneliness. Older adults with cognitive impairments appear to be at particular risk of experiencing anxiety and depression during the COVID-19 pandemic. Psychological distress also appears to be associated with physical activity, sleep, and social and cultural engagement. More research is required to further examine this risk and to identify potential interventions and supports.

Keywords:

Coronavirus

COVID-19

Mental health

Older adult

Psychological distress

Pandemic

Social distancing

Systematic review

Introduction

The COVID-19 pandemic is a major international health crisis, with over 500 million cases and over 6 million confirmed deaths reported by May 2022 (Worldometers.info, 2022). The pandemic has led to the implementation of quarantine and social distancing measures in an attempt to curb the spread of the virus (Stawicki et al., 2020). The resulting school closures, job changes and losses, economic insecurity, and isolation may have been implicated in the increase of a range of psychological difficulties including increased and prolonged feelings of depression, stress, anxiety, and fear of the COVID-19 disease (Ahmed et al., 2020; Alzueta et al., 2021; Di Blasi et al., 2021; González-Sanguino et al., 2020; Özdin et al., 2020; Rossi et al., 2020; Taquet et al., 2021).

Certain groups including the elderly and people with chronic long-term health conditions appear to be particularly vulnerable to psychological distress during the COVID-19 pandemic (Wyper et al., 2020). Older adults seem to be at risk of developing severe and deadly forms of the COVID-19 disease (Centers for Disease Control and Prevention, 2022; Liu et al., 2020); a 25% fatality rate has been found in individuals aged over 80 years, as compared <1% in individuals younger than 50 years (Wang et al., 2020). Older adults have also been more likely to experience unmet non-COVID-19 healthcare needs (Grasselli et al., 2020) and may experience more severe mental health consequences due to social distancing measures (Serafini et al., 2020a).

Even prior to the COVID-19 pandemic, a lack of social support has been found to be associated with an increased risk of depression and anxiety in older adults (Bai et al., 2020; Choi et al., 2021; Ferguson & Goodwin, 2010; Ferreira & Sherman, 2007; Kafetsios & Sideridis, 2006; Kasser & Ryan, 1999). Although online technologies have been increasingly used during the current pandemic to maintain connectedness, older people are likely to be

less literate in digital resources (Mamedova, et al., 2018). Vahia et al. (2020) warned that the pandemic could have long-term mental health consequences for older adults.

There is an emerging body of evidence examining the psychological impact of the COVID-19 pandemic on older adults, but more research is needed to understand it. A global viral pandemic as well as the increased life expectancy in recent decades (Woolf et al., 2019) sees the field of geriatric psychiatry headed into uncharted territory. Therefore, there is a demand for a better understanding of the factors that influence older adult psychological distress during the COVID-19 pandemic. No study has heretofore systematically reviewed the literature on the factors associated with psychological distress of older adults during the COVID-19 pandemic. Thus, the purpose of this review was to identify and assess the peer-reviewed scientific literature on the factors associated with psychological distress in older adults during the COVID-19 pandemic.

Methods

This review was prospectively registered with PROSPERO (CRD42021251492) and reported in accordance with the PRISMA checklist (Appendix A) and the Joanna Briggs Institute checklists for analytical cross-sectional and cohort studies (JBI; Appendix B).

Research question

What are the factors associated with older adults' psychological distress during the COVID-19 pandemic?

Search strategy

PubMed, Embase, PsycINFO and Web of Science were systematically searched according to a protocol to identify relevant articles published between March 2020 and October 2021.

The search strategy was developed by first determining a clear research question (What are

the factors associated with older adults' psychological distress during the COVID-19 pandemic?), and then deciding on key concepts that would be needed to address this question. Embase was chosen as an appropriate interface to begin with due to its more specific thesaurus terms than the MEDLINE thesaurus (Bramer et al., 2016). The searches were then noted in a Word document, to record the steps taken and to ensure the searches would be reproducible. Thesaurus terms were used to generate synonyms for the important concepts of the older adult age group, COVID-19 restrictions and psychological distress, and then truncation was applied to account for term variation. After the initial searches, the search strategy was broadened to increase sensitivity. Any new relevant articles were identified by comparing the set results (for example, search for Strategy #2 NOT Strategy #1 to capture the additional results). The reference lists of the selected studies and relevant reviews were hand searched to identify further relevant articles.

Studies were included if they reported on factors associated with anxiety and depression in people aged 65 years and over living in any residential setting, of any gender, living through the COVID-19 pandemic. Articles were included if they reported on observational/cohort studies, cross-sectional studies, and mixed methods studies; studies were excluded if they reported single case studies, qualitative studies, studies not published in English, studies for which the full text was unavailable or studies where data of participants aged 65 and over could not be separated from other age groups. Search terms used for one of the databases (PubMed) are outlined in Table 1.

Table 1***Search Strategy***

No.	Query
#4	#1 AND #2 AND #3
#3	COVID-19 OR pandemic OR Coronavirus OR social distancing OR physical distancing
#2	Psychological distress OR mental health OR depress* OR anxi*
#1	Older adult* OR elderly OR older people OR senior citizen* OR geriatric* OR senior OR 65+ OR over 65

Data screening

The search results were stored in a Microsoft Excel spreadsheet. Duplicate titles were removed using Zotero, an open-source reference management software. The remaining titles and abstracts were screened by one author (AC) to remove any studies that did not meet the inclusion/exclusion criteria; 10% of the titles and abstracts were also screened by a second author (MM). No disagreements about the inclusion/exclusion of studies occurred. Full texts were then obtained for the remaining abstracts. One author (AC) reviewed each full paper against the inclusion criteria; again 10% of these were also considered by a second author (MM). There were no disagreements about the decisions to exclude full text studies. A PRISMA-style flow diagram of the selection process can be found in Figure 1.

Data extraction

One author (AC) systematically extracted the study characteristics using a data extraction tool (Appendix C). The characteristics of the included studies can be seen in Table 2 below.

Quality assessment

One reviewer (AC) independently appraised the quality of the included studies using the Joanna Briggs Institute checklists for analytical cross-sectional and cohort studies (JBI; Appendix B) and using the scoring guidance by Moola et al. (2017). For cross-sectional studies, the checklist is scored out of 8 and depending on its score, a study was considered low, medium or high quality. A study with 0 to 2 points was considered low quality, 3 to 5 medium, and 6 to 8 high. For cohort studies, the checklist is scored out of 11. A study scoring 0 to 3 was considered low quality, 4 to 7 medium, and 8 to 11 high. The second author assessed the quality of 25% of included studies ($n = 5$). The authors disagreed on the scoring of three studies, however, in each instance the discrepancy was only by one point and did not result in a different quality rating.

Overall the studies included were found to be of a high quality; 16 of the 23 studies included studies were rated as being 'high quality', while the remaining 7 were found to be of 'medium quality'.

Data synthesis

Data was analysed using narrative synthesis. Popay et al.'s (2006) guidance on how to conduct narrative syntheses was followed. Findings related to the review question were identified from the results, discussion, and conclusion sections of included studies. A preliminary synthesis was conducted by developing qualitative textual descriptions for each study including details of the setting, participants, intervention, comparison, and outcomes, along with any other factors of interest. Tabulation of results was then performed to examine the patterns across the included studies and grouping studies by outcomes. The significant associations (using the significance level adopted by each individual study) and adjusted sizes of effect of associations in each study were further compiled into a separate

table (Appendix D). P values were presented as well as effect sizes in odds ratios and Cohen's *d*, where provided. The purpose of this review was to identify, rather than quantify, the factors associated with psychological distress in older adults during the COVID-19 pandemic; a meta-analysis was therefore considered inappropriate, and data were synthesised in a narrative review

Results

Study selection

The 4,410 studies identified from PubMed, Embase, PsycINFO and Web of Science were exported to Zotero where duplicates were excluded ($n = 2,115$). A two-step process was followed to identify relevant studies. First the information contained in the title and abstract was screened to capture all potentially relevant studies; and second, the full-text articles of papers selected were screened, applying the inclusion-exclusion criteria previously described. One reviewer (AC) conducted the database search and study selection. Ten percent of titles and abstracts and 10% of full-text articles were also screened by a second reviewer (MM). Full texts were obtained by searching the University College Cork library database as well as Google Scholar and PubMed. The full texts for two studies could not be found using these means; in these cases, the authors of each study were contacted directly to request the full texts for inclusion in the current review. These requests received no responses, and therefore these articles were excluded.

The selection process resulted in 23 articles being included in the review. A PRISMA-style flow diagram of the selection process can be found in Figure 1.

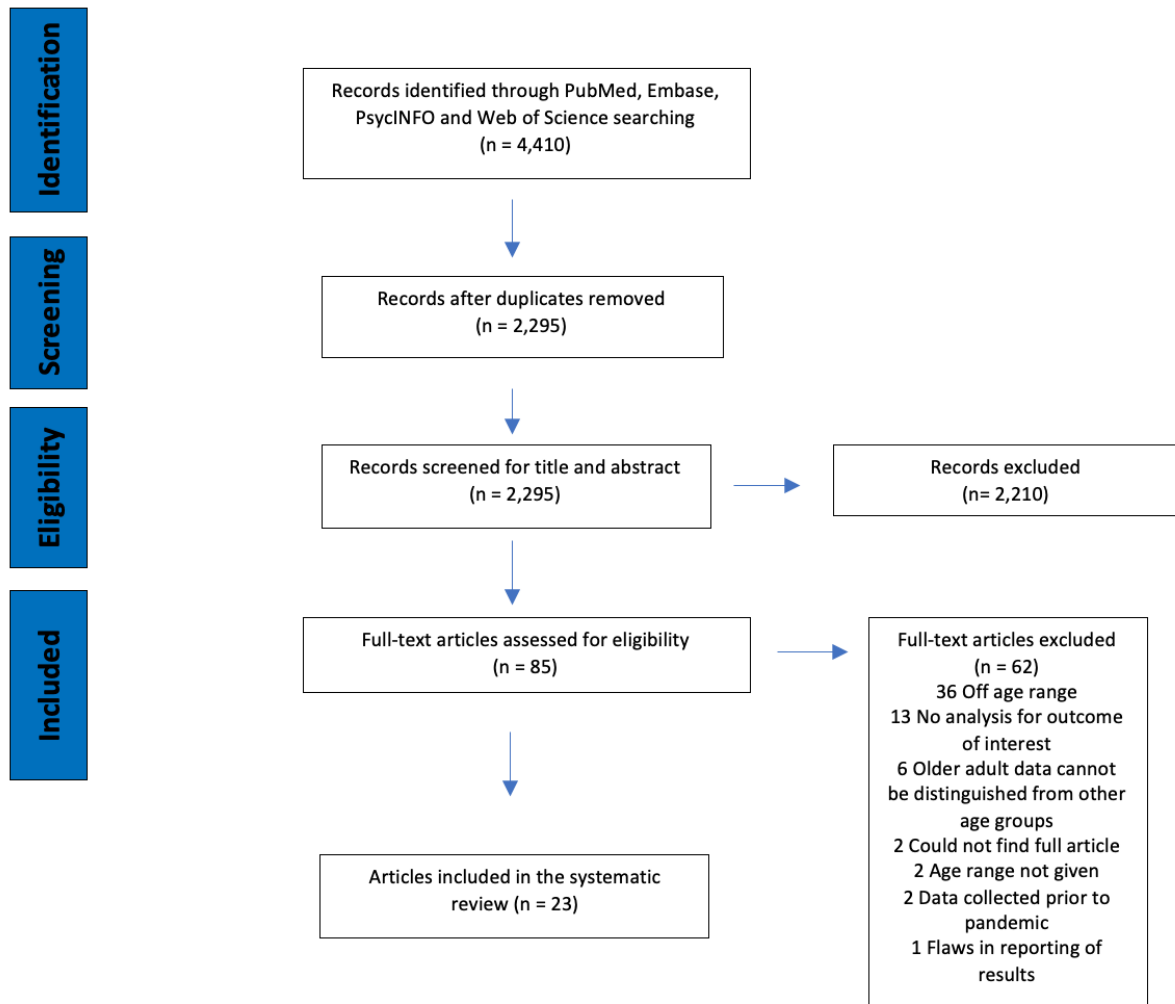
Figure 1*PRISMA flow diagram of study selection process*

Table 2*Characteristics of included studies*

Author, Year	Country	Sample	Study design	Outcomes	Outcome Measures	Significant Findings	JB1 Quality Appraisal
Aisenberg-Shafran et al. 2021	Israel	277. $M = 70.3$, $SD = 4.7$, 69.7% = female	Cross-sectional	Depression Loneliness Suicide risk Death anxiety	The Patient Health Questionnaire-8 The UCLA Loneliness Scale The Suicidal Behaviours Questionnaire-Revised The Death Anxiety Scale	Older adults reported fewer depression symptoms than middle-aged and young adults and lower distress levels but greater suicide risk. Death anxiety was predictive of depression and suicidality. Older adults with high death anxiety levels reported higher loneliness and suicide risk levels than the other age groups.	High quality
Carlos et al. 2021	Italy	204. $Mdn = 82$, 57.4% = female	Cross-sectional	Ability to acquire info, comprehend the COVID-19 pandemic and lockdown, and comply with lockdown policies, the socio-behavioural responses to the health crisis, digital literacy, health problems, and any changes in lifestyle, diet, exercise, sleep Depression levels Subjective memory	A structured questionnaire to determine the ability to acquire information, comprehend the COVID-19 pandemic and lockdown, and comply with lockdown policies; the socio-behavioural responses to the health crisis; and any changes in lifestyle, involving diet, exercise, sleep, and digital literacy The Geriatric Depression Scale (GDS) The Subjective Memory Complaints (SMC)	Depression was found to be significantly associated with the cognitive state ($p = 0.008$). Increased turning on the news ($p < .001$), less interaction with loved ones ($p = .050$), less regular exercise ($p = .002$), less engagement in new hobbies ($p = .017$), more sleep problems ($p = .009$), lower digital literacy ($p = .026$) and more health problems ($p = .024$) were found to be associated with depression. Sleep disturbances and general health problems were both found to independently increase the likelihood of depression ($OR = 2.29$, $CI [1.06, 4.93]$, $p = .034$ and $OR = 2.45$, $CI [1.16, 5.16]$, $p = .018$, respectively).	Medium quality
Carvalho et al. 2021	Portugal	68. $M = 74$, 60.3% = female	Cross-sectional	Physical activity levels Time sitting	Senior Fitness Test and the Portuguese short version of the International Physical Activity Questionnaire	Moderate-to-vigorous physical activity (MVPA) and cardiorespiratory fitness were found to be negatively associated with depression ($<.001$) and anxiety ($<.001$).	High quality

				Physical fitness status after 11 weeks home confinement Depressive symptoms	International Physical Activity Questionnaire Geriatric Depression Scale		
Cigiloglu et al. 2021	Turkey	104. <i>M</i> = 75, <i>SD</i> = 5, 65% = female	Cross-sectional	Depressive symptoms Anxiety symptoms Nutritional status Health-related quality of life Sleep quality	Geriatric Depression Scale (GDS-15) Geriatric Anxiety Inventory (GAI) Participants' nutritional status was assessed based on whether they had experienced a loss of appetite, decreased food intake, and weight loss. European Quality of Life-5 Dimensions (EQ-5D) Richards-Campbell Sleep Questionnaire (RCSQ)	The frequency of depressive symptoms was higher in women, individuals age ≥85 years, and those with less education and low monthly income. Anxiety symptom frequency was also higher in women and those with less education and low monthly income. Quality of life and sleep were worse in those with depressive symptoms and anxiety symptoms.	Medium quality
De Pue et al. 2021	Belgium	640	Cross-sectional	Subjective cognitive functioning Subjective cognitive change Depression Activity and sleep Well-being Social network Resilience	Cognitive Failures Questionnaire (CFQ) Subjective cognitive change: a 3-point scale Depression: Geriatric Depression Scale (GDS) Activity and sleep: rate quality of both, before and during pandemic Personal Wellbeing Index-Adults (PWI-A) Lubben Social Network Scale-6 (LSNS-6)	Older adults reported a significant decrease in activity level, sleep quality, wellbeing and cognitive functioning. De Pue et al. (2021) found that deteriorations in activity level, sleep quality, wellbeing and cognitive functioning were associated with depression. This is perhaps unsurprising at these reflect common depression symptoms.	High quality

					Resilience: Brief Resilience Scale (BRS)		
Ghoncheh et al. 2021	Iran	699	Cross-sectional	Religiosity Fear of COVID-19 Religious coping Anxiety Depression	The Duke University Religion Index (DUREL) The Fear of COVID-19 Scale (FCV-19S) The Spiritual Coping Strategy (SCS) scale Anxiety and depression: The HADS	Religious coping significantly mediated the association between religiosity and anxiety, and between religiosity and depression. A fear of COVID-19 was found to reduce the mitigating effect of religiosity on levels of depression and anxiety.	High quality
Giebel et al. 2021	UK	223	Cross-sectional	Social support service usage before and after COVID-19 public health measures Wellbeing Depression Anxiety	A brief questionnaire asking participants to state types and levels of social support service The Short Warwick-Edinburgh Mental Well-Being Scale (SWEMWBS) Personal Health Questionnaire 9 (PHQ-9) Generalised Anxiety Disorder 7 (GAD-7)	For older adults, increased pandemic-related disruption to their social support service hours were significantly related to poorer well-being, and increased anxiety. This suggests that being unable to access social support services during the COVID-19 pandemic resulted in reduced well-being and increased anxiety.	High quality
Hernández-Ruiz et al. 2021	France	467. <i>M</i> = 88.9, <i>SD</i> = 5.7, 60.1% = female	Cross-sectional	Cognitive functioning Depression Anxiety Living conditions during lockdown, coping strategies, mental health, health status, functional status, social support, digital tools use,	Mini Mental State CES-D scale- selected questions STAI scale- selected questions PACOVID survey interview	Living alone was found to be significantly related to depression ($p = .03$), anxiety ($p = .002$), and loneliness ($p < .001$).	High quality

				knowledge about COVID and the pandemic, knowledge about the recommendations and policy measures taken in response to the pandemic			
Johnco et al. 2021	Australia	37. $M = 75$, $SD = 5$, 65% = female	Prospective	Anxiety levels Depression levels Quality of life	Geriatric Anxiety Inventory Geriatric Depression Scale Kessler-10 WHOQoL-BREF	With increasing emphasis on improving mental health of older Australians, this study suggests that approximately 80% of individuals who were effectively treated with cognitive behaviour therapy (CBT) for anxiety or depression remained asymptomatic approximately 5 years later, even during COVID-19.	Medium quality
Keisari et al. 2021	Israel	196. $M = 72.32$, $SD = 5.6$, 67.3% = female	Cross-sectional	COVID-19 anxiety Resilience Receptive arts engagement	Generalised Anxiety Disorder Assessment (GAD-7) Connor-Davidson Resilience Scale Asked to rate frequency of their receptive arts engagement on single item scale	Being female was associated with higher anxiety. Frequency of receptive arts engagement was positively correlated with level of resilience ($r = 0.28$, $p < .001$) and was negatively correlated with level of anxiety symptoms ($r = -0.24$, $p < .001$) regarding the pandemic breakout.	Medium quality
Kilincel et al. 2020	Turkey	290. $M = 71.2$, $SD = 5.9$, 54.8% = male	Cross-sectional	Anxiety Loneliness	Geriatric Anxiety Scale (GAS) Loneliness Scale for the Elderly (LSE)	There was a significant positive correlation between the geriatric anxiety scale and the loneliness scale ($OR = 1.29$, $p < .001$). Having a chronic disease also appeared to be associated with anxiety ($OR = 3.56$, $p < .001$).	High quality
Minahan et al. 2021	USA	398. $M = 71.3$, $SD = 5.1$, 68.6% = female	Cross-sectional	Loneliness Posttraumatic stress Social contact	UCLA Loneliness Scale Impact of Events Scale- Revised Objective social contact questions	For older adults specifically, social support and avoidant coping style were found to be mediators between pandemic-related stress and depression. These findings suggest that dysfunctional coping is one mechanism that may explain why some	High quality

				Coping Social support Depression Anxiety	Brief COPE scale Medical Outcome Study-Social Support survey PHQ-9 GAD-7	older adults who experience pandemic-related stress suffer higher levels of depression than others. It also suggests that social support is a protective factor against psychological distress brought about by pandemic-related stress.	
Mishra et al. 2021	USA	10	Prospective	Cognitive impairment Depression Fear of falling Activities of daily living Anxiety Physical activity and sleep	Montreal Cognitive Assessment (MoCA) (CES-D) Depression scale Fear of falling (FES-I) Lawton Instrumental Activities of Daily Living Scale Beck Anxiety Inventory (BAI) Physical activity and sleep: a pendant sensor (PAMSys™, BioSensics LLC, Watertown, MA, USA), worn around the neck	This study found that depression symptoms increased by 150%. An increase in depression was found to be significantly correlated with longer, unbroken sitting bouts, reduced walking speed, and sleep duration. As depression symptoms increased, there was a decline in Walking speed, time spent in bed and reduced activity levels.	High quality
Müller et al. 2021	Germany	993. <i>M</i> = 75.5, <i>SD</i> = 7.1, 51.3% = female	Cross-sectional	Loneliness Social isolation Resilience Depression Attitudes towards COVID	University of California, LA Loneliness Scale (UCLA-3) Information on household composition and frequency of direct contact with others German version of the Brief Resilience Scale (BRS) Depression scale of the Brief Symptom Inventory (BSI-18)	Being lonely, but not isolated ($p < .001$) and being both isolated and lonely ($p < .001$) were associated with higher depressive symptoms. Normal and high resilience were associated with lower depressive symptoms across groups ($p < .001$). Women ($p < .001$), being unmarried ($p < .001$), being strongly worried about COVID-19 ($p = .002$), and having higher perceived threat by COVID-19 ($p = .011$), were associated with higher loneliness and isolation.	High quality

