Social isolation amid the COVID-19 pandemic and mental health: perspectives of institutionalized older adults

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Abstract

Objective: To understand the impact of social isolation during the COVID-19 pandemic on the mental health of institutionalized older adults, from the perspective of these residents. *Method*: An exploratory-descriptive study with a qualitative approach was conducted in two LTCFs in the city of Divinópolis, Minas Gerais State, Brazil. A questionnaire was applied for identification, whereas for qualitative data analysis, a semi-structured script with guiding questions about self-perceptions of social isolation during the pandemic was employed. Content analysis was used, drawing on Dorothea Orem's theory. *Results*: Thirteen older adults participated and the following thematic categories were identified: Feelings of the residents about social isolation amid the pandemic; Actions by residents to preserve mental and physical health during pandemic social isolation; Social isolation and physical inactivity as part of the lives of residents; COVID-19 viewed as trivial. *Conclusion*: Social isolation caused by the pandemic had a negative impact on the mental health of the institutionalized older adults and revealed the fact that social isolation was already part of their daily lives.

Keywords: Elderly. Long-stay Institution for the Elderly. COVID-19. Mental Health. Nursing.

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INTRODUCTION

The number of older adults is rising every year and represents a significant contingent of the population[1]. In this context, together with senescence, older individuals are more susceptible to complications due to chronic non-communicable diseases (NCDs)[2], with a high prevalence of cardiovascular diseases. The high morbidity in older adults means chronic NCDs can be associated with loss of functioning and limitations in their activities of daily living (ADLs), rendering them more dependent for carrying out essential tasks.

Initially, the burden of caring for dependent older individuals falls to family members[2]. However, in cases where the level of dependence requires care which exceeds the ability of family caregivers, the relationship with the family is strained, or no family support is available, the older individual may need to be institutionalized[3].

Thus, shifts in family structures and difficulties faced in caring for older adults are some of the factors contributing to the rise in institutionalization. In this scenario, institutionalization can be accompanied by exclusion as a result of estrangement from the family, forcing the older individual to adapt to a new environment with new rules that is removed from the outside world[4]. Removal of material property is an aspect that contributes to the process of distancing, since social isolation and loneliness can be exacerbated by digital exclusion which may not have been experienced prior to residing in long-term care facilities (LTCFs)[4,5].

Resolution no. 502 of the Brazilian Health Surveillance Agency (ANVISA) [6] stipulates, among other conditions for operating LTCFs, the promotion of participation of family and community in the care of the institutionalized resident and the running of activities that promote autonomy and independence, reinforcing that close interpersonal contact represents a positive aspect in the quality of life of older adults[7].

During the Coronavirus Disease 2019 (COVID-19) pandemic, preventive measures were introduced for LTCFs to control the spread of the disease, such as lockdowns, restrictions on group activities and quarantining of professionals suspected of being contaminated by the infection[8]. These measures were especially important in LTCFs, given that the aging process involves greater susceptibility to infectious diseases and physical harm due to the less effective immune response, and lower capacity for tissue repair, an aggravating factor amid COVID-19[9]. As a result, LTCFs that ran group activities and provided social interactions between the residents and their relatives were forced to implement protocols with restrictive measures to prevent the spread of COVID-19[10], resulting in reduced contact among professionals, family members and residents.

Evidence suggests these restrictive measures have negative impacts on LTCF residents, despite the use of strategies to try and combat social isolation, such as video calls. However, when residents resume close real interpersonal contacts, this has a positive impact on their well-being. Thus, personal interactions are essential activities for quality of life of aged individuals[7].

With regard to mental health, emotional vulnerabilities are an issue, where the pandemic and social isolation have led to an increase in psychological disorders such as anxiety, depression and loneliness[11]. Moreover, during the pandemic, a lack of self-care was another serious situation which emerged in older adults infected by COVID-19, favoring deleterious effects on physical and mental wellbeing of this population, besides a loss of independence for basic and instrumental ADLs, especially within the setting of LTCFs[12].

Coping strategies to mitigate the social isolation of this population during the pandemic included the use of technologies for communication and support in managing care, art therapy, music and drawing workshops, and games in a bid to reduce anxiety of residents. Nevertheless, barriers included the level of knowledge held on technology and access to it at the facilities for adopting important measures that favor the autonomy and independence of the residents[13,14].