Noguchi et al. 2021,a	Japan	597	Cross-sectional	Depressive symptoms Changes in social participation	Two-question depression screen Participants were asked about six community-based activities	Decreased social participation was significantly associated with higher levels of depressive symptoms, compared to continued participation, after adjusting for all covariates. Those who developed depressive symptoms at follow-up were more likely to be living alone, have low education, severe economic status, impaired BADL, subjective cognitive impairment, and a lower frequency of going out.	High quality
Noguchi et al.b 2021,b	Japan	957	Cross-sectional	Depressive symptoms Family caregiving Covariates (age, gender, living arrangement, educational attainment, subjective economic status, BADL, self-rated health, and present illness)	Two-question depression screen One question on caregiving status	Compared to non-caregivers, family caregivers were associated with the incidence and persistence of depressive symptoms. Primary caregivers, caregivers for individuals with severe care needs, and caregivers with increased burden during the pandemic had a high risk of depressive symptoms.	High quality
Okamura et al. 2021	Japan	1,736	Prospective	Depressed mood Frailty Covariates (demographic info, memory-related variables, physical health-related variables, daily life competence and psychological variables)	Kihon Checklist (KCL)- comprises 20 items about the overall health status of older people and five items that assess depressed mood Questions were adapted from the Dementia Assessment Sheet for Community-based Integrated Care System-21 item Body height and body weight were assessed to calculate body mass index. Subjective health was assessed using a four-item Likert scale and responses	Being older, not married, low education level, residing in current location for longer than 10 years, difficulty watching educational programs, difficulty taking care of family members or acquaintances, and lack of emotional social support were related to new depressed mood. The multivariate logistic regression analysis showed that subjective memory impairment and difficulty using devices were significantly positively associated with new depressed mood. This is unsurprising, however, as memory and	High quality

					were categorised overall as indicating 'healthy' or 'not healthy.' Japan Science and Technology Agency Index of Competence (JST-IC) Emotional social support was assessed by a question about whether the participant had someone to consult when they were ill. Instrumental social support was assessed by a question about whether the participant had someone who would take care of them when they were ill.	concentration impairment are symptoms of depression; it may also indicate depression as a prodrome for depression.	
Robbins et al. 2021	USA	3,122	Cross-sectional	Sleep quality, sleep duration, watching television, walking as exercise, doing vigorous activities consuming alcohol, eating, and smoking or vaping. Emotional impacts of the COVID-19 pandemic broadly (i.e., regardless of whether someone was affected with COVID-19) were measured by assessing subjective feelings of distress about the COVID-19 pandemic.	Questions using 3 item or 4-point scales for each of the outcomes of interest. Emotional impact was measured by subjective feelings of distress	Pre-pandemic depression and anxiety was not associated with pandemic depression and anxiety. Being female, having arthritis and osteoporosis were risk factors to experiencing depression and anxiety. Individuals with dementia reported higher levels of depression but lower levels of anxiety. Sleep quality, (sleeping more or less), watching more television, and walking less were also associated with more feelings of depression and anxiety about the COVID-19.	Medium quality
Siegmund et al. 2021	USA	477. <i>M</i> = 71.6, <i>SD</i> = 5.4, 51.3% = male	Cross-sectional	Physical activity Social isolation Depression	The Physical Activity Scale for Elderly (PASE) PROMIS Social Isolation scale Geriatric Depression Scale (GDS-15)	Social isolation was positively associated with depression (<.001). Social isolation was negatively associated with physical activity (<.001), and physical activity was negatively associated with depression (<.001), however the magnitude of the	High quality

						standardized effect for both paths was small.	
van der Kaap-Deeder et al. 2021	Belgium	693. $M = 70.06$, $SD = 4.5$, 62.1% = female	Cross-sectional	Risk or protective factors Ego integrity and despair Need satisfaction Well-being and Psychological distress	Risk or protective factors (asked re age, gender, marital status, education level, and the number of children and grandchildren, medical conditions, perceived income and means of communication) Ego integrity scale- a shortened version of scale developed by Van Hiel and Vansteenkiste Basic Psychological Need Satisfaction and Need Frustration scale Most face valid items of the Satisfaction with Life Scale and the Subjective Vitality Scale	Ego integrity was found to be negatively correlated ($p < 0.01$) with well-being and psychological distress. Despair was positively correlated with well-being and psychological distress ($p < 0.01$). Several factors were found to protect (e.g. higher perceived income) or diminish (e.g. being widowed) older adults' well-being during the pandemic, with no evidence for a moderating role of these factors in associations between well-being and psychological distress.	Medium quality
Van Tilburg et al. 2021	The Netherlands	1,679. $M = 73$, 51% = male	Prospective	Social and emotional loneliness Mental health	Social and emotional loneliness were measured with three items The five-item version of the Mental Health Inventory (MHI-5)	The policy measures for physical distancing were not found to be significantly associated with social isolation but personal losses, worries about the pandemic, and a decline in trust in societal institutions were associated with increased mental health problems and especially emotional loneliness.	Medium quality
Vitman Schorr et al. 2021	Israel	201. $M = 74.3$, $SD = 6.3$, 52.2% = female	Cross-sectional	Loneliness Subjective age Depressive symptoms Malnutrition	One question each on loneliness and subjective age Geriatric Depression Scale (GDS) NSI (Determine Nutrition Screening Initiative) Instrument	The relationship between feelings of loneliness and subjective age during the COVID-19 pandemic was mediated by malnutrition, but not by depressive symptoms. High levels of loneliness ($p = .000$), depressive symptoms ($p = .002$), and malnutrition ($p = .000$), correlated positively with subjective age during the pandemic.	High quality

Voss et al. 2021	Europe (25 European countries)	13,819. <i>M</i> = 75.3, <i>SD</i> = 7.5. 55.4% = female	Cross- sectional	Mental health Government stringency response	Two questions on subjective feelings of sadness COVID-19 Government Response Stringency Index from the Oxford Coronavirus Government Response Tracker (OxCGRT)	Increased stringency measures were associated with increased sadness/depression (<i>OR</i> = 1.03, 95% CI [1.03, 1.04], <i>p</i> < .001). Women had a 117% greater likelihood of having increased feelings of sadness/depression (<i>OR</i> = 2.17, 95% CI [2.03, 2.31], <i>p</i> < .001). Financial distress was found to be positively correlated with sadness/depression (<i>OR</i> = 1.3, 95% CI [1.25, 1.43], <i>p</i> < .001) and worse levels of physical health associated with increased sadness/depression (<i>OR</i> = 1.77, 95% CI [1.71, 1.84], <i>p</i> < .001).	High quality
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Characteristics of the studies

The studies included in the present review were published between 2020 and 2021, with most of the studies being published in 2021 ($n = 21$). The majority of the data in the present review were collected between April and August 2020 ($n = 15$). The studies were conducted in Europe ($n = 9$), the USA ($n = 4$), Israel ($n = 3$), Japan ($n = 3$), Turkey ($n = 2$), Iran ($n = 1$), and Australia ($n = 1$). The sample size ranged from 10 (Mishra et al., 2021) to 13,819 (Voss et al., 2021) participants and the follow-up period from 1 (Carlos et al., 2020) month to 10 years (Johnco et al., 2021).

A cross-sectional study design was employed by 19 studies while five utilised a longitudinal design. Ten studies employed depression as their outcome, seven used depression and anxiety symptoms, four used psychological distress, and two used anxiety symptoms. Additionally, measures of government stringency response (lockdown measures such as closing schools and workplaces, cancelling public events, travel restrictions, stay at home requirements, bans on public gatherings and contact tracing), loneliness, ability to acquire information, comprehend the COVID-19 pandemic and lockdown, and comply with lockdown policies, subjective memory, health problems, physical activity, social isolation, social support, time sitting, resilience, subjective age, malnutrition, living conditions, coping, digital use, receptive arts engagement, ego integrity, need satisfaction, sleep quality, quality of life, nutritional status, suicide risk, health locus of control, post-traumatic stress, well-being, frailty, watching TV, alcohol consumption, smoking, fear of falling, activities of daily living, family caregiving status and religiosity were also used in individual studies.

Quality assessment

Regarding quality assessment, studies were classified as low, medium, or high quality depending on their score on the JIB checklists for cross-sectional and cohort studies. In general the studies included were considered to be of a high quality; most studies were found to be robust, generalisable studies which included detailed clearly defined samples as well as valid and reliable outcome measures. Sixteen of the 23 studies included studies were rated as being 'high quality', while the remaining 7 were found to be of 'medium quality'.

Details of the quality appraisal for each individual study are provided in Table 2.

Relation between impact of governmental responses to the COVID-19 pandemic factors and psychological distress in older adults

Four studies included in the present review (Giebel et al., 2021; Müller et al., 2021; Van Tilburg et al., 2021; Voss et al., 2021) investigated whether the impact of governments' responses to the COVID-19 pandemic were associated with psychological distress in older adults. All four studies found increased psychological distress among older adults was correlated with governmental measures to reduce the spread of COVID-19. This suggests that measures such as schools and workplace closures, travel restrictions, and stay at home requirements may be linked with higher levels of depression and anxiety among older adults.

Müller et al. (2021; n = 993) found that feeling restricted by quarantine measures ($\beta = 0.083$; $p = 0.004$) was associated with higher depression scores. Van Tilburg et al. (2021; n = 1,679) also investigated the impact of social distancing measures on older adult well-being and found that personal losses, worries about the pandemic, and a decline in trust in societal institutions were associated with increased mental health problems, especially emotional loneliness. Mental health was perceived as having deteriorated when participants

reported being personally affected by being outdoors less ($\beta = -0.04$, $p < .05$), needing support that was not received ($\beta = -0.06$, $p < .001$), having increasing worries about the pandemic ($\beta = -0.14$, $p < .001$), having declining trust in institutions ($\beta = -0.05$, $p < .01$), and not following government rules ($\beta = -0.05$, $p < .01$). Control variables were self-rated health, report of change in health in the last year, gender, age, living with a spouse or partner, the urbanity of the hometown, educational level, and income.

Voss et al. (2021; $n = 31,819$) found that more stringent measures were statistically associated with worsened mental health among older adults. However, there was a small effect size regarding the association between increased depression and the stringency measures index; on average, for each extra point on the index, the chances of an individual having increased depression rose by 3% ($OR = 1.03$, 95% CI [1.03; 1.04]). Control measures used were age, sex, education, financial stress, self-reported health and closeness of contact with COVID-19.

Giebel et al. (2021; $n = 223$) aimed to explore the relationship between change in social support services availability due to COVID-19-related public health measures and psychological distress. They found that the changes in social support hours were significantly related to increased anxiety ($p = .019$) and reduced well-being ($p = .012$); changes in social support hours were not found to be significantly associated with levels of depression ($p = .155$).

Relation between social support and participation and psychological distress

Impact of loneliness, isolation and social support

In this review, six studies (Aisenberg-Shafran et al., 2021; Kilincel et al., 2020; Minahan et al., 2021; Müller et al., 2021; Okamura et al., 2021; Siegmund et al., 2021) examined the relationship between loneliness, isolation and social support and psychological distress in

older adults during the COVID-19 pandemic. All six studies found that loneliness, isolation and reduced social support were associated with anxiety and depression.

Kilincel et al. (2020; n = 290) aimed to determine anxiety and loneliness levels and associated factors and found that there was a significant relationship between anxiety and loneliness (OR = 1.29, $r = 0.498$, $p = .001$) with anxiety scores being increased 1.29-fold by loneliness scores. Aisenberg-Shafran et al. (2021; n = 66) identified those at higher risk of depression and perceived loneliness in three age groups: young adults, middle-aged adults and older adults (65 years and above). They concluded that death anxiety was predictive of depression and suicidality in older adults; effects for age were found for depression ($p = .03$), and loneliness, ($p = .04$), but not for suicide risk ($p = .32$). Müller et al. (2021; n = 993) found that being lonely, but not isolated ($\beta = 0.276$; $p < 0.001$) was associated with higher depressive symptoms.

Minahan et al. (2021; n = 398) examined the influences of COVID-19 pandemic-related stress on depression and anxiety, and assessed the mediating role of social support. Social support was found to be a mediating factor between stress and depression ($p < .05$), and anxiety ($p < .05$). Müller et al. (2021; n = 993) investigated the associations of social isolation and loneliness with depressive symptoms and found that being both isolated and lonely ($\beta = 0.136$; $p < 0.001$) was associated with higher depressive symptoms. Okamura et al. (2021; n = 1,736) found that a lack of emotional social support ($p < .05$) was associated with new depressed mood. Siegmund et al. (2021; n = 477) found that social isolation was positively associated with depression ($\beta = 0.588$, $p < .001$). Age, income, and education were controlled for.

Impact of social and cultural engagement

Three studies (Carlos et al., 2021; Keisari et al., 2021; Noguchi et al., 2021a) included in the present review examined the relationship between social and cultural engagement and psychological distress in older adults. All three studies found that higher levels of social and cultural engagement were associated with lower levels of psychological distress.

Keisari et al. (2021; n = 196) assessed whether the levels of receptive arts engagements (how often they attended cultural and arts-based events in the preceding year) mitigated the association between COVID-19 resilience and anxiety. They found that the frequency of receptive arts engagement was positively correlated with level of resilience ($r = 0.28$, $p < .001$) and was negatively correlated with level of anxiety symptoms regarding the pandemic breakout ($r = -0.24$, $p < 0.001$). The effect sizes of these correlations were low to moderate.

Carlos et al. (2021; n = 204) found that social interactions with loved ones through telephone and digital media were associated with lower depression scores ($p = .050$).

Noguchi et al. (2021a; n = 597) examined the association between changes in social participation and the onset of depressive symptoms and found that decreased social participation was significantly associated with the onset of the depressive symptoms, compared to continued participation ($p = .045$).

Relation between coping styles and psychological distress

Three studies (Carlos et al., 2021; Ghoncheh et al., 2021; Minahan et al., 2021) assessed the relationship between coping and psychological distress in older adults during the COVID-19 pandemic. Ghoncheh et al. (2021; n = 696) explored how religiosity, religious coping, and fear of COVID-19 explained anxiety and depression among older adults. They found that anxiety and depression were negatively correlated with religious coping ($p < 0.001$).

Minahan et al. (2021; n = 398) found that avoidant coping was the strongest mediator of the relationship between pandemic-related stress and psychosocial outcomes, particularly depression. Avoidant coping significantly mediated the relationship between stress and depression ($p < .05$), and anxiety ($p < .05$), suggesting that dysfunctional coping is one mechanism that may explain why some older adults who experience pandemic-related stress suffer higher levels of depression than others.

Impact of religiosity

In the present review, one study (Ghoncheh et al., 2021) examined the relationship between religiosity and psychological distress in older adults. Ghoncheh et al. (2021; n = 696) found that religiosity was negatively correlated with depression ($B [SE] = -0.087 [0.037]$; $p = .023$) but was not associated with anxiety ($B [SE] = -0.063 [0.036]$; $p = .072$). They controlled for age, sex, marital status, accommodation, occupation, comorbidity, and educational status.

Impact of other coping behaviours

Carlos et al. (2021; n = 204) found that depression was significantly associated with frequency of tuning in on the news; those who checked the news once a day showed less signs of depression, while those who monitored the news more frequently and those who never or rarely did so tended to be more depressed ($p = <.001$). They also found that depression was significantly negatively associated with finding new hobbies ($p = 0.017$).

Relation between family caregiving status and psychological distress

One study (Noguchi et al., 2021b) examined the relationship between family care giving status and psychological distress in older adults. Noguchi et al. (n = 957) examined the association between family caregiving and changes in the depressive symptom status during the pandemic. They found that compared with non-caregivers, family caregivers experienced greater incidence ($OR = 3.17$, $p < .01$) and persistence of depressive symptoms

(OR = 2.39, $p < .01$). Primary caregivers, caregivers for individuals with severe care needs, and caregivers with increased burden during the pandemic had a high risk of depressive symptoms.

Relation between cognitive state and functioning

Three studies (Carlos et al., 2021; De Pue et al., 2021; Robbins et al., 2021) were included that examined the relationship between cognitive state and functioning and psychological distress in older adults. Gender and health conditions were controlled for. Carlos et al. ($n = 204$) found that depression was significantly associated with the cognitive state, with 61.5% of those with dementia scoring meeting the criteria for depression as opposed to the 22.4% of 'normal-old' participants ($p = .008$). De Pue et al. (2021; $n = 640$) found that depression was strongly correlated with cognitive functioning ($p < .001$). Robbins et al. (2021; $n = 3,122$) also found that having dementia or Alzheimer's disease was associated with increased depression ($p < .05$) but less feelings of anxiety ($p < .001$).

Impact of other psychological factors: ego integrity and despair, death anxiety, alcohol consumption and subjective age

One study (van der Kaap-Deeder et al., 2021) was identified that explored the relationship between ego integrity and despair and psychological distress in older adults. van der Kaap-Deeder et al. ($n = 693$) found that ego integrity was positively correlated with wellbeing and negatively correlated with psychological distress. Despair was negatively correlated with wellbeing and positively correlated with psychological distress. (β ranging between 0.14 and 0.35 for the positive effects and between -0.25 and -0.29 for the negative effects, $p < .01$.)

One study (Robbins et al., 2021) was included that examined the relationship between alcohol consumption and psychological distress in older adults. Robbins et al. (2021; $n = 3,122$) examined the relationship between self-reported changes to alcohol

consumption and psychological distress in older adults and found that that neither depression nor anxiety was associated with changes in alcohol consumption.

One study (Vitman Schorr et al., 2021) examined the relationship between subjective age and psychological distress. Vitman Schorr et al. (2021; n = 201) found that subjective age was positively correlated with depression ($r = 0.22$, $p = .002$) when they controlled for gender, age, years of education, and marital status.

Relation between behavioural and physical factors and psychological distress

Physical activity

In the present review, six studies (Carlos et al., 2021; Carvalho et al., 2021; De Pue et al., 2021; Mishra et al., 2021; Robbins et al., 2021; Siegmund et al., 2021) explored the relationship between physical activity and psychological distress in older adults. All six studies found that levels of physical activity were significantly associated with depression and/or anxiety.

Carvalho et al. (2021; n = 68), controlling for age, gender, and educational level, analysed physical activity levels, sitting time and physical fitness and their relationship with depressive symptoms in previously active older adults. They found significantly higher levels of moderate-to-vigorous physical activity (MVPA) in the non-depressed group compared with the depressed group ($p = .003$). Sitting time was not found to be associated with depression scores ($p = .255$). MVPA [$R^2 = 0.191$; $p < .001$] was found to be negatively associated with anxiety, while sitting time [$R^2 = 0.067$; $p = .033$] was found to be positively associated with anxiety, however.

In contrast to Carvalho et al. (2021), Mishra et al. (2021; n = 10) found that an increase in depression symptoms was significantly correlated with inactivity, specifically

unbroken-prolonged sitting bout ($\rho = 0.677$, $p = 0.03$) as well as cadence ($\rho = -0.70$, $p = 0.02$).

De Pue et al. (2021; $n = 640$) found that depression was related to reported declines in activity level ($\beta = -0.22$, $p < .001$).

Robbins et al. (2021; $n = 3,122$) found that walking less was associated with increased feelings of depression ($p < .001$) and anxiety ($p < .001$) about the COVID-19 pandemic.

Siegmund et al. (2021; $n = 477$) examined the relationship between physical activity and depression and also found that physical activity was negatively associated with depression ($SE = 0.001$, $Z\text{-value} = -6.639$, $p < .001$, $\beta = -0.230$), however the magnitude of the standardized effect was small.

Carlos et al. (2021; $n = 204$) found that regular exercise was a protective factor against depression, decreasing its likelihood ($OR: 0.30$; $p = .007$).

Mishra et al. (2021) found that no significant correlation between depression symptoms and light activity ($\rho = -0.566$, $p = .088$) and moderate-to-vigorous activity ($\rho = -0.41$, $p = .24$) levels.

Sleep

Four studies (Carlos et al., 2021; De Pue et al., 2021; Mishra et al., 2021; Robbins et al., 2021) assessed the relationship between sleep and psychological distress in older adults. All four studies found that sleeping problems were associated with increased psychological distress.

Carlos et al. (2021; $n = 204$) found that sleeping disturbances increased the likelihood of depression ($OR: 2.29$; $CI: 1.06\text{--}4.93$; $p = 0.034$). De Pue et al. (2021; $n = 640$) also found that depression was strongly related to declines in sleep quality ($\beta = -0.12$, $95\% CI$, $p < 0.001$). Mishra et al. (2021; $n = 10$) examined changes in sleep and the relationship of this to

depression levels and found depression levels were significantly negatively correlated with sleep duration ($\rho = -0.72$, $p = .019$). Robbins et al. (2021; $n = 3,122$) also found that both depression ($p = <.001$) and anxiety ($p = <.001$) were associated with worse sleep quality and sleeping more.

Relation between previous CBT and psychological distress

One study (Johnco et al., 2021) investigated the relationship between previous treatment with cognitive behaviour therapy (CBT) for anxiety and depression and psychological distress in older adults. Johnco et al. (2021; $n = 37$) assessed the long-term symptom relapse rates among older adults, who had previously treated with CBT for anxiety and/or depression, during COVID-19. They controlled for the number of months between post-treatment ratings and COVID-19 ratings, and found no significant differences in anxiety or depression from pre-COVID- 19 to COVID-19 lockdown.

They concluded that few (7%-17%) older adults with a previous mood or anxiety disorder, who had been treated with CBT showed significant relapse of symptoms during COVID-19, even after a mean of 5.67 years post-treatment; this effect held even after controlling for the duration between treatment and COVID-19. However, this study included no control group of older adults who had not attended CBT for anxiety and depression.

Demographic and participant characteristic-related factors

In this review, 10 (Kilincel et al., 2020; Carlos et al., 2021; Cigiloglu et al., 2021; Hernández-Ruiz et al., 2021; Keisari et al., 2021; Müller et al., 2021; Noguchi et al., 2021; Robbins et al., 2021; van der Kaap-Deeder et al., 2021; Voss et al., 2021) studies highlighted the relationship between key demographic factors and psychological distress in older adults.

Five studies (Cigiloglu et al., 2021; Keisari et al., 2021; Robbins et al., 2021; van der Kaap-Deeder et al., 2021; Voss et al., 2021) found that being female was associated with

increased psychological distress. Four studies (Kilincel et al., 2020; Carlos et al., 2021; Robbins et al., 2021; Voss et al., 2021) found that increased incidences of health problems were associated with psychological distress. Kilincel et al. (2020; $n = 290$) found that anxiety scores were increased 3.56-fold by having a chronic disease ($p = 0.001$) and 3.26 fold by the history of a psychiatric disorder ($p = 0.007$). Carlos et al. (2021; $n = 204$) found that depression was significantly associated with health problems ($p = 0.024$). Robbins et al. (2021; $n = 3,122$) found that having arthritis ($p < .01$), osteoporosis ($p < .001$), and lung disease ($p < .01$) were associated with increased feelings of depression and anxiety. Voss et al. (2021; $n = 31,819$) also found that having physical health problems ($OR = 1.77$, $p < 0.001$) resulted in increased levels of depression.

Three studies (Cigiloglu et al., 2021; van der Kaap-Deeder et al., 2021; Voss et al., 2021) found that lower levels of income were associated with increased psychological distress. Two studies (Cigiloglu et al., 2021; Voss et al., 2021) found that lower levels of education were associated with higher levels of psychological distress, two studies (Hernández-Ruiz et al., 2021; Noguchi et al., 2021) found that living alone was associated with higher psychological distress, and two studies (Müller et al., 2021; van der Kaap-Deeder et al., 2021) found that being single, divorced and widowed were associated with increased psychological distress.

Discussion

This review included 23 studies that explored the factors associated with psychological distress in older adults during the COVID-19 pandemic.

The current review has demonstrated that various types of governmental response to curb the spread of the COVID-19 virus have been linked to psychological distress for older adults (Giebel et al., 2021; Müller et al., 2021; Van Tilburg et al., 2021; Voss et al., 2021).

This suggests that measures such as schools and workplace closures, travel restrictions, and stay-at-home requirements may be associated with higher levels of depression and anxiety among older adults. This could be due to the isolation brought about by these social distancing measures; these measures have evidently increased isolation, loneliness (Kotwal et al., 2021) and reduced social interaction among older adults (Sepúlveda-Loyola et al., 2020), factors which themselves are often associated with psychological distress among older adults (Bai et al., 2020; Choi et al., 2021; Ferguson & Goodwin, 2010; Ferreira & Sherman, 2007; Kafetsios & Sideridis, 2006; Kasser & Ryan, 1999). Cultural differences have been observed regarding adherence to restrictions, for example Anaki and Sergay (2021) found that individuals from the United States and Europe engaged in fewer COVID-19 related preventive behaviours than individuals from Asia. The studies included in this review that explored the impact of governmental response were all conducted in European countries, however, making cross-cultural comparisons impossible. Future research could compare the attitudes and experiences of governmental responses across cultures.

Four studies included in this review found that isolation and loneliness are associated with depression and anxiety in older adults during the COVID-19 pandemic (Minahan et al., 2021; Müller et al., 2021; Okamura et al., 2021; Siegmund et al., 2021). Social support is an important protective factor against psychological distress among older adults (Bai et al., 2020; Choi et al., 2021; Ferguson & Goodwin, 2010; Ferreira & Sherman, 2007; Kafetsios & Sideridis, 2006; Kasser & Ryan, 1999). The stress-buffering theory may offer an explanation for this. The stress-buffering theory that suggests that social support moderates the effect of stress on well-being (Gore, 1981). This emotional buffer may have been impacted by the COVID-19 pandemic as older adults experienced a decrease in their social network and contacts.

Three studies (Carlos et al., 2021; De Pue et al., 2021; Robbins et al., 2021) demonstrated that older adults with reduced cognitive functioning, such as those with dementia, could also be at an increased risk of psychological distress during the COVID-19 pandemic. There is clear evidence that older adults with cognitive impairment are at particular risk of experiencing poor mental health during the pandemic. Although there already existed convincing evidence to demonstrate a link between cognitive impairment and psychological distress among older adults (Butters et al., 2008; Freire et al., 2017), this risk factor may be exacerbated during the COVID-19 pandemic due to the increased isolation (Kotwal et al., 2021) and reduced access to supports (Giebel et al., 2021). More research is required to further examine this risk and to identify potential interventions and supports.

All six studies included in this review that explored the association between physical activity and psychological distress found that levels of physical activity were significantly associated with depression and anxiety. Although this may be unsurprising as physical activity is known to be linked to depression, there appears to have been a decrease in activity levels among older adults during the pandemic. Carvalho et al. (2021) found that during home confinement, approximately 90% of older adults reported a decrease in overall physical levels, while 64.7% reported an increased daily sitting time. Similarly, De Pue et al. (2021) found that over 50% of their participants reported a decrease in activity levels and Mishra et al. (2021) also found an increase in sitting time among their participants. This is consistent with other findings from the general population. Ammar et al. (2020) surveyed 1,047 adults and reported a decline in all levels of physical activity during the home confinement period and a significant increase in sitting time.

Many of the factors identified in this review have been associated with psychological distress among older adults prior to the COVID-19 pandemic. However, understanding the role these factors play within the context a global health emergency and the associated social distancing measures could help inform governmental and public health responses to this and future pandemics.

It is well established that exercise has a positive effect on mental health, especially when performed outdoors or in groups (Burtcher et al., 2020). The studies included in this review as well as other research conducted during the pandemic provide further support for this. Carriedo et al. (2020) investigated the physical and psychological well-being of older adults during home confinement and found that older adults who regularly engaged in moderate to vigorous physical activity reported lower scores in depressive symptoms. Research supports the efficacy of home-based exercise programs to improve physical activity of older adults (Matsuda et al., 2010; Chaabene et al., 2021) and could be a way to mitigate the negative mental health impact of confinement during the COVID-19 pandemic. Boredom, worthlessness, and preferring to stay at home regardless of lockdown were most common depression symptoms as identified by Carlos et al. (2021) and they found that depression was negatively associated with finding new hobbies. Considering these conclusions along with Keisari et al.'s (2021) finding that arts engagement was positively correlated with resiliency and was negatively correlated with anxiety, community engagement and arts programmes could also provide structure as well as connection and participation for older adults during home confinement. Furthermore, as avoidant coping was found to be associated with increased psychological distress, particularly depression (Minahan et al., 2021). Interventions, such as cognitive behaviour therapy or acceptance

and commitment therapy, that target maladaptive coping and encourage behavioural activation and goal-setting could be beneficial.

Carlos et al. (2021) also found that social interactions via telephone and digital media were associated with lower depression scores during the COVID-19 pandemic; interventions that involve increased telephone support or dedicated telephone and text support lines for older adults may therefore be beneficial. Interventions that encourage emotional connection could be beneficial in for older adult wellbeing during future lockdowns. Developing new ways of communication such as using technology to encourage social engagement could be effective in reducing loneliness and its impact on psychological distress. As caregiving status was also associated with psychological distress, online support groups or telephone and text support services may be appropriate here too. Poor digital literacy appears to be associated with increased depressive symptoms (Carlos et al., 2021) and may be a barrier for older adults accessing such supports (Mamedova, et al., 2018) therefore public health initiatives to provide older adults with digital literacy skills should be prioritised.

Sleep was also found to be associated with psychological distress in older adults during the COVID-19 pandemic; this is also consistent with research from before the pandemic (Pigeon et al., 2017). Correspondingly, Losada-Baltar et al. (2021) found that when older adults experienced good quality sleep quality during the COVID- 19 pandemic, they were less likely to experience loneliness. Education and resources on the importance of sleep and sleep hygiene may be beneficial to combat this risk factor. Relaxation techniques have been found to be beneficial in promoting better sleep (Blanaru et al., 2012). It would also be important for future research to explore why sleep has been disrupted for older adults during the pandemic.

Study limitations

Out of the 23 studies included in this review, 19 were cross-sectional in design. While cross-sectional research can provide useful information on the prevalence of symptoms and can offer a snapshot of a cohort's experience, these studies do not provide baseline measures and therefore cannot offer causal explanations. There was also heterogeneity of outcome measures across the 23 studies.

Many of the studies included required that the participants had access to computer and internet in order to take part in the studies. This may have introduced some bias in the recruitment as IT-illiterate older adults were not included and therefore may impact the generalisability of the findings. As poor digital literacy among older adults appears to be associated with depression (Carlos et al., 2021), these studies may exclude some of the most vulnerable individuals in the population they are investigating.

Of the studies included in this review, most participants were from White, educated, industrialised, rich, democratic (WEIRD) countries and only a small portion were of a low socio-economic status (SES); this may impact on the generalisability of the findings. Future research should focus on investigating the experiences of older adults from low SES cohorts as well as minority and ethnic groups as these have been some of the worst affected by the COVID-19 pandemic (Rose et al., 2020).

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Conflict of Interest Statement

The authors have no conflict of interest to declare.

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Chapter Three: Major Research Project Literature Review

Overview

In January 2020, the World Health Organisation (2020b) announced a global pandemic of the coronavirus disease 2019 (COVID-19). Many countries attempted to curb the spread of the SARS-CoV-2 virus utilising public health interventions such as stay-at-home orders, curfews, quarantines, and similar social distancing restrictions, known colloquially as lockdowns (Stawicki et al., 2020). This chapter presents an exploration of the existing literature related to the psychological impact of the COVID-19 pandemic on older adults with pre-existing mental health difficulties. It explores this population's vulnerability during the pandemic and provides an overview of the theoretical frameworks relevant to the major research project. This chapter also offers a rationale for the study, as well as the project's aims.

Older adults and the COVID-19 pandemic

Various psychological difficulties have been found to be associated with the social distancing measures and their associated interruption of education, employment, and social activities. These include increased and prolonged feelings of depression, stress, anxiety, and fear of the COVID-19 disease (Ahmed et al., 2020; Alzueta et al., 2021; Di Blasi et al., 2021; González-Sanguino et al., 2020; Özdin et al. 2020; Rossi et al., 2020; Taquet et al., 2021). Although the governmental responses to contain and mitigate the spread of the virus appear to have negatively impacted upon the mental health of the general population (Pierce et al., 2020; Rossi et al., 2020; Wang et al., 2020), emerging research has suggested that certain groups are particularly vulnerable to experiencing psychological distress, including older adults and those with pre-existing mental health difficulties.

Older adults are at higher risk of developing serious illness from COVID-19 (Centers for Disease Control and Prevention, 2022; Liu et al., 2020). In Ireland, almost 80% of COVID-19-related deaths have involved adults over the age of 75 years (Kennelly et al., 2020). As a result of this increased vulnerability, older adults were advised to ‘cocoon’. The concept of ‘cocooning’ refers to the advice to stay at home and avoid all unnecessary face-to-face interactions. These measures, while intended to protect older adults, appear to be detrimental to their psychological wellbeing and mental health. There is evidence to suggest that feeling restricted by quarantine measures is linked with increased depressive symptoms among older adults (Müller et al., 2021), and that more stringent measures appear to be associated with worsened mental health (Voss et al., 2021). For older adults, lockdown appears to be associated with reduced overall wellbeing (Trabelsi et al., 2021; van Tilburg et al., 2020), higher levels of anxiety and depression (de Pue et al., 2021; Giebel et al., 2021; Kotwal et al., 2021; Krendl & Perry, 2020; Mishra et al., 2021; Lee et al., 2022; Van Tilburg et al., 2021; Voss et al., 2021), and increased loneliness (Krendl & Perry, 2020; Lee et al., 2022; Stolz et al., 2021; van Tilburg et al., 2020). Stolz et al. (2021) also found that loneliness levels were higher during lockdown than when compared to the subsequent re-opening phase.

Conversely, there is some evidence that, in comparison to younger populations, older adults may have been less vulnerable to mental health difficulties during the COVID-19 pandemic (González-Sanguino et al., 2020; Moghanibashi-Mansourieh, 2020; O'Connor et al., 2021; Pieh et al., 2021). Aisenberg-Shafran et al. (2021) found that while older adults reported fewer depression symptoms and lower distress levels than younger populations, they were at an increased risk for suicide. A potential explanation for this could be that older adults may present with atypical depressive symptoms and are less likely to disclose suicidal ideation (O'Connell et al., 2004). These findings suggest that it may not be useful to

consider older adults as a single, homogeneous high-risk group; they may not be uniformly impacted by the pandemic and certain subgroups could be more vulnerable than others.

Individuals with Pre-Existing Mental Health Difficulties and the COVID-19 pandemic

Individuals with pre-existing mental health difficulties also appear to be at risk of experiencing increased psychological distress during the COVID-19 pandemic (Asmundson et al., 2020; Benatti et al., 2020; Bendau et al., 2021; O'Connor et al., 2021; Özdin et al. 2020; Taquet et al., 2021; Van Rheezen et al., 2020). There is evidence to suggest that mental health service provision was negatively impacted by the pandemic. The World Health Organisation conducted a large-scale survey of mental health services from June to August 2020 including data from 130 countries (World Health Organisation, 2020a) and found high levels of disruption to counselling and psychotherapy services, critical harm reduction services, and school and workplace mental health services.

Several studies suggest that pre-existing anxiety and depression symptoms are risk factors for experiencing increased psychological distress during the COVID-19 pandemic. Asmundson et al. (2020) found that individuals with anxiety-related disorders reported higher levels of COVID-related stress than those with no mental health disorder. Bendau et al. (2021) also found that levels of COVID-19-related fear were significantly higher in people with pre-existing anxiety and depression when compared to those without mental health difficulties, while Van Rheezen et al. (2020) reported that individuals with a mood disorder reported higher COVID-19-related psychological distress during the early stages of the pandemic than those with no mood disorder.

Older Adults with Pre-Existing Mental Health Difficulties

As older adults and people with pre-existing mental health difficulties appear to have been at risk of psychological distress during the COVID-19 pandemic, older adults with pre-

existing mental health difficulties may have been uniquely vulnerable. Community-based outpatient services, mental health services, and services for specific age groups such as older adults, were among the most severely disrupted during the early stages of the pandemic (World Health Organisation, 2020b) and there is evidence to suggest that disruption to social support services is associated with reduced wellbeing and increased anxiety (Giebel et al., 2021). However, there is a dearth of research on the impact of the COVID-19 pandemic on older adults with pre-existing mental health difficulties.

The Importance of Social Support

The correlation between mental health difficulties and social distancing measures may be partly due to the impact these restrictions had on social support systems. For older adults in particular, social support has been found to be an important protective factor against psychological distress as it is associated with increased wellbeing and decreased symptoms of depression (Bai et al., 2020; Choi et al., 2021; Ferguson & Goodwin, 2010; Ferreira & Sherman, 2007; Kafetsios & Sideridis, 2006; Kasser & Ryan, 1999). Research has also demonstrated that social support is a protective factor for those with mental health difficulties (Backs-Dermott et al., 2010; Dickenson et al., 2011; Eagle et al., 2016).

The Socioemotional Selectivity Theory (SST; Cartensen, 1991) may offer an explanation as to why reduced social support may be exceptionally detrimental to the wellbeing of older adults. The SST posits that as adults grow older, they begin to perceive their remaining time as being limited and their motivational goals change accordingly. Person-focused, emotionally significant goals become more important than future-oriented goals, so older adults place a greater emphasis on the importance of emotional support and prioritise emotional satisfaction over new learning and growth opportunities. So, although

social support has generally been found to be associated with wellbeing, it may be especially important for older adults.

Another explanatory model for why social support is associated with increased wellbeing comes from the stress-buffering theory. This theory suggests that social support moderates the effect of stress on wellbeing (Gore, 1978). The main effects hypothesis of social support offers a further explanation, suggesting that people with high social support have better health outcomes, regardless of the presence or absence of stressors (Cohen, 2004; Rook, 1990). However, as social support is likely to have been impacted by the social distancing measures, older adults may have been at risk for increased psychological distress.

Among older adults, the lockdown restrictions appear to have increased feelings of loneliness (van Tilburg et al., 2020), and social isolation as well as decreased social participation during the pandemic was found to predict depression (Müller et al., 2021; Noguchi et al. 2021; Siegmund et al., 2021). Additionally, reciprocity is an important consideration; when older adults are unable to reciprocate, received support can have limited benefits (Abolfathi Momtaz, 2014; Nemoto, 1998; Thomas, 2010). So, although older adults may have received support from relatives, friends, and neighbours during the lockdown restrictions, if they were unable to reciprocate, this may have been of limited benefit.

The Impact of Health Anxiety, Chronic Stress and Multimorbidity

Health anxiety among older adults appears to occur following stressful life events, loss, and serious illness (Asmundson et al., 2010; Barsky & Klerman, 1983) all of which have been common experiences during the COVID-19 pandemic. Furthermore, disease-related media coverage, such as COVID-19 coverage, has been found to be associated with increased health-anxiety (Marcus et al., 2007; Taylor & Asmundson, 2004). Additionally, during the

COVID-19 pandemic older adults appear to be at increased risk for developing serious illness from COVID-19 (Centers for Disease Control and Prevention, 2022; Liu et al., 2020), socially isolated, and may be experiencing a loss of control and independence, potentially making them especially susceptible to health anxiety.

The impact of chronic stress is also an important consideration for older adults who had been experiencing anxiety and depression prior to the onset of the COVID-19 pandemic. Chronic stress has been associated with increased negative health outcomes for older adults including Alzheimer's disease (Bisht et al., 2018), immune dysregulation (Gouin et al., 2008), and depression and cognitive functioning (Marin et al., 2011). As previously discussed, COVID-19 has likely exacerbated stress and emotional distress for older adults and for people with pre-existing anxiety and depression, potentially further heightening their vulnerability. Multimorbid chronic diseases as well as previous psychiatric history were found as risk factors for health anxiety (Özdin & Bayrak Özdin, 2020). Therefore, there is a further urgency in our need to understand the effects of the COVID-19 pandemic on this vulnerable population.

Ego Integrity Versus Despair and the COVID-19 Pandemic

The eighth stage of Erikson's (1963) theory of psychosocial development, the stage of ego integrity and despair, begins at approximately age 65. Older adults' experience of this conflict may have contributed to their resiliency, or lack thereof, during the pandemic. At this stage, the key conflict focuses on questioning whether an individual has led a meaningful life, and success at the stage is thought to lead to the virtue of wisdom. The theory proposes that in older adulthood, ego integrity refers to the ability to look back on life with a sense of accomplishment and involves acceptance, feeling at peace and, and a sense of achievement. Conversely, despair refers to looking back on life with feelings of

regret. Research has shown that increased ego integrity is associated with better overall mental health and lower psychological distress, while despair has the opposite impact (Derdaele et al., 2019; Lamers et al., 2011; Van Hiel & Vansteenkiste, 2009).

This crisis of ego integrity and despair is often particularly significant when older adults are confronted with difficult life events such as important losses (Kivnick & Wells, 2014). The COVID-19 pandemic resulted in significant losses and an increased risk for illness and death for many. If older adults were able to face these challenges with a sense of ego integrity, they may have experienced higher resiliency to distress. A recent study by van der Kaap-Deeder et al. (2021) explored the relationship between ego integrity and despair and psychological distress in older adults during the pandemic. They found that increased ego integrity was associated with increased life satisfaction and decreased loneliness, anxiety, and depression. Despair was found to relate to these factors also, in the opposite direction.

Self-Determination Theory and the COVID-19 Pandemic

The self-determination theory is also an important consideration when thinking about older adults' experiences of the lockdown restrictions. This theory suggests that there are three essential psychological needs necessary for individuals' wellbeing (Ryan & Deci, 2017; Vansteenkiste et al., 2020). These needs are for autonomy, competence, and relatedness. Research has shown that satisfaction of these needs is positively associated with wellbeing and negatively associated with anxiety and depression (Abolfathi Momtaz, 2014; Ferrand et al., 2015; Hahn & Oishi, 2006; Kasser & Ryan, 1999; Souesme et al., 2016). Due to the COVID-19 pandemic, however, older adults may have experienced difficulties in getting these needs met, leading to a potential increased risk for psychological distress.

The Present Study

Although older adults and individuals with pre-existing mental health difficulties have both been identified as vulnerable populations during the COVID-19 pandemic, no existing research has focused on the lockdown experiences of older adults with pre-existing mental health difficulties. Extant research has focused only on the experiences of older adults or those of individuals with mental health difficulties, but none has examined the experiences of this vulnerable subpopulation.

This subpopulation warrant attention for several reasons. Although the public health advice to stay-at-home and ‘cocoon’ was intended to protect older adults, there is strong evidence to suggest that the social distancing restrictions are associated with reduced wellbeing (Trabelsi et al., 2021; van Tilburg et al., 2020), increased feelings of anxiety and depression (de Pue et al., 2021; Giebel et al., 2021; Kotwal et al., 2021; Krendl & Perry, 2020; Mishra et al., 2021; Lee et al., 2022; Van Tilburg et al., 2021; Voss et al., 2021), as well as loneliness and social isolation (Krendl & Perry, 2020; Lee et al., 2022; Stolz et al., 2021; van Tilburg et al., 2020). Individuals with pre-existing mental health difficulties also appear to be at increased risk of experiencing psychological distress during the COVID-19 pandemic (Asmundson et al., 2020; Benatti et al., 2020; Bendau et al., 2021; O’Connor et al., 2021; Özdin et al., 2020; Taquet et al., 2021; Van Rheezen et al., 2020). Social support has been found to be a protective factor for older adults and people with mental health difficulties, and this has likely been impacted during the pandemic. Due to these changes in social support as well as the impact of chronic stress and the potential frustration of the essential needs of autonomy, competence relatedness, this subpopulation is likely to be particularly vulnerable.

Although the COVID-19 pandemic was an unprecedented phenomenon, some have warned of future waves of the COVID-19 virus as well as potential future pandemics (Behl et al., 2022). With an ageing population, and in case of the need for future similar social distancing and lockdown-type measures, clinicians and policymakers need a comprehensive understanding of how this subgroup understands and experiences these restrictions in order to mitigate the impact the restrictions may have.

Aims of the Present Study

The current study aimed to fill gaps in the extant literature by exploring the lockdown experiences of older adults with pre-existing mental health difficulties. The study aimed to provide an insight into how these individuals experienced and made sense of the changes brought about by the restrictions and offers an original contribution as it is the first study of its kind to focus on the lockdown experiences of this vulnerable subgroup.

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Chapter Four: Major Research Project

A cocoon or a prison:

Older adults with mental health difficulties and the COVID-19 lockdown restrictions- An Interpretative Phenomenological Analysis

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Abstract

Background

Research indicates that older adults and individuals with pre-existing mental health difficulties were among the groups particularly at risk of experiencing increased mental health difficulties due to the lockdown restrictions introduced during the COVID-19 pandemic. Older adults experiencing anxiety and depression may have been particularly vulnerable. Researchers have warned of potential long-term mental health consequences for these older adults and pointed out that the field of geriatric psychiatry is in uncharted territory given the confluence of a global viral pandemic and increased life expectancy.

Aims

The aim of the current study is to explore how older adults with pre-existing anxiety and depression experienced and understood the COVID-19 lockdown restrictions.

Participants and setting

Nine older adults, aged 65 years and over, with pre-existing anxiety and depression were recruited from the Older Adult Mental Health Services of the Irish Health Service Executive.

Methods

Data were collected via semi-structured interviews. Interviews were audio-recorded and transcribed verbatim. Transcripts were analysed using Interpretative Phenomenological Analysis (IPA).

Results

Six themes were generated, organised under two super-ordinate themes: 'Sent to the Sidelines' and 'The End, or a New Beginning?' Participants experienced a sense of lost purpose and belonging in society, and experienced feeling no longer needed by society. For

some, there was a sense of hopelessness, and that this new way of life was permanent.

While for others there remained hope that brighter days would follow.

Conclusion

Findings highlight the importance of social connection and belongingness, purpose and meaning, and a sense of agency in the lives of participants.

Introduction

As a response to the COVID-19 pandemic, countries implemented public health interventions to curb the spread of the virus. These interventions included stay-at-home orders, curfews, quarantines, and similar social distancing restrictions, known colloquially as lockdowns. These lockdowns resulted in school closures, work-from-home orders, job losses, economic insecurity, and isolation (International Labour Organisation, 2021), and appear to be associated with a slew of psychological difficulties including increased and prolonged feelings of depression, stress, anxiety, and fear of COVID (Ahmed et al., 2020; Alzueta et al., 2021; Di Blasi et al., 2021; González-Sanguino et al., 2020; Özdin et al. 2020; Rossi et al., 2020; Taquet et al., 2021).