In this scenario, the strict health approach to institutionalized older adults was an aspect that may have negatively impacted the mental health of this population and should be carefully considered by health professionals in the context of care provided within these facilities. Against this backdrop, it is

vital to investigate the impact of social isolation on the mental health of institutionalized older adults amid the COVID-19 pandemic. Therefore, the objective of the present study was to understand the impact of social isolation on the mental health of institutionalized older adults amid the COVID-19 pandemic from the perspective of these residents.

METHOD

An exploratory, descriptive study with a qualitative approach based on Orem´s Theory of Self-Care for guiding questions of the investigation and the discussion of results was conducted. This theory involves the autonomy and independence of the individual for maintaining life and wellbeing. When there is a lack of self-care, intervention of the caregiver for the provision of care is needed[15]. The methodological guidelines observed the Consolidated Criteria for Reporting Qualitative Research (COREQ)[16] checklist as the framework underpinning the execution of this study.

The study took place at two philanthropic LTCFs in a city located in the Mid-West region of Minas Gerais State. These facilities ensured lockdown and the safety of residents during the COVID-19 outbreak, particularly with respect to outside visitors and group activities within the facilities.

The study participants comprised older adults aged ≥60 years who were residents of the participating LTCFs and had sound orientation for time and place, as confirmed by the Mini-Mental State Exam[17]. Exclusion criteria were cognitive impairment due to pre-existing dementia and poor clinical health status precluding completion of the questionnaires. Recruitment of participants was performed by the researchers who visited the LTCFs and invited residents to take part in the study.

Data collection was carried out via face-to-face interviews between September and October 2022, with application of the questionnaire gathering sociodemographic data and information on health status to characterize the profile of this population. Quantitative data analyses entailed conducting a scripted interview based on the following guiding questions: (1) How did you feel during the social isolation amid the COVID-19 pandemic?; (2) How did the social isolation amid the COVID-19 pandemic affect your mental health?; (3) What did you do during the social isolation period amid the COVID-19 pandemic?;(4) How was your self-care during the social isolation period amid the COVID-19 pandemic?

Individual interviews were conducted in rooms reserved within the premises of the facilities to ensure privacy, confidentiality and secrecy of information. Interviews lasted an average of 20 minutes and were sound-recorded with the consent of participants after signing of a Free and Informed Consent form (either in written form or by fingerprint for participants unable to sign their name).

For data analysis and treatment, the interviews were transcribed by the researchers. The sociodemographics data and health status information were tabulated in the Excel software, free version from Microsoft 365. The analysis and interpretation of the data was based on content analysis according to Bardin[18], conducted in three stages: (1) Pre-analysis: transcription of raw data and "floating reading" of data, providing an initial impression of the material; (2) Material exploration: with the aim of reducing the text to expressions and subsequently clustering data into categories; (3) Treatment, inference and interpretation of results: analysis of data based on theoretical material, done by independent reading of transcriptions by the researchers in the present study. Triangulation for treating data was adopted by the researchers, who stored recordings, transcriptions and notes in the cloud which were produced and assessed by both researchers. After "floating reading", the researchers elected categories for later discussion. Two other researchers were involved in the data analysis, for a team of 4 researchers. In order to ensure anonymity and secrecy of the information, the phrases produced were labeled with the word "Resident", followed by Arabic numerals in ascending order to reflect the order of participation in the study.

This study was approved by the Ethics Committee for Human Research under the Certificate of Submission for Ethical Assessment (CAAE) 57935622.6.0000.5545 and permit no. 5.407.900. All

of the participants signed the consent form and ethics aspects were followed and observed in accordance with Resolution 510/16.

AVAILABILITY OF DATA

The full dataset underpinning the results of this study are available from Mendeley Data and can be accessed at DOI: 10.17632/5d23cvn94y.1.

RESULTS AND DISCUSSION

The sample consisted of 13 institutionalized older adults, comprising 9 (69%) females and 4 (30%) males. Regarding participant age, 3 (23%) were in the 60-75 years age group, 9 (69%) in the 75-89 group and 1 (7%) in the ≥90 years group. For education, 2 (15%) reported no formal education, 7 (53%) incomplete primary education, 3 (23%) complete primary education, and 1 (7%) complete secondary education. With regard to self-rated health status, 7 (53%) rated their health as good, 4 (30%) fair, 1 (7%) poor, and 1 (7%) as very poor. In response to the question on presence of chronic diseases, the majority (n=8, 61%) of participants reported at least one comorbidity, including hypertension, diabetes mellitus, thyroid disorder and Parkinson´s disease. Regarding the qualitative approach probing the impacts of social isolation on mental health of institutionalized participants during the pandemic, the thematic analysis of the interviews revealed 4 categories, namely:

Feelings of residents about social isolation amid the pandemic

The participants reported their feelings, largely negative and apprehensive, including fear, sadness, concern, anguish, isolated and feeling cut off, and also feelings of agitation and being upset, as portrayed in the excerpts from the interviews below:

> "I felt very sad, you know? And scared.. As each day went by the hospitals filled up with people.. right? It left us feeling down, you know? That was a lot.. a real downer. It seems to be getting a bit better now..that´s it.. it was bad for everyone, right? That pandemic was really sad, it was so sad, wasn´t it? [...] We felt really worried about our family members out there. [...] It struck fear into us, you know? (Resident 1)

> "I was really agitated and upset… I was really agitated and upset… It´s bad, you know´. And there are people without a clue about it. How to deal with this. I knew nothing about it. So it hit me hard. You know? I already had my issues and suffered a lot. After, I was no longer worried about this." (Resident 2)

> "Oh the isolation.. yep.. that business of us not.. not having a cell phone to see the family, right? To communicate. We become isolated[..] I felt really isolated, you know? Cut off, isolated…" (Resident 3)

> "I didn´t feel anything, except fear. [...]" (Resident 4)

These reports reveal that the need to establish social distancing measures which, while helping control spread of the coronavirus, rendered people more vulnerable to negative thoughts and changes in patterns of behavior, particularly among aged individuals. This took place mainly owing to fears and uncertainties surrounding the pandemic[7].

Akin to the present study, other reports also showed that lockdowns promoted feelings in the older population of loneliness and being cut off, besides feelings of anguish and deep sadness, favoring mental health problems[7,19,20]. In this respect, the mounting concerns over the situation, themselves and the family, produced a heavy emotional burden in aged individuals, giving rise to depressive symptoms, insomnia, anxiety, stress, irritability, moodiness and low energy[7].

In terms of self-care of older adults during the pandemic, it is important to emphasize that, with the increase in psychological symptoms, self-care became neglected by many older individuals, reducing the level of well-being and increasing perceived stress[12].

Furthermore, several factors such as the reduction or loss of social and family interaction, individual pre-disposition to mental health problems, and the risk of death experienced with the threat of the virus, played a role in promoting the onset of these negative

symptoms in older adults during the pandemic[19]. In addition, institutionalization alone also represents a factor that can lead to negative feelings and mental problems in residents[4].

Another factor generating negative feelings during lockdown was the lack of access to technologies, as a result of having no cell phone. Given this means of communication can enable institutionalized residents to keep in touch with family and friends, its use constitutes an alternative allowing instant communication of older individuals with their loved ones.

Indeed, the social isolation of older adults could have been mitigated with the aid of technology as a coping strategy during the pandemic, since proper use of these devices can help maintain ties with family members and friends, and attenuate negative psychosocial effects of the pandemic. Consequently, negative sentiments can be reduced along with the feelings of being cut off and lonely [7] and use of technology, although no substitute for person-to-person contact, can have a positive impact on wellbeing of this group. Digital inclusion of the older population, particularly institutionalized elders, warrants debate, given that the use of technologies as an occupational strategy can help ease the problems associated with social isolation[21].

Contrasting with the negative feelings reported by participants, a feeling of protection against COVID-19 was also expressed, in as far as being safely confined in a controlled environment amid vulnerability to the infection. The discourse below illustrates this point:

> "In my case I felt protected here, if I had been outside it may have been worse. In other words, protected from the pandemic. It´s because we stay here, isolated. Nobody left or entered. Nobody came in and nobody went out. Gradually, after vaccination you (visitors) began coming in, but no one would enter. After everyone here had been vaccinated, then yes." (Resident 13)

Despite the negative factors, the decrease in close interpersonal contact contributed to feelings of protection. In this sense, because the LTCFs are places of high risk for infection by the coronavirus, owing to the high number of older residents sharing the same space, most of whom present comorbidities and physical and cognitive disabilities, having strict lockdowns was construed as a positive factor for slowing transmission of the virus and paramount to protect the residents[2,8,9,22].