The COVID-19 pandemic and the resulting lockdown restrictions were a novel and unprecedented global phenomenon and emerging research has suggested that certain groups are particularly vulnerable to experiencing psychological distress as a result of the social distancing measures. Older adults are at higher risk of developing serious illness from COVID-19 (Centers for Disease Control and Prevention, 2022) and were therefore advised to ‘cocoon’, to stay at home and reduce face-to-face interaction with other people. This advice to limit social contact likely considerably impacted older adults’ social support systems. Social support has been found to be particularly important for older adults as it is associated with increased well-being and decreased symptoms of depression (Bai et al., 2020; Ferguson & Goodwin, 2010; Ferreira & Sherman, 2007; Kafetsios & Sideridis, 2006; Kasser & Ryan, 1999). Furthermore, receiving support, without the ability to reciprocate, has been found to be less important to older adult well-being (Abolfathi Momtaz, 2014; Nemoto, 1998; Thomas, 2010). Therefore, researchers (Pfefferbaum & North, 2020) predicted that older adults would be at higher risk of experiencing psychological distress due to lockdown

measures and recommendations to cocoon. And while older adults may have received some support from relatives and neighbours during the lockdown restrictions, if they were unable to reciprocate, this may have had limited positive effects. Some early research confirmed these concerns that the lockdown restrictions negatively impacted older adults' mental health (Bailey et al., 2021; Krendl & Perry, 2020; van Tilburg et al., 2020).

At the same time, individuals with pre-existing mental health difficulties also appear to be at risk of experiencing increased mental health difficulties during the COVID-19 pandemic (Benatti et al., 2020; O'Connor et al., 2021; Taquet et al., 2021) particularly those with pre-existing mood and anxiety disorders (Asmundson et al., 2020; Bendau et al., 2021; Özdin et al. 2020; Van Rheenen et al., 2020). Social support has also been found to be a protective factor for individuals with anxiety and depression (Backs-Dermott et al., 2010; Hybels et al., 2011; Hybels et al., 2016).

In a population for which loneliness and isolation have already been described as an epidemic (Day et al., 2019), the impact of lockdown and social distancing measures as a result of COVID-19 requires further investigation.

The Present Study

The present study aims to fill gaps in the current literature by exploring the lockdown experiences of older adults with pre-existing mental health difficulties.

Research Questions

Primary research question

How did older adults who were experiencing symptoms of anxiety and depression prior to the COVID-19 pandemic experience and understand the COVID-19 lockdown restrictions?

(The term 'lockdown restrictions' refers to the periods where there were strict national restrictions banning all social and family gatherings. These were first introduced in March

2020 and remained in place until May 2020. They were introduced again in October 2020 remaining in place until the end of November 2020, and again at the end of December 2020 to March 2021. Although these are the periods of specific interest to the current study and participants will be asked to consider their experiences of these periods when all social and family gatherings were banned, the nation's ability to socialise was significantly impacted for much of 2020, and the overall impact of the COVID-19 pandemic restrictions are relevant to the study.)

Secondary research questions

1. How did the participants understand and experience the changes the lockdown restrictions brought about in their lives?
2. How did they understand and experience relationships and social support during the lockdown restrictions?
3. How did the participants understand and experience the COVID-19 pandemic as a whole?
4. From the participants' perspectives, were there any supports that could have benefitted them during this experience?

Method

Design

A qualitative design using Interpretative Phenomenological Analysis (IPA) methodology was employed to explore the experiences of older adults with pre-existing anxiety and depression of the COVID-19 lockdown restrictions.

Participants

Participants were nine Irish older adults aged 65 years and over; their ages ranged between 69 and 81, and the mean age was 75. Participants were interviewed after giving informed consent (Appendix E). Five participants were female, and five participants were living alone during the periods of lockdown. Demographic information for participants is presented in Table 3.

Table 3

Demographic information

Pseudonym	Age	Living situation
Mary	75	Lives alone
James	79	Carer of wife with dementia
Rose	81	Carer of husband with dementia
Violet	73	Lives with husband
Betty	75	Lives with husband
Sandra	78	Lives alone, husband died by suicide, difficult family relationships
Charlie	76	Lives alone, wife passed away recently
Brian	69	Lives with wife
Stephen	71	Lives alone, divorced

Smith et al. (2009) have suggested that a sample of between four and ten participants is suitable for professional doctorate studies. As the aims of this study was not to generate theory, theoretical saturation was not considered (Pietkiewicz & Smith, 2014).

Consistent with IPA principles, participants were selected through purposive sampling and were recruited through the Older Adult Mental Health Services. The third author (JW), a senior clinical psychologist in the Older Adult Mental Health Service, reviewed the services caseload and identified potential participants using the inclusion criteria. These potential participants were provided with an information sheet and consent form (Appendix E) and were advised to contact the researcher to express an interest in taking part in the study. Inclusion criteria were (a) attendance of the Older Adult Mental

Health Service (b) having experienced the symptoms of both anxiety and depression in the previous year, (c) aged 65 years or over, (d) being able to understand and speak English, (e) being physically and mentally able to converse for an hour, (f) having no cognitive impairments or significant physical disabilities, (g) not experiencing symptoms of psychosis and (h) not experiencing severe levels of depression that included active suicidal intent will also be grounds for exclusion from the study.

There was no pre-existing relationship between the participants and the lead researcher (AC). Participants were given information about the researcher (AC) in the information sheet, including that the research was being conducted for a Doctorate in Clinical Psychology thesis.

Data Collection

Detailed, first-person accounts of their experiences were required to gain insight into participants' experience of the 'lockdown' restrictions (Smith et al., 2012); therefore, semi-structured interviews were used to collect this data. Semi-structured interviews were chosen due to their flexible structure, and their ability to facilitate deep explorations of individual thoughts, feelings, and experiences (DeJonckheere & Vaughn, 2019). These interviews were conducted by the first author (AC) to obtain thorough descriptions of participants' thoughts and feelings as well as their attempts to understand and make sense of the 'lockdown' restrictions. In line with IPA principles outlined by Smith et al. (2009), an interview schedule was developed following consultation with the research and clinical supervisors. The interview schedule comprised nine open-ended questions designed to elicit information about how the lockdown restrictions had impacted participants' day-to-day lives, their relationships, and their mental health. Due to the COVID-19 restrictions, interviews were unable to be conducted in-person; therefore, all interviews were conducted

via telephone. Interviews were audio-recorded, and recordings were transcribed verbatim.

Interviews were on average 52 minutes, with a range of 33 minutes to 66 minutes.

Analysis

IPA (Smith et al., 2009) was used to analyse the data. IPA is an approach to qualitative research which aims to provide a detailed examination of individual lived experience. As a phenomenological approach, IPA does not attempt to offer an objective account of individual experiences but aims to offer insights into how individuals make sense of their experiences. IPA is also rooted in the hermeneutic tradition and recognises the concept of the hermeneutic circle. This occurs in the researcher's attempt to understand the dynamic relationship between the individual 'parts' of an experience and the experience as a 'whole'. Understanding the whole is always dependent on an understanding of the individual parts and in order to understand the parts, one must look to the whole (Smith & Shinebourne, 2012).

IPA also acknowledges the double hermeneutic that occurs during analysis (Smith et al., 2009). This is the process of the researcher attempting to make sense of the participants' attempts to make sense of their experience. It is a highly idiographic technique and seeks to achieve an in-depth analysis of a participant's account before moving on to analysis subsequent accounts (Smith et al., 2009). IPA requires that the researcher attempts to 'bracket' or put to the side any preconceived ideas. It also acknowledges that an understanding of another's experience is always dependent on what that individual tells us about the experience, and that the researcher then needs to interpret the participant account to understand their experience (Smith et al., 2009).

As the first step of the analytic process, the researcher immersed herself in the original data; this involved listening to the audio-recording of the interview, transcribing the

interview, and then reading and rereading the transcript. During this stage, the researcher employed 'free coding', which involved using a clean copy of the transcript and documenting all emotional reactions, images, metaphors, ideas and ideas provoked by the data (Larkin & Thompson; 2012). The aim of 'free coding' is to capture initial ideas and responses to the data in order to 'bracket' these off and proceed with a more systematic and consistent focus (Larkin & Thompson, 2012). A reflexive journal was also utilised to capture thoughts, feelings, opinions, assumptions, and judgements I identified in relation to the research. I further identified assumptions and biases by appraising my knowledge of and interest in the research topic and reflecting on my experience of working with older adults. Potential assumptions and biases were identified, discussed with supervisors and these were, to the best of my ability, bracketed and put to the side for the duration of the analysis. The next step involved a close, line-by-line analysis of the transcript, noting the conceptual, linguistic, and descriptive aspects. Once the transcript was coded in this way, themes were identified by examining and exploring the initial codes in relation to the relationships and patterns between codes. Themes were organised in this way and a set of super-ordinate themes were identified.

These steps were then repeated for each additional transcript. Once each transcript had been analysed individually, the themes across all nine transcripts were explored and organised into super-ordinate and sub-themes. The second author (MM) reviewed a sample of these themes for reliability and to ensure a coherent representation of the data had been achieved. The themes were then presented narratively, to denote the overall story of the data, highlighting convergence and divergence, with verbatim extracts from the transcripts.

Researcher orientation

The lead researcher (AC) carried out this study as part of the requirements for a Doctor of Clinical Psychology. She has professional experience of working with older adults with anxiety and depression. The second author (MM) is an academic research psychologist, with an interest in wellbeing across the lifespan and in social support and engagement. The third author (JW) is a clinical psychologist on the Older Adult Mental Health Services team with extensive experience working with older adults with mental health difficulties.

Ethical considerations

The study received approval from the University's Clinical Psychology Research Ethics Committee.

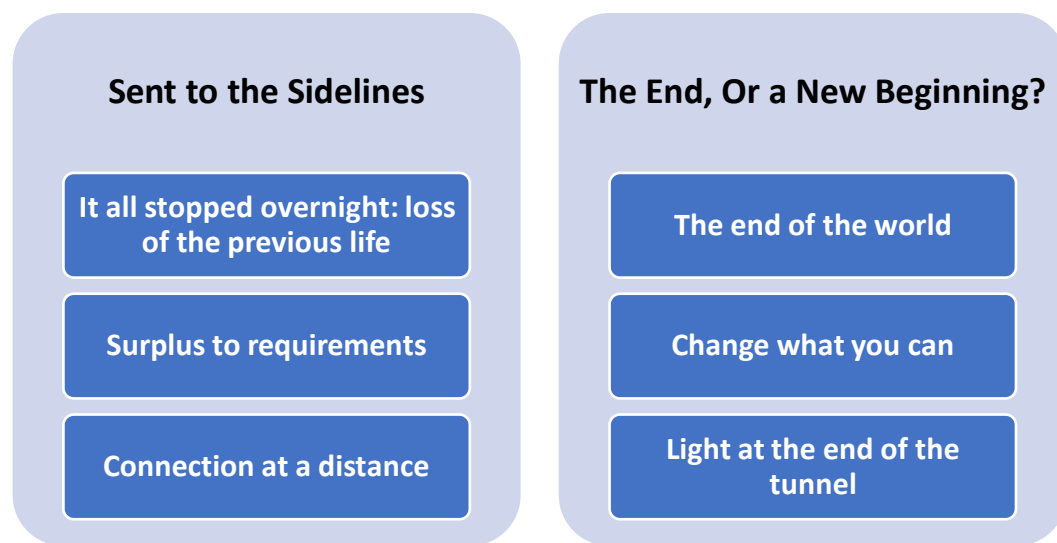
For this study, important ethical considerations included ensuring potential participants were contacted in a non-coercive way, that informed consent was obtained, and that participants understood what was involved in their participation and the potential risks of taking part in the study. It was also important to ensure confidentiality was maintained in as far as was practicable therefore transcripts were anonymised to disguise the participants' identity. A distress protocol was developed and this was outlined to participants before the interviews were conducted. To ensure these issues were addressed appropriately, the Psychological Society of Ireland's Code of Ethics (PSI, 2011) and University College Cork's Code of Research Conduct (UCC, 2021) were consulted and adhered to when planning the study and in the drafting of the information and consent forms. Ethical approval was granted by the Ethics Committee of the School of Applied Psychology, UCC (Appendix F). Anonymised data will be securely held on an encrypted computer for 10 years after the completion of the study (in line with UCC guidelines).

Results

Six themes were generated, organised under two super-ordinate themes (Figure 2).

Figure 2

Superordinate themes and sub-themes



Sent to the Sidelines

When the Irish government introduced a nationwide stay-at-home order on 27th March 2020, and older adults were advised to ‘cocoon’, all participants experienced a sudden and drastic change in their day-to-day lives. The unexpected and abrupt change to their usual routine, hobbies, independence, and social support was experienced emotionally as a powerful feeling of lost purpose and belonging in society. Participants felt they had been sent to the sidelines, where they experienced feeling no longer needed by their families and communities; there was a sense of feeling left behind and unheard. Participants had to find new and creative ways to achieve social connection and support. For some, they felt the strength of their emotional connections could withstand the social distance, while others found this more difficult.

It all stopped overnight: the loss of the life before

The changes brought about by the first stay-at-home order were experienced by participants as a dramatic and unsettling loss of their day-to-day lives. Several participants communicated this keen sense of loss through strong, emphatic use of language. When describing their lives before the pandemic, participants used positive language such as “fulfilled” (Violet), “busy” (Mary), “pleasant”, “lovely” and “great” (Rose), and spoke fervently:

“So life before the lockdown for me was fantastic! I'm a retired teacher and I'm joined [name of association]. I used to run groups in the community. I'm a [mental health worker]. And I'm a volunteer, I used to visit people in [name of hospital]” (Violet).

When speaking about the new life brought about by the pandemic, however, participants' language use shifted. They employed strong, abrupt language to capture the sudden, jarring nature of the stay-at-home orders. Betty exclaimed “Bang! Everything changed” while Rose stated that, for her, “Everything stopped!”.

This jarring shift in their lives was captured by participants in descriptions of a sense of altered reality. This is captured in Rose's compelling comparison of her new reality to that of a horror film, emphasising the strangeness as well as her fear and discomfort:

“it's just unreal really- the whole thing looks like a horror film” (Rose).

This idea that their new reality felt fake or unreal was a strong theme for several participants. Here Violet speaks to the illusive, ominous presence of the virus alongside the apparent normality of seeing people going about their day:

“you know, sometimes I think it almost feels unreal you know. There's this awful bug out there and it's, you know, we can't see it, we can't feel it, it doesn't seem to be in

our area... but there *is* a pandemic. We're still seeing people around and there's the normality *and* an abnormality. It's kind of surreal. It is surreal" (Violet)

She alluded to an incongruity in knowing that the virus exists and altering their daily lives to protect from it, while also seeing no evidence of the danger. It is clear that this early stage in the pandemic was particularly uncomfortable for participants.

Many participants had been busy with weekly hobbies and activities such as going to the gym and playing cards (Mary), learning the piano (Rose), singing in a choir and playing golf (Charlie), shopping (Betty), photography (Brian), volunteering (James) and playing music with friends (Stephen); all of these pursuits were halted due to the 'lockdown' restrictions. Several participants spoke about their previous routines as being supportive and protective factors for their wellbeing:

"overall that routine kept me feeling fit and well and in good form and I enjoyed the people I met" (Mary).

Likewise, there is a sense that participants lost all the important and enjoyable aspects of their lives when the stay-at-home orders were introduced. Betty notes that "Everything changed. Everything important", while Violet says:

"But now I can't see my grandchildren, I can't see my family, I can't do anything really" (Violet).

In this quote she repeats that she "can't", emphasising how limited she feels. She also moves from saying that she can't see grandchildren and family to the sweeping statement that she can't do anything, highlighting the magnitude of this loss of family for her.

Surplus to requirements

The centrality of social connection in the participants lives is clearly evident and the loss of this in a crisis of belonging and purpose. In many cases, this was associated with a shift in their own sense of identity.

As his wife's full-time carer, James described feeling lonely before the 'lockdown' was introduced but volunteering one day a week had provided him with a purpose outside of being his wife's carer. The shared experience and the relationships he had formed with the staff had given him a lifeline to the world outside his family and afforded him a strong sense of belonging:

"And you know there was a great gang there. You always had somebody [...] we were a very close-knit bunch. We were always having a good old chat. I used to look forward to that. It was my day out. It was fantastic social connection [...] That was like my little club really, you know. Other people might find it strange you know because it's a hospice but we used to have a great time there." (James).

The use of positive adjectives like "great", "close-knit", "good" and "fantastic" emphasise his fondness towards the group. He said it was "like my little club", the word little again suggesting a fondness and claiming it as his own also demonstrates the sense of belonging he experienced. This strong social connection appears to have also provided him with a purpose and a meaning in life, which was lost when the lockdown began.

Violet had been an active volunteer in various community projects prior to the lockdown, but when these activities ceased, she also experienced a deep loss of belonging to society as a whole:

“I'm surplus to requirements is what I'm saying. We're over 70 now and they no longer have volunteers over 65. We're not wanted, and we were doing huge work.”
(Violet).

This quote demonstrates her feeling of being unneeded and expendable to her community. This sudden loss of meaning has led to a feeling of being ostracised from society.

Although these kinds of activities were impacted for all age groups, the participants understood that, for their population, these activities may never return:

“I volunteered in a charity shop. Except I think I'm too old now so they won't take me back” (Sandra).

For many participants, this identification with an older age group was new and uncomfortable. Violet specifically described feeling that she had been “put into another generation”. The use of the word “put” here suggests that this was something done *to* her, against her will, and again there is a sense of being side-lined. For Violet, this appears to be dissonant with her own view of herself:

“I'm healthy and energetic, I'm very well trained and I have a lot to give, and nobody wants it. Nobody wants it” (Violet).

Many participants grappled with these changes, and it left them feeling unwanted, unneeded, and ostracised them from society. Although these social distancing measures were intended to protect vulnerable populations in society, participants experienced these restrictions as stigmatising:

“I feel people would look at me and think, you know, because you're older that you shouldn't be out either” (Sandra).

Instead of feeling cared for, the participants felt dismissed and left behind. The agony of this social exclusion is highlighted by Violet when she said:

“But I used to be part of family life and I'm outside the circle now. There's a huge divide now [...] I'm a social person. I need to belong. I need people” (Violet).

The language use here when she says “but I used to be” alludes to a sense of grappling with a harsh new reality. She appears to be struggling to make sense of the change, but it feels wrong to her. This is portrayed in her declarative and plaintive sentences “I'm a social person. I need to belong. I need people.” Violet's expression of grief at her loss of belonging is powerful and this experience of being suddenly on the outside is salient for many participants.

Connection at a distance

While the participants mourned the loss of belonging, they also tried to maintain some semblance of connection. James suggested that the physical barriers erected in supermarkets and shops had created an emotional distance between people. He noted that:

“they put up the barriers between the customers and the staff. And I used to always have the chat with them and you'd ask them ‘how are you’ and we'd be talking about things, maybe some of the kids making their communion and all the normal things of life. But you can't even do that now” (James).

Several participants made attempts to bridge this gap; Violet noted that she has “been talking to strangers in queues in Dunnes and places”; however, this distance appears to be associated with increased isolation and loneliness. James explained that now, he's so desperate for connection that “it's a small bit of a holiday” when someone does talk to him.

Rose said:

“And usually I loved that, when people would pass the garden and I would greet them and say just a few words. But all that changed. I was fearful to talk to people and I just stayed away” (Rose).

Rose has become frightened of people and has tried to avoid social contact, whereas before it was something she loved. This reveals a real change in emotional and behavioural response and suggests the extent of the impact the restrictions have had on participants' lives.

While participants experienced changes and losses in their social support, many still received some emotional and practical support from various people in their lives. For those who lived with a partner or child, they felt a sense of shared experience. Rose expressed gratitude that her daughter was living with her to help her:

“Thankfully my daughter is here with me. She's always helping me” (Rose).

This ability to help each other and share duties was found to be highly beneficial by participants. Brian spoke about “sharing” the cooking with his wife, there is a sense that they can rely on these people in their lives and there is a comfort in this.

Some experienced a strong connection with friends and family and demonstrated a faith in this emotional connection to withstand the physical distance:

“So apart from the actual physical presence of a person or going to the house or going on a trip, it has remained very much the same. I think that's important” (Stephen).

There is a quiet confidence in his words “it has remained very much the same” and this is clearly valued by him. Rose demonstrates a similar confidence in her close friendships:

“But even if we didn't stay in contact, even if we were to meet up after this madness, we wouldn't have to start again. We will go straight into something and this was built up over the years, we've such a good friendship” (Rose).

She also speaks about the impact these connections have had for her:

“My daughter came down and she gave me a lift. She brought out the best in me and I can tell you my grandchildren were laughing to see their grandmother dancing”

(Rose)

and many other participants prioritised maintaining these social bonds in any way they could.

Others, however, had less faith in the quality of their friendships and felt more isolated. Some experienced little emotional support from family and friends and this was experienced as particularly painful. The sense of being deliberately abandoned was particularly salient for Sandra as she had been experiencing turbulent relationships with family and friends prior to the lockdown. She appears to have interpreted the distance between her and her family and friends as being deliberate:

“then I just kind of thought ‘nobody ever really came to me’, I always go to them but nobody would call to me and you know, it was beginning to dawn on me that maybe they didn't want me.”

This simplicity in the phrase “maybe they didn’t want me” reveals a child-like understanding, as if the loss of this core need has left her exposed and vulnerable.

Charlie also felt alone in his distress and although he didn’t experience this isolation as deliberate on the part of others, he expressed a deep fear that if he expressed his needs, they would go unheard:

“essentially, I am very lonely and I'm sure people looking at me or talking to me or listening to me mightn't understand how- how awful, you know, how awfully lonely I am”

There is a hesitancy when he says “how- how awful, you know, how awfully lonely I am”, as if he is playing out his fear in vivo by expressing his loneliness to the researcher. He is

unwilling to “burden” people in his life with his emotional needs and so he remained silent in his loneliness.

Even when the emotional connection *was* present, the physical distance was difficult for many participants, and this too created loneliness. Sandra speaks to how the two physical metre distance feels much bigger:

“I never knew that two metres could create such a distance between people”

(Sandra).

Practical support was also offered by friends, family members and neighbours. Doing shopping for older adults seemed to be the most common practical support on offer.

Participants had mixed experiences with this help, however. Mary explained that although she felt “blessed” that her neighbours were doing her shopping, she also felt very much out of her “comfort zone [...] because [she] wouldn’t normally be asking other people to do that sort of thing for [her]”. She noted that it made her “uncomfortable” to be “dependent on other people for something so simple”. Sandra echoed this discomfort, explaining that her daughter “wouldn’t even get all the stuff that [she] ordered; she might give [her] something else or vegetables that were slightly gone off or milk that only had two days left”. She stated that she “just left like [she] should be in control of that” herself.

So while some expressed gratitude for this help, there was also a sense that participants didn’t want to need this kind of support:

“they certainly stepped up and took over and would have done more if I had needed them to, they were very, very kind. But I didn’t like having to live that way.” (Mary)

and:

“to have to rely on someone, and someone you don’t even know very well, to do something so basic as getting groceries... and it’s not like I was providing her with anything...” (Mary).

This sense of having nothing to offer in return bothered many participants.

The End, or a New Beginning?

Within the participants’ accounts of their experiences of the ‘lockdown’ restrictions can be seen two distinct attitudes to the changes brought about by the COVID-19 pandemic and the associated restrictions. All participants experienced a sudden and drastic change when lockdown was introduced, and all grieved the absence of what they felt was ‘normal’ life. However, for some, there was a sense of hopelessness, a feeling that there “was no way out” (Betty) and that this new way of life was permanent, while for others there remained hope that brighter days would follow, and that life could begin again after the restrictions were lifted.

The End of the World

While the purpose of the stay-at-home order was to keep older adults safe, many experienced their losses as a death of their life ‘before’:

“every avenue of activity and contact seemed to be cut off” (Mary).

Mary speaks to the sense that her resources had been taken from her. The use of the phrase “cut off” emphasises the violent, forceful nature of this loss. Many spoke with a sense of finality about the changes the lockdown had brought about and experienced little hope that the important aspects of life would ever fully return. The loss of meaning appears to be associated with feeling helpless and out of control. For many, this hopelessness stemmed from a sense of being disempowered by the government’s social distancing measures and stay-at-home orders:

“I didn’t like to feel so useless... and needy really I suppose. I felt powerless and useless” (Mary).

The repetition here highlights her desperate desire to communicate the magnitude of this feeling.

There was an ominous sense that COVID-19 had invaded the participants’ lives. Many spoke about how “no one has any news, it's only COVID, COVID, COVID [...] It's a non-stop drip with the pandemic” (Stephen) and James explained that:

“even watching programmes before would have given you something to talk about but the radio and the television are constantly talking about it. And there’s no getting away from it, you know” (James).

There is a sense that the COVID-19 virus felt inescapable to the participants. Betty captures this overwhelming and bleak sense of hopelessness in her repeated assertions:

“And it was like the end of the world to me. It really was. It felt like the end of the world” (Betty).

Participants no longer felt a sense of control over their own lives. Charlie notes that he “became very much controlled, whereas before this, [he] always felt like [he] was in control” and this is echoed across most of the participants’ accounts. Stephen states:

“There are aspects of my life that have been taken away, yeah, so it does affect your freedom. It has definitely affected my freedom, my independence, not feeling- in the sense of being allowed to do things” (Stephen).

This sense of not “being allowed” to do things created a feeling of being trapped and this too was alluded to by many participants. Rose stated that she felt “like [she] was an inmate in [her] own garden”, suggesting a sense of injustice to feel trapped in her own home, while Charlie likened the lockdown experience to being in “solitary confinement”

(Charlie). Capturing both the sense of being punished and encaged as well as impact of the sheer isolation.

This feeling of being trapped seems to have heightened participants' sense of helplessness. Rose's words provide a demonstration of her learned helplessness:

"That was really difficult. Helpless, helpless. Not being able to solve what you would hope you could."

For many, this sense that they were trapped and helpless went further, in that many felt as if they had been robbed. Violet said:

"I think I've been robbed [...] they're stealing the best part from us" (Violet)

And:

"that feeling of control was completely taken away" (Rose).

The use of the words "robbed" and "stealing" here suggests a deliberate and unjust act and this sense of injustice runs through many of the participants' accounts.

This experience of being unfairly controlled appeared to result in some participants creating the concept of an 'enemy', something or someone on which they could place their blame. While time is often considered a commodity, for the participants with little to fill their time, time became an enemy. Several participants spoke about time being something to defeat:

"That was it, my big problem: how was I going to pass the day, you know?"

(Betty)

and:

"I wake up in the morning and I think 'what's the point in getting up?'. If you sleep in, if you sleep 'til 11:00 o'clock then at least that's most of the morning gone anyway"

(Violet).

There is a sadness to Violet's positive framing of getting rid of the morning. Charlie echoes this when he alludes to how daunting the task of filling his day had become:

"I used to wake up in the morning and think about the fact that I had an empty day ahead of me" (Charlie).

This image of his day being empty, like a void, is powerful, and similar to others' experiences of having their daily lives stripped of their enjoyment and meaning. The use of the words "ahead of" him to describe his empty day further suggest that he is facing time as an adversary. Violet reveals this fear when she speaks about missing out on her grandchildren's formative years. She portrays an urgency when she says "I feel time is running out [...] And we could get sick and die next year and we've missed all that". She exposes a fear of her mortality, depicting it as something looming that could occur at any moment.

For Rose, the pandemic itself became an enemy. She blames the pandemic for her husband's worsening dementia:

"I feel that the pandemic has really worsened all of that, from the constant reminders and since the vaccine. I mean it could have happened anyway but after the vaccine, he had totally deteriorated" (Rose).

She seems to superficially admit that his symptoms may have worsened anyway but dismisses this quickly in favour of the view that the pandemic is to blame. She is ignoring the degenerative nature of dementia but this rigid view serves to allow her to place her blame and anger on something concrete.

Charlie focused much of his anger on young adults who he believed were not adhering to the restrictions:

"that annoys me. Myself? I was rigidly applying these restrictions as I should and then other people are not" (Charlie)

Betty appears to have internalised her family's attitude that she should 'get on with it' and seems to have become her own enemy. Although she experienced feelings of overwhelming anxiety, she invalidates and minimises her own experience. She demonises her own reaction saying:

"And I just didn't handle it that well. I made it all about the masks"

And:

"I made it all out to be massive [...] I blew it out of out of proportion really"

And:

"I say to myself 'boy, did you let yourself become so bogged down in such darkness!'"

She describes her behaviour in an almost child-like fashion, saying she'd "put it on and then [she'd] pull it off again".

These feelings of anger and resentment are evident across the participants' accounts and the creation of an 'enemy' in these examples may speak to the fact that there is nowhere else to direct these feelings. Each 'enemy' became something participants could focus their anger on and to blame for their uncertainty, fear and loss.

This narrative of being the helpless victim of a controlling enemy was a relatively rigidly held view for the participants. Their language became more black-and-white and emphatic when they spoke about this:

"I want to go out but then where would I go? Nowhere! I can't go anywhere"

(Sandra),

And:

"But you know the gym is closed, the choir has stopped, the golf is done, the matches are stopped" (Charlie).

The repetition here of “closed”, “stopped”, “done”, “stopped” offers an insight into how overwhelmed and limited Charlie felt by the restrictions. A learned helplessness appears to present here again. Indeed, those who maintained this view also seemed to abide more rigidly to the restrictions, holding an inflexible idea that adhering to the rules was the ‘correct’ thing to do, despite suffering from this rigid adherence.

Change what you can

Some participants demonstrated high levels of proactivity and creativity in finding ways to combat boredom and loneliness and regain a sense of control. Brian reported that he has started to:

“make CDs or burn CDs and then I send them to my family and friends. So that was an extra way I stayed in contact with people, by sending them cards and a CD of some of my favourite music” (Brian).

Violet also found different ways to feel connected to family during the lockdown restrictions:

“I spend my time, you know, popping into [the name of shop] and popping into [name of shop], and sending them parcels because that's the only way I can keep in touch with them, you know?” (Violet).

Many participants made attempts to regain control over their day-to-day lives:

“So I tried to restructure my day then in that I would do some sort of exercise in the morning and [...] once I got the treadmill going, even if it was a very wet day, I could say to myself ‘right well at least I've done, whatever it was, maybe 5000 steps or something so even if I don't get outside, you know, I've done something and I'm not being a couch potato’.”(Mary)

And:

“And I started painting again! I've done two paintings and I'm just starting a third one” (Brian)

Exercising some control seems to have resulted in a sense of agency for the participants and may have combatted feelings of being controlled and helpless. The impact of this reassertion of control can be seen again here in Stephen’s account of turning off the radio to avoid listening to further coverage of the COVID-19 pandemic:

“I would say ‘no I'm not listening to that, I've heard the headlines and that's enough for me” (Stephen).

Even asserting control over something simple such as not listening to the news allowed him to feel in control.

Light at the end of the tunnel

Some participants maintained the belief that, although they had experienced dark times, there was a light at the end of tunnel. Indeed some, like Betty, experienced a shift over time from a hopeless to a hopeful attitude. Despite initially repeating that the pandemic felt like the end of the world, she explained that at the time of the interview she could see the “light at the end of the tunnel”.

This optimism can also be seen in the way some participants saw the COVID-19 pandemic as a shared experience and felt that this had brought humanity closer:

“We're all in it together, in this. There's nobody exempt from it. It's a shared experience, that's it exactly, it's a shared experience. No matter what your creed is, or your stage in life, it all seem to be one. It has integrated people that way” (Rose)

This view that everyone is suffering together seemed to offer solace to the participants who recognised this. The power of social connection is demonstrated here again as there is a sense that as long as they feel connected to others, the pain is bearable.

Shifting perspective to the bigger picture appeared to be helpful for some. Stephen acknowledged that humans “have a very good way of putting things behind us”. There is a certain flexibility evident in this sense of hope here that the pandemic won’t last forever. Similarly, James explained that we need to accept “the good, the bad and the ugly”, noting that life is “a very much mixed bag”. James and Stephen demonstrate an ability to accept the present reality while not condoning or approving of it. Stephen explains that he thinks people should:

“go with the flow really. If you get a broken leg then you can't go walking around, you've got your leg in the cast so you might as well take up something that you can do. And that's been my attitude. It very much depends on how you look at it”
(Stephen).

He speaks to the benefits of accepting and adapting to challenges and changing one’s perspective.

Although the pandemic and the resulting restrictions had put an end to a certain way of life for the participants, many saw the potential for a new beginning. Mary noted that the changes had provided her with an opportunity to reappraise her life:

“I've found that I've had time to think about what I'm doing and what is enjoyable in my life”

and she had realised that she enjoyed the new routine:

“the new routine was slower and yes, certainly less rushed and not really as tied to time. And I enjoyed it”

The concept of there being light at the end of the tunnel was drawn on by several and both Violet and Brian spoke about the changing seasons and the new hope that spring

brings. Violet comments that the flowers she planted last year are coming up now, portraying an image of hope and new growth:

“But my tulips are coming out now and my daffodils are out and that's lovely. I can see buds coming out on things that I planted last year.”

Brian also uses nature to capture this sense that life is returning:

“The weeping willow and the horse chestnuts, they’re pretty well out now and the beach trees are coming and it’s lovely to see these on my ways. Maybe twice a week I’d bring my camera with me and photograph the development of the vegetation. And I do think I appreciate these changes more now because of the restrictions. I notice the beauty more.”

He observes that he has become more aware of the beauty around him and although the pandemic may have changed certain things in his life, there is a sense that life goes on.

Discussion

The older adults involved in this study experienced a sudden, unsettling, and dramatic change to their daily lives when the lockdown restrictions were introduced in late March 2020. The most prominent and painful loss across participants’ accounts was that of social connection. Even when participants lived with a spouse or one of their children, the experience of disconnection, loneliness and isolation was striking. For many, they felt ostracised from society, a feeling that is captured in Violet’s description of feeling “surplus to requirements”. The motivation to belong is a strong evolutionary drive and is central to human existence and a strong link between belongingness and mental health has been well established (Baumeister & Tice, 1990; O’Keeffe, 2013; McAdams & Bryant, 1987; Stebleton et al., 2014; Williamson et al., 2018). Social exclusion has been found to be linked with

anxiety (Baumeister & Tice, 1990) and belongingness has been found to be a protective factor against depression (Choenarom et al., 2005). For older adults who were experiencing mental health difficulties prior to the lockdown, this loss of belongingness may have been more detrimental.

Another important consideration is Erikson's (1968) theory of psychosocial development. According to this theory, at this stage in life older adults are seeking to reappraise their life with a sense of accomplishment and fulfilment and achieve ego integrity which is characterised by acceptance, feeling at peace and a sense of success. Factors that positively influence this stage of development are having supportive social connections and feeling a sense of belongingness (Erikson, 1968) and therefore for the participants, this may be complicated by the experience of a lack of belongingness.

Compounding this distress and associated with this seems to be the sense that participants are running out of time to spend with loved ones. The socioemotional selectivity theory (SST; Carstensen (1991) posits that as individuals get older, they perceive limitations on their remaining time which leads to a reorganisation of their goals, and in particular a prioritisation of emotionally meaningful goals such as social connection. At a time when older adults are seeking out increased emotional connection, the lockdown restrictions seems to have increased the felt distance between older adults and their loved ones. Although this loss of connection may have been felt by the general population, the SST outlines why this may have been more salient and painful for older adults.

The self-determination theory suggests that the three essential psychological needs for wellbeing are autonomy, competence, and relatedness (Ryan & Deci, 2017; Vansteenkiste et al., 2020). Throughout the participants' accounts, there is a sense that with the loss of belongingness and control in their day-to-day lives, they have also lost purpose

and meaning. There is evidence to suggest that satisfaction of these needs for autonomy, control, and relatedness is associated with wellbeing and negatively associated with anxiety and depression (Abolfathi Momtaz, 2014; Ferrand et al., 2015; Hahn & Oishi, 2006; Kasser & Ryan, 1999; Souesme et al., 2016) The participants appear to have experienced difficulties in getting these needs met during the lockdown, however.

A further important consideration is the experience of reciprocity. Although the participants experienced practical support in the form of family, friends and neighbours doing their shopping, the participants' experience of not being able to return this support was distressing. While participants expressed a gratitude towards family, friends and neighbours who offered practical support, their inability to reciprocate appears to have added to their sense of being side-lined and no longer belonging in society. This finding is supported by research into the role of reciprocity in older adults' relationships, as studies have shown that receiving support, without the ability to reciprocate, has been found to be less important to older adult well-being (Nemoto, 1998; Thomas, 2010).

While all participants experienced losses due to the lockdown restrictions, some felt a real sense of hopelessness that seemed to be associated with feelings of being controlled by the restrictions and feeling trapped and unable to escape exposure to the COVID-19 pandemic. Others found proactive and creative ways to stay in touch and regain control and agency which appeared to be associated with more optimistic and hopeful outlook. Research supports this finding as more proactive coping has been found to be associated with an increased sense of control and better psychological wellbeing (Dijkstra & Homan, 2016).

While the sample recruited was a clinical sample of older adults who had presented to an Older Adult Mental Health Service with symptoms of anxiety and depression in the

year prior to the lockdown, the participants rarely referred to how the lockdown had impacted upon their mental health difficulties. The impact the lockdown had had on their social world and their sense of purpose and meaning appeared to be more salient for them.

Clinical implications

The present study is the first of its kind to explore the lockdown experiences of older adults with pre-existing mental health difficulties. As IPA is an idiographic approach, the findings are not representative of all older adults with pre-existing mental health difficulties and are not generalisable to all age groups. The findings do contribute to the body of knowledge about how the COVID-19 pandemic and associated social distancing measures and stay-at-home orders were experienced by older adults and people with mental health difficulties. Clinicians working with older adults with mental health difficulties during future lockdowns are encouraged to consider the insights offered by the present study.

It would be important for clinicians to acknowledge the importance of emotional connection to older adults and the impact the loss of this can have on their mental wellbeing. Prioritising ways to promote emotional connection and belongingness could be beneficial in interventions aimed to improve older adult wellbeing during future lockdowns. Developing new ways of communication such as using technology to encourage social engagement could be effective in increasing feelings of belonging and reducing loneliness. Smartphone use has been linked to decreased loneliness and increased ego integrity (Kim et al., 2020).

Existential therapy places an emphasis on universally experienced concepts including death, belongingness, loss, and meaning and purpose in life (Iacovou & Weixel-Dixon, 2015). As many of these issues, particularly belongingness and meaning in life, appear to be central to the participants' experience of the COVID-19 pandemic, interventions informed by

existential therapy may reduce distress among this population. Moreover, as existential therapy tends to view anxiety and depression not as disorders but as natural stages in a normal process of development, it may uniquely lend itself to contextualising and validating these individuals' experiences.

Acceptance and commitment therapy (ACT) informed interventions have been shown to be beneficial for older adults (Wetherell et al., 2011). ACT'S emphasis on acceptance may encourage older adults to accept the changes brought about by lockdown; for those who experienced the COVID-19 pandemic as an ending, this approach could encourage cognitive flexibility (Wilson et al., 2003) and reframing this perspective as a new beginning. ACT also focuses on identifying and living by individual values and therefore may allow this population to cultivate meaning and purpose in their lives amid the challenges brought about by COVID-19.

Use of timelines with older adult clients with an emphasis on the impact of such social distancing measures could also help them to achieve validation for their experiences and a sense of ego integrity. A cognitive behaviour therapy approach could allow older adults to develop skills such as cognitive reframing, a skill some of the participants appear to have found beneficial. Behavioural activation could also improve older adults' sense of agency and competence which could in turn lead to better mental health outcomes. A compassion-focused therapy approach could also improve their ability to self-validate and experience of self-compassion during such a stressful time.

Limitations

The results of the present study should be considered in the context of the study's limitations. The inclusion criteria for the study required that participants not be experiencing severe levels of depression including suicidal ideation and intent. This was to

minimise the impact of any distress caused by taking part in the study. The inclusion criteria also required participants to be attending the Older Adult Mental Health Services.

Therefore, the sample is not representative of all older adults with anxiety and depression and the experiences of older adults with more severe levels of suppressive symptoms and those not attending mental health services may be different.

Despite attempts to achieve homogeneity, the sample included both older adults who lived alone and those who lived with spouses or children. It also included two participants who were caring for spouses with dementia. These factors may have resulted in variations in their experiences of the lockdown restrictions.

Future directions

This study recruited both older adults living with a spouse and those living alone; two of the sample were carers for spouses with dementia. Future research could focus solely on the experiences of carers and of those living alone separately. Findings indicate that belongingness and social connection were important aspects of older adults' experiences of lockdown. It was beyond the scope of the current study to explore family members perspectives of these relationships. A multi-perspective IPA study could provide further insight into these relationships.

Conclusion

The present study aimed to explore how older adults with pre-existing anxiety and depression experienced and understood the COVID-19 lockdown restrictions. These measures, while intended to protect older adults, appear to be detrimental to their wellbeing and mental health. Findings indicate that older adults experienced a loss of social connection and a feeling of ostracization from society. Furthermore, many felt a sense of urgency that their time was running out and felt that they had little control over the

important aspects of their lives. Despite the extensive loss and change brought about by the pandemic, some reported a sense of hope that the future would be brighter.

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Chapter Five: Major Research Project Extended Methodology

Overview

This chapter provides additional information about the research design, sampling and recruitment, data collection and analysis, ethical considerations, and quality assurance. It also offers reflections on the process of conducting the research. It provides a description of some of the ways I engaged with reflexivity throughout the research process and as the research was conceived, conducted, and written during the COVID-19 pandemic, the impact of this is considered.

Research Design

Interpretative Phenomenological Analysis

Interpretative Phenomenological Analysis (IPA) is a qualitative approach which aims to present a comprehensive examination of individual lived experience. It's a methodology that offers insights into how people make sense of a specific experiences. The aim of IPA is to provide an interpretation of lived experience in its own terms rather than one informed by existing theoretical frameworks (Smith et al., 2009). IPA is informed by ideas from the philosophical concepts of phenomenology, hermeneutics, and idiography (Smith & Shinebourne, 2012).

Phenomenology is the philosophical study of experiences. Husserl, the father of phenomenology, states that it is concerned with understanding how an individual develops an accurate understanding of their own experience. Husserl argued that if the essential qualities of an experience could be identified, these qualities would allow us to draw conclusions from the particular that could be applied to the general (Smith et al., 2009). Phenomenology holds that although lived experience is always embodied and

contextualised and therefore can never completely be captured, the pursuit of this experience is an important and worthwhile endeavour (Smith & Shinebourne, 2012).

Husserl encouraged the act of stepping outside our everyday experience and ‘bracketing’ or putting to the side any preconceived notions. An IPA researcher therefore needs to set aside any biases and concepts that are taken for granted, in an attempt to capture and describe the essence of another’s experience (Smith & Shinebourne, 2012). This was something I strived to achieve throughout the research process through use of a reflexive journal as well as supervision (for more information, see Subjectivity and Reflexivity section). The philosophers, Heidegger and Gadamer, propose that because interpretation inevitably elicits assumptions, the interpretative process should be allowed to influence the researcher’s assumptions, which then in turn will influence the understanding of the experience. The concept of bracketing in IPA is therefore considered to be an iterative, cyclical process. This was also my experience as during the data analysis stage, I identified certain assumptions that had been brought to light by the data, of which I had previously not been aware.

As IPA is an interpretative approach, it is also informed by hermeneutics, which is the study of interpretation. The concept of the hermeneutic circle is integral to IPA. I endeavoured to engage fully with the hermeneutic circle in my attempts to keep in mind the dynamic relationship between the individual ‘parts’ of a participant’s experience and the experience as a ‘whole’. This process was circular, as an understanding of the whole was dependent on an understanding of the individual parts and correspondingly, to understand the parts, I needed to look to the whole. Indeed, the relationship between me and the data continued to change and shift throughout the analysis and write-up, as Smith et al. (2009) point out, interpretation can be made on a number of different levels, all of which relate to

each other and offer different perspectives on the part-whole coherence of the phenomenon.

IPA also shares with hermeneutics the stance that human beings are essentially sense-making and any account of lived experience will inevitably be reflective of their own attempts to understand their experience (Smith & Shinebourne, 2012). Any understanding of another's experience is therefore always dependent on how the individual understands the experience and what they tell us about it (Smith & Shinebourne, 2012); my job was to interpret the participants' account to in order to understand their experience. I found myself engaged in a *double hermeneutic*, a concept outlined by Smith et al. (2009) which involved my attempts to make sense of the participants attempts to make sense of their experience.

Finally, central to IPA is the idiographic approach. Unlike nomothetic research which aims to make claims at the group or population level, idiographic research is committed to making sense of the depth and detail in analysis. The detail of the individual account can bring us closer to important aspects of the universal (Smith et al., 2009). I endeavoured to remain loyal to this approach by immersing myself fully in each participant's account, affording each my full attention and commitment, before moving on to analyse the next transcript. This was a time-consuming process but was necessary to ensure that each participants' experience was captured in enough detail to remain true to the idiographic approach as well as to allow me to examine convergence and divergence across the sample. As Smith et al. (2009) point out, an IPA researcher also aims to bridge the gap between a comprehensive analysis and the extant psychological literature to offer an insight into how the individual experience can be understood in terms of the nomothetic research.

Rationale for Methodology

As the lead researcher, my theoretical orientation in relation to the current study is one of constructivism. Constructivism holds that human experience is created by each individual and is socially constructed; that is, individuals create what they know based on their own experiences. Truth is therefore a result of perspective (Savin-Baden & Howell-Major, 2013). In keeping with this epistemological position, I aimed to explore individually constructed meanings and to understand how these meanings were constructed. The primary research question reflected this constructivist stance as its aim was to understand the individual experiences of older adults with anxiety and depression during the lockdown restrictions. A qualitative approach was considered to be the most appropriate methodology for this enquiry due to its subjective and personal orientation, its acknowledgment of multiple constructed realities, as well as its focus on the perspectives, perceptions, meanings and interpretations of individuals (Savin-Baden & Howell-Major, 2013).

In choosing a qualitative method, Grounded Theory (GT) was considered as a potential approach. GT is an approach that involves hypothesising from the data to produce a theory that explains the phenomenon in question (Strauss & Corbin, 1997). However, the aim of the current study was not to generate an explanatory theory of the lockdown experiences of older adults with anxiety and depression, but to describe and explore these experiences and the ways in which participants made sense of these experiences. Thematic Analysis (TA) was also considered as a method of data analysis. TA identifies, organises, and offers insights into patterns, or themes, of meaning (Braun & Clarke, 2012). However, TA focuses on meaning across a data set, emphasising collective or shared meanings and experiences (Braun & Clarke, 2012). The current study aimed to identify and explore unique and idiosyncratic meanings and experiences as well as detecting commonalities.

IPA, as an idiographic, qualitative approach dedicated to examining how individuals make sense of experiences, was considered the most appropriate methodological framework. IPA also attempts to establish links between the participants' understandings and interpretations and the theoretical frameworks of psychology (Smith et al., 2009). As the lockdown experiences of older adults with pre-existing anxiety and depression were considered likely to be relatively complex, ambiguous and emotionally-laden, IPA was an appropriate choice of methodology (Smith et al., 2009). Furthermore, as the COVID-19 pandemic was a novel event, it was important to capture the essence of the lived experience of the participants ideographically and in their own terms.

Sampling

Participants were recruited through purposive sampling which involves identifying and selecting individuals that have experience of the phenomenon of interest (Creswell & Clark, 2017). It is a technique that maximises the selection of information-rich cases for the most effective use of resources (Patton, 2014). It also ensures the inclusion of participants who are willing and able to express and reflect upon their experiences and opinions (Bernard, 2002).

The following inclusion criteria were applied in the present study:

- Participants must have been aged 65 years and over.
- Participants could identify as any gender.
- Participants must have presented to the Older Adult Mental Health Services with symptoms of both anxiety and depression in the year prior to the onset of the COVID-19 pandemic.
- Participants must have had no cognitive impairments, significant physical disabilities, or be experiencing symptoms of psychosis.

- Participants must not have been currently experiencing severe levels of depression that included active suicidal intent.

As the inclusion criteria specify that participants should be older adults who have no cognitive impairments, symptoms of psychosis or active suicidal intent, capacity to consent was assumed for individuals eligible to participate.

As the COVID-19 pandemic and lockdown restrictions were on-going at the time of data collection, the topic was salient and sensitive and had the potential to induce distress during participation. Participants were required to be open and active clients of the Older Adult Mental Health Team and were excluded if they were experiencing severe levels of depression that included suicidal intent. These criteria were chosen in order to minimise the potential risk of distress for the participants and to reduce the impact of any distress experienced.

IPA studies usually involve small sample sizes and an emphasis on achieving homogeneity across the sample is prioritised (Smith et al, 2009). Establishing this homogeneity is important so that the researcher can engage in a detailed examination of the convergence and divergence within the sample (Smith et al, 2009). The specificity of how the sample is defined will vary across studies and as Smith et al. (2009) suggest, decisions about homogeneity are often made for practical reasons such as how easily the population will be contacted and recruited. Initially it was decided to recruit only older adults who were living alone during the COVID-19 pandemic; however, due to recruitment difficulties, and after consultation with the academic and clinical supervisors, the inclusion criteria were expanded to include older adults living with a spouse or offspring also.

The current study recruited nine participants, allowing for a detailed and comprehensive analysis of each account while also providing enough data to attend to

convergence and divergence across the data set. Smith et al. (2009) have suggested that a sample of between four and ten participants is suitable for professional doctorate studies. As the aims of this study was not to generate theory, theoretical saturation was not considered (Pietkiewicz & Smith, 2014).

Recruitment

Participants were recruited through the Older Adult Mental Health Services in the Cork and Kerry region. The third author (JW), a senior clinical psychologist in the Older Adult Mental Health Service, as well as other mental health professionals in these services identified potential participants using the inclusion criteria. These individuals were then made aware of the study. The information sheet and consent form (Appendix E) was given to these individuals at this stage, and they were advised to contact me if interested in taking part. My contact details were provided in the information sheet. When these potential participants contacted me by phone, verbal informed consent was obtained. Participants also provided written informed consent by signing the consent form and returning this to the primary researcher.

Data Collection

Method

As Smith et al. (2009) attest, IPA works best with methods of data gathering that provide rich, detailed accounts of lived experience, and therefore the use of in-depth interviews is highly appropriate. The goal is to facilitate the participants to speak freely and reflectively while eliciting stories, thoughts, and feelings about their experiences (Smith et al., 2009). Highly structured interviews do not offer the same space for reflection and as such, individual, semi-structured interviews were selected as the most appropriate method of data collection for the present study.

Interview Schedule

Following a consultation with the academic and clinical supervisors, a semi-structured interview comprising 10 open-ended questions was developed (Appendix G). My goal was to come at the research questions ‘sideways’ as Smith et al. (2009) recommends, and I developed the interview schedule with the aim of facilitating a discussion that would answer the research questions.

I choose open-ended questions that made no assumptions about what participants experiences had been like. As Smith et al. (2009) point out, people are not used to being asked for detailed, comprehensive reflections on their experiences and therefore need some encouragement to engage in deeper discourse. I started with the question ‘could you tell me a bit about what life was like before the lockdown?’ as a ‘scene-setting’ question (Smith et al., 2009); it was hoped that as this question would allow the participants to recount their experience and allow them to get used to talking before moving on to the more sensitive topics. The next question in the schedule was ‘when the lockdown started, did anything about your day-to-day life change?’, the wording of this question was chosen to avoid any assumptions that the participants did experience change and leave room for the possibility that nothing about their lives changed. The questions then moved on to ask about any changes to their relationships and mood. The questions also sought to elicit information on participants’ understanding of the restrictions and how they made sense of the impact the restrictions had had on their lives. Possible prompts for each question were developed for use if participants didn’t understand what was being asked.

The semi-structured schedule served as a guide during the interviews, while also allowing the researcher to pursue any relevant concepts introduced by the participants that had not been anticipated. Smith et al. (2009) emphasises that a good interview schedule is

merely a guide and regardless of the schedule, the researcher must engage deeply with the participants and their concerns in order to generate data rich enough for analysis. They explain that both interviewer and interviewee should be active participants in the process and suggest that often the “unexpected turns” (p. 58) offer the most valuable data (Smith et al., 2009). I allowed participants to guide the interview and did not stick rigidly to the order of questions in the schedule, allowing participants to lead the conversation. I omitted certain questions if they appeared irrelevant to the individual’s experience.

Procedure

As previously mentioned, participants contacted me by phone to express interest in taking part in the research and at this stage I outlined the information on the information sheet and used this conversation to build rapport (for more information, see *Conducting Research During the COVID-19 Pandemic*, Data Collection below). At the beginning of each interview, I began by introducing myself as researcher and also outlining my role as a trainee clinical psychologist. The information sheet was then reviewed, and informed consent confirmed. Participants were advised that that I would be asking questions about their lockdown experiences and explained that I was interested in their own experiences, opinions, and feelings about the lockdown restrictions. The distress protocol (detailed below) was outlined, and participants were encouraged to seek clarification for anything they were unsure of.

The interviews ranged in length from 33 minutes to 66 minutes, with an average duration of 52 minutes. All interviews were audio-recorded and then transcribed verbatim.

Data Analysis

The data were analysed in adherence to the steps outlined in Smith et al. (2009). However, as IPA is an iterative process, I moved back and forth between the steps, considering aspects

of the data from different perspectives, rather than completing each step, one after the other.

Step One

The first step of the analysis began with at my attempt to immerse myself in the original data; this involved listening to the audio-recording of the first interview several times, transcribing the interview, and then reading and rereading the transcript. During this stage, I also employed ‘free coding’, which involved using a clean copy of the transcript and documenting all emotional reactions, images, metaphors, and ideas provoked by the data (Larkin & Thompson; 2012). The aim of ‘free coding’ is to capture initial responses to the data in order to ‘bracket’ these off and proceed with a more systematic and consistent focus (Larkin & Thompson; 2012). ‘Free coding’ can act as a method of slowing down the “habitual, propensity for ‘quick and dirty’ reduction and synopsis” (p. 82; Smith et al., 2009).

Step Two

The second step involves initial noting. This step in the analysis is the most detailed and time-consuming (Smith et al., 2009). At this stage, I began examining the semantic content and language use of the data, making note of pronoun use, pauses, repetition, and degree of fluency. Descriptive comments were also made, using key words and phrases to capture the objects, events, and experiences most salient for the participant. Conceptual comments were also noted; these were more interpretative and involved an interrogation of the data to achieve a detailed overview of the participant’s experience. An example of initial noting can be seen along with emergent themes in Appendix H.

Step Three

At this stage, I had accrued a large data set of notes and now needed to condense this data without losing the depth and complexity. This was achieved through the development of

emergent themes. This step involved a shift from working with the transcript itself to working primarily with the initial notes. The hermeneutic circle was evident here, as I began to break up the narrative flow of the interview and re-organise the data. The whole interview becomes fragmented into a set of parts which then form a new whole at the end of analysis (Smith et al., 2009).

A variety of approaches were used to identify patterns and connections between emergent themes. Abstraction involved identifying patterns between themes by putting similar notes together and developing a 'super-ordinate' theme. Subsumption was also used which is when an emergent theme acquires super-ordinate status as it draws together several related themes. Contextualization involved identifying contextual elements within a narrative.

Step Four

The emergent themes were then organised into super-ordinate themes; some themes were discarded at this stage while others were combined to form new themes. An example of the development of emergent and super-ordinate themes can be seen in Appendix I. I created a table of the structure of the emergent themes with accompanying extracts from the transcripts; I also created a table of themes across transcripts (Appendix J).

Step Five

This step involved moving to the next participant's transcript and repeating the process. Each additional transcript was treated in its own terms which involved bracketing off ideas from the previously analysed transcripts, maintaining IPA's idiographic commitment.

Step Six

Once all transcripts had been analysed, the next stage involved identifying patterns of convergence and divergence across all transcripts. At this stage some themes were

reconfigured and relabelled. To achieve this, I printed out a table of themes for each participant, cut out each theme and using a large surface, moved them around seeking patterns and connections. I questioned how themes might add to, or impact upon each other. At this stage, there was a focus on themes that were particularly relevant to the research questions and some themes were discarded as they were not directly pertinent to the experiences of lockdown. To facilitate the development of super-ordinate themes, themes that seemed to cluster together were colour coded.

At this stage, I had generated six themes organised under three super-ordinate themes. I utilised supervision with both my clinical and academic supervisors to discuss the theme development and from discussion, I realised that the importance of social connection could be seen across all subthemes, but this was not being captured appropriately and was perhaps getting lost within the current themes. I then reorganised the themes to capture the importance of the social experience, generating instead two superordinate themes, with six subthemes. A table of themes was then devised, displaying superordinate and sub-themes with examples from each participant.

Step Seven

The final step in the process was the write-up. I moved straight from step six to step seven as this is recommended to maintain momentum (Smith et al., 2009). As with IPA, analysis continued into the write-up phase as I deepened my interpretations of themes and identified gaps in my understanding throughout this stage.

Ethical Considerations

Ethical Approval

Ethical approval was applied for and granted by University College Cork (UCC) Clinical Psychology Research Ethics Committee (Appendix F). A Data Protection Impact Assessment

(DPIA) was also conducted to minimise the data protection risks of the study. Through the DPIA, UCC identified any potential privacy issues before they arose, and supported the lead researcher in devising a plan to mitigate them.

Informed Consent

Participants were provided with an information sheet before the interviews and this information was reviewed at the start of each interview. Participants were encouraged to ask questions and seek clarification regarding anything they were unsure of. Written informed consent was obtained from all participants.

Anonymity

The transcripts were pseudonymised, with identifying information removed.

Participants Wellbeing and Distress Protocol

Given the sensitive nature of the topic, attempts were made to minimise the risk of participants experiencing distress during the interviews or as a result of taking part in the research study. As outlined above, participants were excluded if they were experiencing severe levels of depression including suicidal intent; this was to minimise the impact any distress caused. Participants also had to be in attendance of the Older Adult Mental Health Services in order to be eligible to take part; this ensured that they were receiving ongoing support. A distress protocol was devised to for managing distress:

- **Stage 1 – Response:** Stop the interview and offer support. Assess mental status: Tell me what thoughts you are having? Tell me what you are feeling right now? Do you feel you are able to go on about your day? Do you feel safe?
- **Stage 2 – Review:** Encourage the participant to contact a member of the Older Adult Mental Health Team OR offer, with participant consent, for the lead researcher to do so.

- **Stage 3 – Follow-up:** Follow participant up with courtesy call (if participant consents)

As a trainee clinical psychologist, I have experience identifying and responding to emotional distress. Throughout the interviews, I monitored participants' answers and tones of voice for any signs of distress. At the end of each interview, each participant was asked about their emotional state. No participants reported feeling distressed.

Limits of Confidentiality

As a trainee clinical psychologist, I am a mandated person under the Children First Act. I am therefore required to report any disclosures of child abuse and neglect (Department of Children and Youth Affairs, 2017). Participants were advised verbally and in the information sheet of that although all information provided would be treated as confidential and anonymized as far as possible, an exception to this confidentiality would be made if information was disclosed which indicated that there was a serious risk to the participants or to others. Participants were made aware that if risk was identified, I would inform the Older Adult Mental Health Team of this. In this instance, every effort would be made to discuss this with the participant first, and if possible, to encourage the participant to be involved in the process of reporting the identified risk.

Validity and Quality Assurance

Yardley's (2000) criteria for the assessment of quality in qualitative research informed the data collection, analysis, and write-up. Yardley's first principle is *sensitivity to context*. Yardley (2000) argues that the context of a qualitative study is multifaceted and suggests that all contexts warrant equal consideration by researchers. While quantitative investigations rely on standardised measurement and random sampling to ensure what Johnson (1997) refers to as "horizontal generalisation", qualitative studies seek instead to build theory, linking the particular to the abstract and to the existing theory and

understanding. For this reason, it is particularly important for qualitative researchers to ground their approach in the philosophy of the methodology and the theoretical context. This theoretical sensitivity began in the early stages of the research process by extensive grounding in the philosophical foundations and methodological features of IPA. IPA was chosen as the methodology for this study due to the identified need for an idiographic approach to explore the participants' lived experiences and their attempts to make meaning of these. It was also important to maintain a sensitivity to sociocultural factors; the small and relatively homogenous sample size lent itself well to this endeavour as I was able to devote ample time and resources to immerse myself in the personal, social, and cultural experiences of each participant. Sensitivity to the idiographic, raw material is evidenced in the considerable use of verbatim extracts to capture and display the participants' voice throughout. I also used the practice of reflexivity to maintain cognisance of my own involvement in the process and the relationship between me and the participants, and the data (see Subjectivity and Reflexivity below). This sensitivity to context continued through the analytic process, as the results of the present study were also considered within the framework of established psychological theories and relevant existing literature.

The second criterion outlined by Yardley (2000) is *commitment and rigour* referring to the thoroughness of data collection, analysis, and reporting. I demonstrated commitment to the process by a prolonged engagement with the topic. I engaged with the subject both as a researcher in my perusing the relevant literature, but also as a clinician in my work with older adults throughout the COVID-19 pandemic. I developed competency in utilising IPA through the use of workshops, reflecting on past research experience utilising IPA and building on my experience and understanding of the methodology. Rigour was achieved through developing a comprehensive but flexible interview schedule and conducting in-

depth interviews, allowing the participants to lead the interviews and offering them the space to express and explore their experiences. Rigour also involves a sufficiently interpretative analysis of the data (Yardley, 2000). Smith et al. (2009) warn that a common pitfall of novice IPA researchers is to be too descriptive and not interpretative enough in their analysis of the data. I therefore dedicated ample time to immerse myself in each participants' account, slowly and carefully reading the transcripts, documenting my reflections on my own opinions, reactions and perceptions of the data, and careful attention to the descriptive, linguistic and conceptual aspects of the data.

Transparency and coherence, Yardley's (2000) third principle refers to the clarity and persuasiveness of the analysis and findings. This was achieved by a detailed description of the methodology including full descriptions of how participants were selected, how the interview schedule was developed and what steps were used in analysis. The interview schedule as well as samples of initial notes and emergent themes are provided to enhance transparency. The use of supervision helped to ensure coherency through discussion of how the themes relate to one another and to identify any ambiguities and inconsistencies within the data and analysis.

Yardley's final criterion is *impact and importance* and relates to the influence and utility of the research. Yardley (2000) argues that it is not enough to produce sensitive, thorough, and plausible analyses if they offer no theoretical or clinical value. The current study captures the experience of a vulnerable population during the novel COVID-19 pandemic. It is the first qualitative study to explore these experiences with this population and offers findings that contribute to the existing body of research as well as have implications for clinicians working with older adults in the aftermath of the COVID-19

restrictions and in potential future epidemics or pandemics that require similar lockdown measures.

The use of supervision enhanced the validity of the study throughout the research process. For quality assurance purposes, my academic supervisor reviewed and critiqued the analysis of a sample of transcripts. The development of emergent and super-ordinate themes was also discussed with both my academic and clinical supervisors to ensure credibility and congruence of the analysis (Smith et al., 2009).

Subjectivity and Reflexivity

Qualitative research is a subjective endeavour and IPA in particular is inherently idiosyncratic and interpretative in nature. As such, reflexivity is an essential element in qualitative research as a method of reducing bias and for quality assurance purposes (Savin-Baden & Major, 2013). Reflexivity characteristically involves identifying researcher positionality, which refers to the researcher's world view. The researcher's world view, their beliefs, values, and assumptions, is informed by aspects of their life experience including gender identity, sexual orientation, ethnicity, race, religious beliefs, political allegiance, historical and geographical location, and socioeconomic status. Positionality influences the entire research process and reflexivity aims to recognise the aspects of the researcher's position in relation to the research that may have inadvertently influenced the study design, data collection and analysis (Savin-Baden & Major, 2013).

At the outset of the project, I began a reflexive journal in which I documented the thoughts, feelings, opinions, assumptions, and judgements I identified in relation to the research. Moustakas (1990) points out that even in the earliest stages of the research process, the researcher should be engaging in reflexivity. He attests that when forming the research question, the task is to discover an "intense interest, a passionate concern that

calls out to the researcher” (p. 27; Moustakas, 1990). The research topic was chosen, and the research questions developed during the initial few months of the COVID-19 pandemic. My interest in the area was shaped in part by my recent experience of conducting research with older adults during my first year of the Doctorate in Clinical Psychology. I was acutely aware of how under-represented older adults often are in research (Veronese et al., 2021) and considered it important to capture this population’s voice in the unusual phenomenon of the COVID-19 pandemic. My interest also stemmed from my work with two older adult clients in my placement on an adult mental health team. At the time of choosing a research project, I was working with two older adult clients who were struggling with the uncertainty brought about by the pandemic. While I acknowledged that my experiences lead to a passion for the topic, I was also aware of the assumption that the COVID-19 pandemic was challenging and distressing older adults. The following extract from my reflexive journal demonstrates my consideration of this assumption:

My interest in the area undoubtedly comes from my work with [name of client 1] and [name of client 2] who have struggled considerably with the lockdown restrictions. I notice a heightened empathy for older adults who have been told to ‘cocoon’ and are fearful of doing their own shopping because of these clients experiences. I also feel some anxiety about the pandemic and dislike the restrictions and their impact on my personal and social life. I am assuming that most people will be experiencing similar feelings and that older adults will be particularly distressed. Is this my implicit assumption that the lockdown restrictions are difficult for everyone because they are for me and have been for my clients? I need to be mindful that some people may have positive experiences of lockdown. Research question and data collection need to allow for all experiences to be captured. I don’t

want to bias my findings with an implicit assumption that these restrictions are challenging.

I also raised this concern with my clinical and academic supervisors; we discussed the possible spectrum of experiences and explored how best to phrase the questions to allow for both positive and negative experiences to be captured. These reflections were also particularly important when developing the interview schedule. I used the question ‘when the lockdown started, did anything about your day-to-day life change?’ rather than assume change had occurred. I encouraged participants to consider how their experiences compared with their life before lockdown started, again in an attempt to avoid swaying participants to discuss positive or negative experiences. I also included a more closed question: ‘are there any benefits to the lockdown restrictions?’. This was used to encourage the participants themselves to challenge potential assumptions that the restrictions were inherently negative.

During the data collection stage, I engaged with intersubjective reflection (Finlay, 2002) as part of my reflexivity. Finlay (2002) describes this as an exploration of the mutual meanings within the researcher relationships, between the researcher and the participants. At the time of conducting the interviews, the participants were relatively vulnerable and socially isolated, to varying degrees, as Ireland was in its most stringent level of lockdown restrictions. I reflected on my dual roles as doctoral researcher affiliated with University College Cork as well as trainee clinical psychologist working with the Health Service Executive. I acknowledged that these roles may have afforded me the status of ‘professional’ with assumed authority as well as ‘clinician’ with experience of working with mental health difficulties and the qualities of empathy, compassion, and patience. I acknowledged that this may have encouraged participants to openly discuss their thoughts,

feelings and experiences and may have contributed to the generation of rich, detailed interviews.

On the other hand, it was tricky navigating the dual roles of researcher and clinician. During the first interview, I noticed that my natural response to participants' accounts was to validate and reflect back their experiences. In clinical practice, these are useful tools to help clients to regulate their emotions and make sense of their experiences, however, in IPA Smith et al. (2009) warn against any kind of interpretation during the interview process. Based on these reflections, I chose more neutral responses such as "could you say more about that?" to avoid influencing the flow of participants' accounts. Having implemented these changes in my interview style, I noticed a worry that without these validating and supporting comments, I may appear cold and unsupportive to the participants during the interviews. I considered how, as mental health service users, participants may have had an expectation of how a trainee psychologist would interact with them and. I had also already built some rapport prior to the interview in the initial telephone contact, and I was conscious that my style of engagement may be seem formal and unusual to them. Acknowledging these concerns, I spoke to my academic supervisor and decided to outline this at the outset of the interview. I explained to participants that the interview would be like a one-sided conversation.

Reflexivity was also important when analysing the data. Finlay (2002) emphasises the importance of introspection as part of the data analysis. The hermeneutic circle is evident here when researchers' reflections provide information regarding the social and emotional world of the participants and thus these reflections help the researcher make sense of the participants' attempts to make sense of their experience (Finlay, 2002). The following extract outlines an experience of this introspection informing the analysis:

Analysing transcript: Charlie expresses anger at young people and students who he believes have not been adhering to the restrictions. As I am a student and would probably qualify as a young person in relation to Charlie, I notice my own anger here. I have experienced my own distress due to the lockdown restrictions and resent the generalisation that all young people are flouting the restrictions. I notice the thought that older adults have little understanding of what it's like to be a young person in the current economic and environmentally unstable climate. I immediately realise that I am engaging in an 'us and them' narrative, similar to Charlie's comments. In considering how it is often more comfortable to have someone or something to blame, I realise that Charlie may also be creating an enemy of young people as a means of directing his fear and anger towards something more tangible than the virus or the restrictions.

This extract demonstrates how my own reflections on my own reaction to the data illuminated the participant's experience. As Finlay (2002) suggests, my reflections acted as a "springboard" for the interpretation and added a deeper understanding of the participant's experience.

Throughout the research process, I was aware of my age in relation to the participants. Underwood et al. (2010) discuss how age is an important factor in the relationship between research researcher and participants. I am young enough to be the participants granddaughter and have a limited understanding of what life was like growing up during the 40s, 50s and 60s in Ireland. I acknowledged that many of my life experiences likely differ greatly from that of the participants. I considered how the discourse around mental health has changed significantly over the years; conversations about mental health difficulties have become normal and acceptable and it is common for young people to

recognise and speak about their thought and feelings. However, this was not the case when the participants were growing up. I considered how participants might feel at being asked to discuss these internal, mental experiences. In order to ease the participants into speaking about the more sensitive aspects of their lockdown experiences, I began the interview with an invitation to tell me about their life before lockdown. It was hoped that this would allow participants to get used to talking in the interview before being asked to discuss potentially more difficult topics. At the end of the interviews, many of the participants commented that they were appreciative of the opportunity to talk and stated that they had found me easy to talk to. Reflecting on my age and how it may have impacted upon my engagement with the research, I acknowledged that my position as a younger adult had partly informed my initial assumption that the lockdown restrictions would be particularly challenging for older adults. This assumption had resulted in a certain sensitivity to and a passion for capturing older adults' experiences. This passion and empathy may have come across in the interview and helped the participants to speak about their experiences.

Conducting Research During the COVID-19 Pandemic

The World Health Organisation (2020) announced a global pandemic of the COVID-19 virus in January 2020; I was five months into my first year on the Doctor of Clinical Psychology course and just starting to think about potential topics for my systematic review and major research project. The COVID-19 pandemic became the foundation of this project as the systematic review explored factors associated with psychological distress in older adults during the COVID-19 pandemic and the major research project explored how older adults with mental health difficulties experienced the COVID-19 lockdown restrictions. As well as its topical relevance to the research, the COVID-19 pandemic also significantly impacted the research process. In this section, I present some of the challenges I experienced in

conducting research during the COVID-19 pandemic and outline the approaches I took to address these challenges.

Developing Research Questions

The research questions were developed during the first few months of the COVID-19 pandemic, when the virus and its impact on individual lives loomed large. Like most people, I was experiencing significant changes in the work, social, and personal aspects of my life, and was feeling anxious about the future. In previous years, the doctoral course in Clinical Psychology had facilitated a research fair, in which local academic researchers and clinicians could present their areas of interest and propose potential research questions to facilitate the trainee clinical psychologists in their selection of research topic. Due to the COVID-19 pandemic, this research fair was conducted online, as were initial discussions with potential supervisors. Although I had considered the current project at this stage, I noticed that I was feeling quite removed from the research process and initially found it difficult to identify that “intense interest” that Moustakas (1990) speaks about. It was at this stage that I began my reflexive journal and utilised this to capture these experiences. I acknowledged that I had some interest in the project relating to older adult experiences of the lockdown restrictions but that my own dislike and anxiety about the restrictions and pandemic were causing a resistance to choose this project. With this realisation, I noted that this anxiety could also translate into a passion to capture these experiences for others and so I contacted my research supervisor to discuss this project further. From discussion with him, I came to realise the potential benefits of this research and felt encouraged and excited to get started.

Recruitment

At this stage of the project, I anticipated experiencing challenges with recruiting participants, especially as all conversations about the project had to be conducted over the phone due to the lockdown restrictions. I felt that due to the pandemic, engaging with research would not be a priority for older adults. I was pleasantly surprised, however, to find that this was not the case. With the invaluable help of my clinical supervisor, I recruited nine participants.

Data collection

When drafting the project proposal, I had naively anticipated that pandemic would be over by the time data collection commenced. Instead, I found myself facing the challenge of conducting interviews with nine older adult participants during the third implementation of Ireland's most stringent level of lockdown. I was forced to accept that I could not conduct my interviews face-to-face and after consultation with my supervisors, I made the decision to conduct the interviews over the phone. Digital communication was considered as a potential means for data collection, but the clinical supervisor advised that the participants had relatively poor digital literacy and so this was rejected as a collection approach.

Although I appreciated that telephone interviews were the most appropriate available method of data collection, I was concerned about establishing trust and rapport without face-to-face contact and the impact this may have on the elicitation of rich data. I utilised supervision with my clinical and academic supervisors to discuss these concerns and together we developed a plan to address these issues. Once participants had agreed to take part and had provided written consent, I called each participant to introduce myself, reiterate the details in the information sheet and consent form, and offer them the opportunity to ask questions. In the absence of face-to-face communication and non-verbal cues, it was important to provide participants with as much detail as possible about what to

expect in the interview. I explained that due to the sensitive nature of the topic, it was possible that some distress might be experienced. I outlined the distress protocol and again reiterated the voluntary nature of their participation. At this stage, we scheduled a time for me to call to conduct the interview. I encouraged participants to consider practical aspects of the interview such as what day and time would be best for them, where they would be most comfortable sitting for the duration of the interview, and how they might practice self-care afterwards. This aspect of the conversation was very collaborative and facilitated the development of rapport.

The participants engaged very well at the interview stage. They presented as eager to discuss their experiences which facilitated the collection of rich data. Although conducting interviews during the highest level of restrictions was challenging it also meant that participants were discussing experiences that were current and relevant, rather than retrospectively reflecting. This may have also contributed to the richness of the data and overall conducting the interviews was a rewarding process.

Use of supervision

As much of the project took place during lockdown restrictions, most supervision meetings were conducted online. Although it was helpful to have this option in the absence of face-to-face meeting, these online sessions did not always capture the richness of face-to-face contact. Later in the research process, when face-to-face meetings could be conducted, it was noted that these were more productive, collaborative and useful.

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Chapter Six: Discussion and Conclusion

Summary of Findings

The overall aim of this thesis was to explore the experiences of older adults during the lockdown restrictions of the COVID-19 pandemic. The systematic review in Chapter Two aimed to synthesis quantitative research on the factors associated with psychological distress in older adults during the COVID-19 pandemic. Twenty-three studies were synthesised using narrative synthesis. The review concluded that the way in which governments responded to the pandemic played an important role in older adults' mental health during the pandemic. Stricter restrictions such as schools and workplace closures, travel restrictions, and stay-at-home orders appear to be associated with increased depression and anxiety among older adults. This may be due to the impact of isolation, loss of social support and loneliness as increases in these factors were also associated with increased psychological distress while higher levels of social and cultural engagement were associated with lower levels of distress. Levels of physical activity were significantly associated with depression and anxiety and furthermore, there appears to have been a decrease in activity levels among older adults during the pandemic. Religiosity and religious coping appear to be protective factors for older adults while older adults with cognitive impairments appear to be at particular risk of experiencing anxiety and depression.

In Chapter Four, the major research project aimed to explore how older adults with pre-existing anxiety and depression experienced and understood the COVID-19 lockdown restrictions. In-depth interviews were conducted with nine older adult participants; these interviews were then analysed using Interpretative Phenomenological Analysis (IPA). Older adults experienced substantial changes to their daily lives when the lockdown restrictions were imposed, and a strong sense of lost belonging was captured in their accounts. The

participants described feeling like they were no longer needed or wanted by their families and communities and that they had been ostracised from society. Research has indicated that a sense of belonging is fundamental to wellbeing and mental health (Baumeister & Tice, 1990; O’Keeffe, 2013; McAdams & Bryant, 1987; Stebleton et al., 2014; Williamson et al., 2018), while social exclusion appears to be associated with higher levels of anxiety (Baumeister & Tice, 1990) and depression (Feng et al., 2019; Tong et al., 2011) in older adults.

For many participants, feelings of powerlessness and hopelessness were salient. A sense of being trapped and imprisoned was captured as participants experienced a loss of control and agency in their lives. Similar to this feeling was the sense that older adults were running out of time to spend with loved ones and that this valuable time in their lives was being taken from them. Many spoke about feeling disempowered by the restrictions and experienced frustration and anger; however, with nowhere for the anger to be directed, many created ‘enemies’, something or someone on which they could place their blame.

Some older adults managed to maintain the belief that, despite the challenges they had experienced as a result of the pandemic, there was a light at the end of tunnel. For others, they experienced a shift from a hopeless outlook to an optimistic appreciation that the end of the pandemic would herald a new beginning of sorts.

Contribution of the Research

The systematic review on the factors associated with psychological distress in older adults during the COVID-19 pandemic offers an original contribution to the emerging literature on the impact of the COVID-19 pandemic on mental health. The review outlined how more stringent governmental responses have been associated with increased psychological distress and highlighted a link between reduced social support and poor mental health. The

findings also demonstrated a decrease in activity levels among older adults during the pandemic which has in turn been associated with anxiety and depression.

The review has some important clinical implications. It highlighted the importance of providing interventions that promote exercise to increase the physical activity of older adults and to mitigate feelings of boredom. Community-based outdoor programmes could also offer structure, engagement and participation for older adults during periods of lockdown. Other interventions that encourage emotional connection could be beneficial for older adult wellbeing during future lockdowns. Public health initiatives and interventions that improve digital literacy skills should be prioritised as technology could be an effective way to connect with others and improve social support. This could in turn help to reduce loneliness and its impact on psychological distress. Online support groups or telephone and text support services could also be beneficial.

As disrupted sleep was found to be an important factor contributing to the psychological distress in older adults during the pandemic, the review also highlighted the need for education and resources on the importance of sleep and sleep hygiene as well as interventions that utilise relaxation techniques.

The major research project also offers a unique contribution to the existing literature as it is the first of its kind to explore the lockdown experiences of older adults with pre-existing mental health difficulties. The findings suggest recommendations for clinicians working with older adults in the aftermath of the COVID-19 pandemic and in potential future epidemics or pandemics. Interventions that focus on improving older adults' social connections and belongingness should be prioritised. Encouraging older adults to develop new and creative ways of communicating, including improving their digital literacy skills could increase feelings of belongingness and bolster their social support systems.

Acceptance and commitment therapy, cognitive behavioural therapy as well as compassion-focused interventions could be particularly useful for this population.

Limitations

There are several limitations of the thesis. In the systematic review, of the 23 studies included, only five were longitudinal in design. The remaining 19 were cross-sectional and while cross-sectional research offers useful information on the prevalence of symptoms, they do not allow for causal explanations.

Several of the studies included required the participants to have access to computer and internet which may have discriminated against older adults with poor digital literacy skills. The studies also included mostly participants from White, educated, industrialised, rich, democratic (WEIRD) countries and only a small portion were of a low socio-economic status. This limits the generalisability of the findings.

The major research project findings should also be considered in light of its limitations. The inclusion criteria required participants not be experiencing severe levels of depression including suicidal ideation and intent and also to be attending the Older Adult Mental Health Services. This will have impacted upon the representativeness of the sample. The sample also included both older adults who lived alone and those who lived with spouses or offspring, as well as those who were caring for spouses with dementia. These factors may have resulted in variations in their experiences of the lockdown restrictions.

Conclusion

The aim of the current thesis was to explore the experiences of older adults during the lockdown restrictions of the COVID-19 pandemic. The systematic review and the empirical research project have contributed to the existing literature on older adults' experiences of

the COVID-19 pandemic, and have provided important recommendations for policy clinicians working with this population.

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Appendices

Appendix A: PRISMA checklist

PRISMA-P (Preferred Reporting Items for Systematic review and Meta-Analysis Protocols) 2015 checklist: recommended items to address in a systematic review protocol*

Section and topic	Item No	Checklist item
ADMINISTRATIVE INFORMATION		
Title:		
Identification	1a	Identify the report as a protocol of a systematic review
Update	1b	If the protocol is for an update of a previous systematic review, identify as such
Registration	2	If registered, provide the name of the registry (such as PROSPERO) and registration number
Authors:		
Contact	3a	Provide name, institutional affiliation, e-mail address of all protocol authors; provide physical mailing address of corresponding author
Contributions	3b	Describe contributions of protocol authors and identify the guarantor of the review
Amendments	4	If the protocol represents an amendment of a previously completed or published protocol, identify as such and list changes; otherwise, state plan for documenting important protocol amendments
Support:		
Sources	5a	Indicate sources of financial or other support for the review
Sponsor	5b	Provide name for the review funder and/or sponsor
Role of sponsor or funder	5c	Describe roles of funder(s), sponsor(s), and/or institution(s), if any, in developing the protocol
INTRODUCTION		
Rationale	6	Describe the rationale for the review in the context of what is already known
Objectives	7	Provide an explicit statement of the question(s) the review will address with reference to participants, interventions, comparators, and outcomes (PICO)
METHODS		
Eligibility criteria	8	Specify the study characteristics (such as PICO, study design, setting, time frame) and report characteristics (such as years considered, language, publication status) to be used as criteria for eligibility for the review
Information sources	9	Describe all intended information sources (such as electronic databases, contact with study authors, trial registers or other grey literature sources) with planned dates of coverage
Search strategy	10	Present draft of search strategy to be used for at least one electronic database, including planned limits, such that it could be repeated
Study records:		
Data management	11a	Describe the mechanism(s) that will be used to manage records and data throughout the review

Appendix B: JBI Checklists

JBI Critical Appraisal Checklist for cohort studies

	Yes	No	Unclear	Not applicable
1. Were the two groups similar and recruited from the same population?	☐	☐	☐	☐
2. Were the exposures measured similarly to assign people to both exposed and unexposed groups?	☐	☐	☐	☐
3. Was the exposure measured in a valid and reliable way?	☐	☐	☐	☐
4. Were confounding factors identified?	☐	☐	☐	☐
5. Were strategies to deal with confounding factors stated?	☐	☐	☐	☐
6. Were the groups/participants free of the outcome at the start of the study (or at the moment of exposure)?	☐	☐	☐	☐
7. Were the outcomes measured in a valid and reliable way?	☐	☐	☐	☐
8. Was the follow up time reported and sufficient to be long enough for outcomes to occur?	☐	☐	☐	☐
9. Was follow up complete, and if not, were the reasons to loss to follow up described and explored?	☐	☐	☐	☐
10. Were strategies to address incomplete follow up utilized?	☐	☐	☐	☐
11. Was appropriate statistical analysis used?	☐	☐	☐	☐

High quality: 8 to 11

Medium quality: 4 to 7

Low quality: 0 to 3

JBI Critical Appraisal Checklist for analytical cross sectional studies

	Yes	No	Unclear	Not applicable
1. Were the criteria for inclusion in the sample clearly defined?	☐	☐	☐	☐
2. Were the study subjects and the setting described in detail?	☐	☐	☐	☐
3. Was the exposure measured in a valid and reliable way?	☐	☐	☐	☐
4. Were objective, standard criteria used for measurement of the condition?	☐	☐	☐	☐
5. Were confounding factors identified?	☐	☐	☐	☐
6. Were strategies to deal with confounding factors stated?	☐	☐	☐	☐
7. Were the outcomes measured in a valid and reliable way?	☐	☐	☐	☐
8. Was appropriate statistical analysis used?	☐	☐	☐	☐

High quality: 6 to 8

Medium quality: 3 to 5

Low quality: 0 to 2

Appendix C: Data Extraction Table (blank)

Title:	
Author:	
Date of extraction:	
Citation:	
Country of origin:	
When study was conducted:	
Objectives:	
Study design:	
Recruitment:	
Number of participants including dropouts:	
Participant characteristics:	
Setting:	
Interventions if appropriate:	
Measures:	
Outcomes (which were primary, secondary and pre-specified):	
Analysis:	
Number of participants included in analysis:	
Length of follow-up if appropriate:	
Main results:	
Study sponsorship:	
Strengths:	
Weaknesses:	
NOS Star Rating:	

Appendix: D: Significant associations and adjusted sizes of effect of associations

Study	Association measurement	Outcome measure	Adjusted effect size
<i>Impact of government response</i>			
Giebel et al., 2021	Social support service usage before and after COVID-19 public health measures	Wellbeing Depression Anxiety	Changes in social support hours positively correlated anxiety ($p = .019$) Changes in social support negatively correlated with well-being ($p = .012$)
Müller et al., 2021	Attitudes towards COVID	Depression	Feeling restricted by quarantine measures positively correlated with depression ($\beta = 0.083$; $p = 0.004$)
Van Tilburg et al., 2021	Impact of restrictions	Social & emotional loneliness Mental health	Mental health associated with: being personally affected by being outdoors less ($\beta = -0.04$, $p < .05$) needing support that was not received ($\beta = -0.06$, $p < .001$) increased worries about the pandemic ($\beta = -0.14$, $p < .001$) decline in trust in institutions ($\beta = -0.05$, $p < .01$) when government rules were not followed ($\beta = -0.05$, $p < .01$)
Voss et al., 2021	Government stringency response	Mental health	Stringency of measures positively correlated with mental health difficulties (OR = 1.03, 95% CI [1.03; 1.04])
<i>Social support, community engagement, loneliness and isolation</i>			
Aisenberg-Shafran et al., 2021	Loneliness	Depression Suicide risk Death anxiety	Being lonely, but not isolated was positively correlated with depression ($\beta = 0.276$; $p < 0.001$)

Kilincel et al., 2020	Loneliness	Anxiety	Loneliness positively correlated with anxiety (OR = 1.29, r = 0.498, p = .001)
Minahan et al., 2021	Social contact Loneliness	Posttraumatic stress Depression Anxiety	Social support a mediating factor between stress and depression (p < .05), and anxiety (p < .05)
Müller et al., 2021	Loneliness Social isolation	Depression	Being both isolated and lonely (β = 0.136; p < 0.001) positively correlated with depression
Okamura et al., 2021	Emotional social support	Depression	Emotional social support was positively correlated with depression (p < .05)
Siegmund et al., 2021	Social isolation	Depression	Social isolation was positively correlated with depression (β = 0.588, p < .001).
Carlos et al., 2021	Social interaction	Depression	Social interactions with loved ones negatively correlated with depression (p = .050)
Keisari et al., 2021	Cultural engagement	Anxiety	Frequency of receptive arts engagement negatively correlated with anxiety (r = -0.24, p < 0.001)
Noguchi et al., 2021a	Social participation	Depression	Social participation negatively correlated with depression (p = .045)
<i>Coping styles and methods</i>			
Carlos et al., 2021	Consumption of pandemic-related content Finding new hobbies	Depression	Consumption of pandemic-related content positively correlated with depression (p = <.001) Finding new hobbies negatively correlated with depression (p = 0.017)
Ghoncheh et al., 2021	Religiosity Religious coping	Anxiety Depression	Religiosity:

			negatively correlated with on depression (B [SE] = -0.087 [0.037]; $p = .023$) not correlated with anxiety (B [SE]= -0.063 [0.036]; $p = .072$)
Minahan et al., 2021	Coping	Posttraumatic stress Anxiety Depression	Avoidant coping significantly mediated relationship between stress and depression ($p < .05$), and anxiety ($p < .05$)
<i>Caregiver status</i>			
Noguchi et al., 2021b	Care giving status	Depression	Compared with non-caregivers, family caregivers experienced greater incidence (OR = 3.17, $p < .01$) and persistence of depressive symptoms (OR = 2.39, $p < .01$)
<i>Cognitive state and functioning</i>			
Carlos et al., 2021	Cognitive state	Depression	Cognitive state negatively correlated with depression ($p = .008$)
De Pue et al., 2021	Cognitive functioning	Depression	Cognitive functioning negatively correlated with depression ($p < .001$)
Robbins et al., 2021	Cognitive state	Subjective feelings of distress	Having dementia or Alzheimer's disease associated with increased depression ($p < .05$) but less feelings of anxiety ($p < .001$)
<i>Other psychological factors</i>			
van der Kaap-Deeder et al., 2021	Ego integrity and despair	Wellbeing	Ego integrity was positively correlated with wellbeing and negatively correlated with psychological distress. Despair was negatively correlated with wellbeing and positively correlated with psychological distress.

			in the expected direction (β ranging between 0.14 and 0.35 for the positive effects and between -0.25 and -0.29 for the negative effects, $p < .01$).
Robbins et al., 2021	Alcohol consumption	Anxiety Depression	Alcohol consumption not associated with anxiety or depression
Vitman Schorr et al., 2021	Subjective age	Depression	Subjective age positively correlated with depression ($r = 0.22$, $p = .002$)
<i>Behaviour and physical factors</i>			
Carlos et al., 2021	Physical activity Sleep	Depression	Physical activity negatively correlated with depression ($p = .003$) Sleeping problems positively correlated with depression (OR: 2.29; CI: 1.06–4.93; $p = 0.034$).
Carvalho et al., 2021	Physical activity	Depression	Unbroken-prolonged sitting bout positively correlated with depression ($\rho = 0.677$, $p = 0.03$)
De Pue et al., 2021	Physical activity Sleep	Depression	Physical activity negatively correlated with depression ($\beta = -0.22$, $p < .001$) Sleeping problems positively correlated with depression ($\beta = -0.12$, 95% CI, $p < 0.001$)
Mishra et al., 2021	Physical activity Sleep	Depression	No significant correlation between depression symptoms and light activity ($\rho = -0.566$, $p = .088$) and moderate-to-vigorous activity ($\rho = -0.41$, $p = .24$) levels Sleep duration negatively correlated with depression ($\rho = -0.72$, $p = .019$)

Robbins et al., 2021	Physical activity Sleep	Depression	Physical activity negatively correlated with depression ($p = <.001$) and anxiety ($p = <.001$) Sleeping problems positively correlated with depression ($p = <.001$)
Siegmund et al., 2021	Physical activity	Depression	Physical activity was negatively associated with depression ($SE = 0.001$, $Z\text{-value} = -6.639$, $p = <.001$, $\beta = -0.230$)
<i>Previous Cognitive Behaviour Therapy</i>			
Johnco et al., 2021	Previous treatment with cognitive behaviour therapy	Anxiety Depression	Previous cognitive behaviour therapy associated with low relapse rates

Appendix E: Information sheet and consent forms

INFORMATION SHEET

Thank you for considering taking part in this research project. This handout will explain to you what the study is about and what your participation would involve. It is important for you to have this information so you can make an informed choice.

What is the purpose of the study?

This study aims get an understanding of what the COVID-19 'lockdown' restrictions were like for older adults who are experiencing anxiety and depression.

What will the study involve?

If you choose to participate, you will be asked to take part in a one-to-one interview to discuss your experiences of the 'lockdown' restrictions. This will last for approximately 45 minutes and will be audio- or video-recorded.

Do you have to participate?

No, participation in this study is completely voluntary. If you choose to take part, you can refuse to answer specific questions, or decide to withdraw from the study. You do not have to give any reason for this.

Will your participation in the study be confidential?

All information you provide will be anonymized as far as possible, with identifying information removed. However, the researcher cannot guarantee complete anonymity as someone who knows you may recognise a detail of your story. The information you provide will be protected throughout the study and your details will only be available to the researcher. The only exception is where information is disclosed which indicates that there is a serious risk to you or to others. Staff members of the Adult Mental Health Team will not be aware of your decision to participate or not.

Your name and any identifying information will not be included in the study or any reports on the study. Once the interview is completed, the recording will immediately be

transferred to a HSE-encrypted laptop and wiped from the recording device. The interview will then be transcribed by the researcher, and the transcript will be anonymized as far as possible. Once this is done, the audio-recording will also be deleted and only the anonymized transcript will remain. This will be stored on the University College Cork OneDrive system and subsequently on the UCC server for a period of ten years, in line with the University College Cork Code of Research Conduct. The information you provide may contribute to research publications and/or conference presentations and will contribute to a thesis.

How do you withdraw from the study?

You have the right to withdraw from the study at any stage up to two weeks after completion of the conversation. You do not have to provide a reason for your withdrawal.

What if there is a problem?

We do not think there will likely be any negative consequences from taking part in this study. Some of the topics of conversation may be of a sensitive nature, however, so should you wish to do so, you can choose not to answer questions, or to withdraw from the study. Should you experience distress arising from taking part in the research, you can discuss with Ms Judy Wall, Senior Clinical Psychologist on 021 4927280.

Who has approved this research project?

This study has obtained ethical approval from the University College Cork Clinical Psychology Research Ethics Committee.

If you have a concern about how we have handled your personal data, you are entitled to raise this with the Data Protection Commission.

<https://www.dataprotection.ie/>

If you have any queries about this research, you can contact me at [email]

Alternatively, you can contact my research supervisor Dr Mike Murphy, at [email] or [number]

If you have a complaint about how this research was conducted please contact in writing:

The Ethics Committee,
School of Applied Psychology,
University College Cork,
Cork

If you agree to take part in this study, please complete the consent form overleaf.

CONSENT FORM

I agree to take part in the research study that has been outlined above.

- ✓ The purpose and nature of the study have been explained to me in writing.
- ✓ I am participating voluntarily.
- ✓ I give permission for my interview to be audio- or video-recorded.
- ✓ I understand that I can withdraw from the study, without repercussions, before or while I am participating.
- ✓ I understand that I can withdraw permission to use the data within two weeks of the interview, in which case the material will be deleted.
- ✓ I understand that anonymity will be protected as far as possible in the write-up by disguising my identity.
- ✓ I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

Signed:

Date:

PRINT NAME:

Appendix F: Ethical Approval Letter



Coláiste na nEalaíon, an Léinn Cheiltigh
agus na nEolaíochtaí Sóisialta
College of Arts, Celtic Studies
and Social Sciences

Scoil an Síceolaíochta Feidhme
School of Applied Psychology

University College Cork,
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T +353 (0)21 490 4551 / 4552
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25th January 2021

Clinical Psychology Research and Ethics

Dear Alice

Experiences of older adults with anxiety and depression of the COVID-19 'lockdown' restrictions

Alice Cashman

Thank you for your ethics application and subsequent changes. Your application has been approved by the Clinical Psychology Research and Ethics Committee and you have full ethical approval for the above named project.

Yours sincerely,

Dr Mike Murphy
Chair Clinical Psychology Research and Ethics Panel

Dr Carol Linehan
Head of School of Applied Psychology

Ollscoil na hÉireann, Corcaigh
National University of Ireland, Cork

Appendix G: Interview Schedule

Interview Schedule

Researcher introduction and purpose of the interview

The interview will begin with greeting and welcoming the participants and a brief estimation of time will be given (approximately 45 to 60 minutes). The participants' rights to withdraw, to refuse to answer questions and to take breaks will be highlighted as well as the procedure for if distress is experienced.

Body of interview

1. Today we'll be talking about your experiences of the 'lockdown'. To start off, could you tell me a bit about what life was like before the 'lockdown'?
Possible prompts:
 What would an average day have looked like; what would you have done; how did you keep busy; who would you have seen; what was this like?
2. When the lockdown started, did anything about your day-to-day life change?
Possible prompts:
 What about your life changed; how do you spend your time during 'lockdown'; were there any things that you used to do before 'lockdown' that you can no longer do during the restrictions; what is this like?
3. Tell me about your relationship with other people during the 'lockdown'? How does this compare with your relationships prior to the 'lockdown'?
Possible prompts:
 Would you have seen any family or friends regularly before the 'lockdown'; do you see or speak to anyone during 'lockdown', how regularly, how do you stay in touch; what is the purpose of the interactions (social, emotional support, practical support); how is this different from the interactions you had before 'lockdown'; if a change occurred, can you describe how that feels?
4. How do you feel during the 'lockdown'?
Possible prompts:
 How would you describe your mood at the moment; have you noticed any changes in your mood during 'lockdown'; do you notice any particular emotions or feelings at the moment; is this a change from how you were feeling before 'lockdown'?
5. How are you coping with the changes brought about by the 'lockdown' restrictions?
Possible prompts:
 Does anything help/make it better; what would help you to cope?
6. How often would you have seen someone from the Mental Health Team before the 'lockdown'? Has this changed?

Possible prompts:

How do you stay in touch at the moment: face-to-face, over the phone; what is this like; do you find it useful to link in with this person; what is helpful or unhelpful about this; would you change anything about this if you could?

7. What do you think about the 'lockdown' restrictions?

Possible prompts:

Do they make sense to you; what is your opinion of the restrictions; what is it like adhering to the restrictions?

8. Is there anything challenging about the 'lockdown' restrictions (that we haven't already discussed)? Was there anything that makes these easier; what helps?

9. Are there any benefits to the 'lockdown' restrictions?

Possible prompt:

Is there anything enjoyable or positive about 'lockdown'?

Closing

Thanks for allowing me to talk to you today and sharing your experiences. Your comments will be very valuable to the study. Thanks again for your time.

Appendix H: Sample Analysis

Emergent themes	Transcript	Initial notes/exploratory comments
Life before pandemic	P: Well, before, life was great. We'd a very good social life and did a lot of travelling, you know, me going to the family, they coming to us. I had a lovely life, myself and my husband, you know, particularly me, I was out all the time.	Concept of 'before' pandemic- what is it now?
Narrative of life before as 'good'	You know, I was having lunch with my friends. I was meeting my sister-in-law. It was marvellous. And then just bang! Everything changed.	Use of language- positive adjectives- great, good, lovely, marvellous- emphasising that life before was 'good', contrast between pre- and during pandemic
Reciprocity of social interaction		Interesting- moving between me and we, we moved to I- why is this?
Varied, busy life before		Social connections in visiting and receiving visits from family, reciprocal nature of interactions
Sudden change	I: It sounds like you had a very full life.	Had varied lifestyle- socialising different people, travel
Narrative of life before as 'good'	P: Oh yes, very busy, very social. Before, we were involved in loads. We do really have a great social life. We could be out a two or three times a week. And it all stopped overnight. Really, I suppose, what happened to me was, it was just a shock, you know? How am I going to pass the day now? You know, I can't see family, only from outside the door. Yeah, everything about my day-to-day life changed overnight. And everything was doom gloom. I was watching Sky News on-the- hour. I couldn't sleep, you know.	Use of language- "Bang"- suddenness, indicating magnitude of change, abrupt Narrative of before = good, pandemic = bad Had depression and anxiety prior to pandemic, however- is she looking back with rose-tinted glasses, through lens of pandemic?
Sudden change	I was worried, you know, it really overwhelmed me. That's how I would put it and if we'd only known how long it was going to go on... It all overwhelmed me, and I was very worried all the time. That's how I'd put it.	Use of language- "very", "loads", "great", "two of three times"- sense of abundance More talkative and animated when discussing pre-pandemic "All stopped overnight", "everything about day-to-day life"- sudden change, loss of routine and lifestyle Strong emotional response "Happened to me"- external locus of control?
Sense of loss		"Shocked" reaction to changes, sense of loss Questioning how she will cope Sense of being cut off from family- "outside the door"- a distance or barrier, physical distance vs emotional closeness- did that change?
Shock		Consuming news hourly- for sense of control, what was impact of this?
Sense of isolation		Sleep difficulties, worry, overwhelmed Trails off... unspeakable, "that's how I'd put it" difficult to articulate?
Heightened anxiety	I: Can you remember what kinds of things was that were worrying you?	
Not worried about the virus	P: It wasn't the fear of getting the virus. No, that didn't really worry me. But then- the masks! I got a complete aversion to the masks. No way would I wear the masks! I thought I'd be smothered in a mask. My family and my very good friend, she got me these visors and I wouldn't wear that! You know, I was very stubborn really. No, I just didn't want to wear the mask. I mean I'd wear the visor and I put up with that but it all over took me. And I made it all out to be massive, which it was. Just suddenly the friends that I'd met for lunch- it all stopped. We did have a good social life then, you know, as did everyone else. As you know. it	Very clear language- not worried about getting the virus Emphatic- emphasising her "complete aversion" to the masks- did they represent the whole pandemic in a way? A physical object to reject? "Smothered" dramatic use of language or genuine fear? Family and friends tried to help- what exactly is she saying about family- this gets lost?
Aversion to masks		Acknowledges stubbornness in hindsight
Retrospective insight- or internalising others' reactions to her		"didn't want to" suggests preference rather than anxiety- a way of communicating her distress?
Sense of helplessness		"Took over me" – external locus of control, sense of helplessness, powerlessness?
Attempt to understand her behaviour		
Aversion to masks		
Rigid rejecting of reality		

Feeling helpless and out of control	changed completely. And I just didn't handle it that well. I made it all about the masks. It was that feeling of not being able to breathe. Yeah, it was the masks were the huge thing. You know, I just would say over and over that I couldn't wear them. I just I won't. I wouldn't be able to and I would panic.	"I made it out" taking responsibility for her reaction in hindsight? "which it was"- justifying her response, does she feel guilty?
Invalidation from family-internalising family's view		Acknowledging that she struggled to cope with the changes
Feeling out of control	My husband was fantastic! He was absolutely marvellous. He was always trying to get me to wear the mask. I'd put it on and then I'd pull it off again.	"Made it all about the masks"- masks as a symbol of whole pandemic
Invalidation from family-internalising family's view	And it was a real issue. I suppose if you like I latched onto the mask. And I, you know, people were saying to me 'try to wear it around the house, put it on for 10 minutes' and I put it on in the house and I pulled it off again! But, you know, I think- I did, I latched on to that. And then blew it out of out of proportion really. I suppose that was something that I could control really. And I couldn't, you know, control anything else that was going on. I was completely out of control really! My whole life had changed. So yeah, that was something, you know, you know, where everything changed. Everything important. I was always a big shopper. I loved shopping! And I couldn't. All the shops closed. And it was like the end of the world to me. It really was. It felt like the end of the world. And looking back on it now, I say to myself 'Oh my God, I'm embarrassed'.	Not being able to breathe in masks analogous to feeling out of control Say it "over and over", "I just won't", "I wouldn't be able to"- rigid rejecting of reality, couldn't accept the changes? Lots of repetition even now Insight into this reaction now? Or has she internalised her family's perspective?
Attempts to regain sense of control	But you know it- it just it did. It just overtook me. You know, we had a holiday booked for us to go to [name of country]. We'd another one booked for September. Everything cancelled. To me, it was really the end of the world, absolutely the end of the world.	Husband was supportive- would encourage her to wear masks, to accept changes- or was he not acknowledging her fear? "I'd pull it off again"- stubbornness, childishness, indicative of panic Acknowledges that her reaction was irrational, "latched on"- something she could control when feeling out of control Invalidating her own experience of panic?
Loss of important aspects of life		"But, you know, I think- I did"- contemplative, has considered this, now understands it was an anxiety response
Script- justifying her reaction		Is she embarrassed now?
Attempt to understand her behaviour		Insight into her reaction as attempt for control- felt overwhelmed and out of control due to changes in her life
Feeling overwhelmed		The important aspects of her life changed Loss of old life Loss of feeling of control Loss of hobbies
Feeling helpless		Use of language, repetition of "end of the world", "it really was"- emphasising the magnitude of change and loss she experienced at the time, helplessness, did she feel an inability to cope? has perspective now- "looking back on it now" Sense of embarrassment as her reaction
Feeling unable to cope		"Overtaken"- sense of no control, helpless to the anxiety and panic, external locus of control
External locus of control		Loss of holiday plans, things to look forward to, maybe lost sense of meaning and purpose?
Hopelessness		"To me" emphasising her own reaction Repetition- communicating her distress at the time
Grief reaction	I: Can you remember the kinds of thought and worries you'd had at the time?	Didn't worry about the future due to depression and anxiety- could see no way out- was this a worry about the future in itself?
Feeling overwhelmed	P: Well, strangely I didn't really worry about the future at all because I was so- I became so depressed, I suppose, and anxious. You know, I could see no way out. The weight started to drop off me, my appetite was gone, I wasn't sleeping.	
Feeling helpless	You know, I'm so much better now but looking back on last year, it absolutely took over my whole thought process.	

External locus of control	I: It sounds like it was very overwhelming for you. P: It was, yeah, it was very overwhelming. Yeah, I mean, I go out in the car, you know, just to say to myself, you know, I have to do something. And then there were days when I wouldn't want to go out at all. And my husband would say 'come on, we'll go out' and then you couldn't go very far. And it was just awful.	Sense of hopelessness- future seemed bleak? Grief reaction symptoms- weight loss, appetite change, sleep disturbances, cognitive distortions Sense of it being all consuming- can see this "looking back" but couldn't at the time "Took over thought process" sense of helplessness, external locus of control
Time as enemy	I: How did you then spend your, you know, day-to-day life?	Feeling overwhelmed
Emotional support from husband- invalidating		Grief symptoms- anhedonia, lack of motivation Husband was supportive and encouraging- what was effect of this, did it help?
Feeling trapped	P: That was it, my big problem: how was I going to pass the day, you know? Yeah, we'd just be sitting on the couch. And you know, my neighbours and friends were watching television but I had no interest in that and I'm not a big reader. I'd only read when I go to bed. And everybody else was doing a bit of baking but I'm not a baker. Just everything was just taken away from me. My concentration went, my interest in doing things- my concentration, it was like nothing was left. Gone completely. My husband took over the cooking because I couldn't even get my mind around when would I put on potatoes, how would I time things? Everything was huge.	Even if you did go out, were restricted in how far you could go- sense of being limited, trapped? "just awful"- clear language, communicates distress, rigid view, non-dialectical thinking
Pooping coping skills	Everything was overwhelming. Yeah, it was just- it was very overwhelming. And looking back on it now, and I do look back, and I was completely overwhelmed. It took over my thoughts. It was a very tough time. My life had just changed completely, you know. I would have gone to my neighbour's house frequently and they would have come here- we couldn't do any of that. And I started to have terrible panic attacks. And it was just awful.	Biggest issue- trying to pass the day, like time is money to be spent? What did she try to pass the day? Ways of coping- no sense of this
Passive approach		Inactive, no interest in tv or reading or baking- did she try these things? Get a sense of what she didn't do but not what she did try to help? Sense of being passive and having a negative outlook?
External locus of control		Aware friends and family were staying occupied by watching tv and reading and baking but she had no interest
Rigid, black-and-white view Rejecting reality		"Taken away" sense of being robbed, injustice, lack of control "Concentration went" external locus of control, grief process Very expressive language "nothing was left. Gone completely" demonstrates her state of mind, rigid, rejecting reality
Grief reaction		Reaction similar to grief process- shock, overwhelmed by simple tasks
	I: And you had mentioned family and friends who would have been encouraging you to wear the masks and stuff. How did your relationships with other people change within the lockdown?	Repetition- emphasising overwhelmingness
Sense of being overwhelmed	P: Well they were absolutely marvellous to me, they really were. They were absolutely fantastic. And they tried their best to help me too. And my family	"and I do look back"- gained perspective, can see how overwhelmed she was, magnitude of reaction, drawing a comparison between then and now, highlighting improvements, still sense of trying to understand her reaction, some embarrassment? "Over took my thoughts"- sense of no control, helplessness, external locus of control

Attempting to make sense of her reaction	then, they would come into the house because, you know, they would stand inside the house and I'd talk to them. Because they felt like, if it made meant that I wouldn't get any worse then they were prepared to come in. No, I didn't go to their houses. And we were able to keep in contact with a few people, yeah. It was a couple of family and friends really, at the end of the day. It was them that pulled me through the whole thing. And of course [name of consultant]. I suppose the strength of the friendships I had before stood the test of time, absolutely. And half of my friends are widows and living on their own. I can't think about how are they managing this. At least I have my husband and even though I would say that to myself, at the time, it didn't make me any better. But no, I was very aware of how lucky I was in that. But it didn't- it didn't kind of stop it. I would just think 'my God, I would be so much worse without him' but it didn't really help me to feel better. I suppose, yes, I was well aware of it. We know we could have been short of money, you know, which we weren't. I used to, you know, be trying to talk to myself and saying you know 'such-and-such a person is down there in an empty house'. And there was nobody at all going into their house because, you know, my family knew that it was the lesser of two evils to support me like that.	Providing lots of examples for how her life changed, really trying to get across the scale of change and loss she experienced
Support from family		Started experiencing panic attacks
Family putting her needs first		Family were supportive, she's aware of this "marvellous", repetition and positive adjectives emphasising their support
Maintain contact with people		Family bent the rules for her- seems to be just for her own benefit and not for theirs- how did they feel about this? How were they coping?
Nonadherence to restrictions		
Gratitude?		"they were prepared to come in" sense of their sacrifice for her, didn't want her to get worse
Passivity		Had contact with some friends and family
External locus of control		Gratitude to friends and family and consultant psychiatrist- they "pulled her through" sense of effort on their part but also lack of her own agency, passivity, external locus of control
Limited ability to empathise		Emotional connection survived the changes
Limited impact of empathy		Thinking of others who were more isolated than her- is she able to empathise? Is he understanding and sharing feelings, or superficially acknowledging that their situations were more isolating, "can't think"- difficult to even imagine their experience, is she trying to empathise?
		Aware of luck but this gratitude didn't help
		Cognitively aware of their relative luck but this didn't help her to accept the changes in her life
		Making comparisons in an attempt to gain perspective but didn't work; "trying to talk to myself" trying to coach herself, or talk herself out of distress using comparisons- didn't make a difference
		Acknowledging that others were more isolated than she was
Gratitude not helpful	I: It sounds like you got that, kind of, practical support and that people were helping with shopping and things but you also had kind of the more emotional support as well?	Sudden shift back to her situation- highlights difficulty putting herself in others' shoes perhaps, seeing things only through lens of her own distress
Use of self-talk	P: Ah we did. I had support in all ways really. I was incredibly lucky. And somebody had said to me that I would have been the first one to help somebody else so I suppose...	"Lesser of two evils" acknowledging that it was not right maybe but necessary to prevent her from become more distressed- did they feel they had a choice? Family supporting her, was she supporting them in return or unable to?
Gratitude not helpful		
Limited ability to empathise		
Justifying nonadherence to restrictions	I: Yeah, yeah, We've been talking a lot about how you were feeling during the lockdown and I was wondering how long do would you say that overwhelmed state lasted for?	Had emotional and practical support
Non-reciprocal nature of support		Acknowledges luck but this didn't seem to help much at the time
		Someone told her that she would have provided support to others if the situation had been different- guilt? Excusing her reliance on others? Did she support her family or husband

Concept of stages of pandemic Lack of insight into recovery External locus of control Sense of hope and optimism Noticed her own behaviour change	P: I suppose it started around March and it went on all through the summer really, into about August really. I: What do you think it was that helped? P: I really don't know. I've been thinking about that, I think it was just the fact that things were opening up. I don't know when I really started to feel like I started to see light at the end of the tunnel again, you know? In summer, I would have always painted my toenails and I would wear nice shoes. And I think, I looked back on things like that and thought, you know, 'please God, I'll enjoy this summer'. Even though I was always very careful about my appearance, it was doing those bits extra like painting the toenails that I'd stopped doing. So I could really see a difference in my own behaviour then.	during the pandemic? Did she feel unable to support them, or that they didn't need it? Overwhelmed state lasted approximately six months of pandemic Unsure about what helped her recover from that distress, has been thinking about it but still unsure- lack of self-awareness? Life returning to normal helped her recover rather than anything she did herself? Reality changed rather than her attitude or coping? "Things opening up"- sense of hope and optimism- "see light at the end of the tunnel" Started to consider and appreciate small things such as painting her nails in summer, started to have hope that she might enjoy the summer. Acknowledging that she had stopped taking care of herself and could see a difference in her own behaviour- gave her perspective, she could see how she had changed
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Appendix I: Sample Development of Emergent and Super-ordinate themes

Conceptual comments from transcript	Emergent theme
Feels unwanted and unappreciated	Surplus to requirements
Loss of feeling needed and wanted	
Feeling forgotten and unimportant	
Feeling on the outside	
Loss of purpose	
Left behind	
On the outside	
Alienated	
Feels irrelevant	
Act of being left being	
Overwhelming need to belong	

Development of a Superordinate Theme from Emergent Themes, with excerpts

Excerpt	Emergent themes	Super-ordinate theme
"but I used to be part of family life and I'm outside the circle now. There's a huge divide now." "If I disappeared off the face of the earth this minute, it wouldn't make one bit of difference."	Loss of belonging	Sent to the Sidelines
"Yeah, I had a very fulfilled life. I was involved in different groups for different things as well. And now there's nothing." "We have a lovely seaside house not too far from (name of town) and we can't get to it. We're just barred from it" "they're stealing the best part from us."	Loss of control of life	
"... But now I can't see my grandchildren, I can't see my family, I can't do anything really."	Feeling removed from others	
"I'm surplus to requirements is what I'm saying. We're over 70 now and they no longer have volunteers over 65. We're not wanted and we were doing huge work." "It feels like you're on the slag heap you know. I'm healthy and energetic, I'm very well trained and I have a lot to give, and nobody wants it. Nobody wants it."	Ostracised	

Appendix J: Themes Across Transcripts

[illegible]