Hence, there is clearly a host of different factors which contributed to the feelings and apprehensions among the institutionalized residents during the period of social isolation. It is noteworthy that this group is naturally more frail and vulnerable not only to COVID-19, but also to developing a range of mental problems. This creates a need to adopt strategies that minimize the negative impacts of social isolation on the mental health of this population[7].

Actions by residents to preserve mental and physical heath during pandemic social isolation

When probed about the coping strategies used during pandemic isolation to preserve mental health, the participants reported measures of being involved spirituality, domestic tasks, efforts to promote health and general wellbeing, such as praying, meal routine and sleep habits, personal hygiene measures (bathing) and use of prescribed medications, besides social distancing and use of face masks. This category can be exemplified by the views below:

> "It´s just to pray, eat and sleep. And summon God to help eradicate this problem, yes? Ah, I had to pray, right? (Resident 1)

> "Wow.. Did I summon God. I summoned God and pleaded with him to help me." (Resident 2)

> "It was sweeping up, taking care of the corner, taking care of this corners of the canteen, the refectory, you know? Taking showers, right?..." (Resident 3)

> "I showered the same way, ate, but wouldn´t go to the refectory the way I´m doing now, right?" (Resident 6)

> "Yeh, when I went out, I had to wear a face mask, right?" (Resident 7)

> "I had a shower, took my medications, lunch, dinner and breakfast, I slept and got up.. [...] They said "going out, you have to take the face mask, right?... We protected ourselves like that.." (Resident 10)

Based on Orem´s theory of self-care, which considers the individual ability to carry out actions for one´s own health and wellbeing, routine self-care activities are highly pertinent for leading life[15]. Given the pandemic period, when loss of autonomy and therapeutic requirements intensified, stimulating autonomy is relevant in the context of LTCFs so that older individuals can remain healthy and independent, particularly for basic activities of daily living (BADLs), such as bathing and feeding, as outlined earlier, as well as care activities promoting health, such as sleep, taking medications and using masks.

Also from this perspective of self-care, evidence shows that, possessing the capacity for resilience in coping with the challenges posed by the pandemic, older individuals are better equipped to deal with the difficulties imposed by the pandemic, restoring balance more easily and aiding the recovery of physical and mental health[12].

With regard to the activities undertaken by the older population during this period, engagement in spiritual practices through religion stood out. The activities cited by the participants, particularly praying, corroborate the fact that stimulating the use of religion as a form of resilience in challenging times is highly beneficial. These practices favor preservation of mental health in older adults, where benefits conferred by spirituality include regulating stress hormone and, in turn, well-being[23].

Another strategy mentioned was performing instrumental activities of daily living (IADLs), such as cleaning communal areas of the facility and tending to planters/gardens. The act of carrying out these activities, particularly by institutionalized residents, favors cognitive and motor stimulation and, consequently, helps these individuals maintain autonomy and independence. Thus, given the risk of sedentarism within LTCFs, it is fitting to encourage these activities in this population[24,25].

Social isolation and physical activity as part of the lives of residents

The interview revealed that social isolation and physical inactivity are part of the lives of institutionalized residents, irrespective of the pandemic and its social distancing rules. The fact that the residents showed they would normally remain isolated within the facilities, meant that many noted no differences between the lifestyle they led prior to and during the pandemic. Despite the biosafety measures adopted by the facilities, most notably rigorous lockdown and use of face masks, the routine within the facilities did not change greatly. This is evident in the narratives of the residents when asked about changes to their everyday routines during lock down amid the pandemic.

> "Ah, I didn´t do anything different at all. That was just it. Exactly the same." (Resident 4)

> "Well, same thing {…} So I felt no difference." (Resident 6)

> "No, didn´t affect anything really. We were ok here." (Resident 13)

> "But, I was like this, the same state as I am today. […] Just as I said, it came and went as if nothing had happened. We weren´t affected here, so I have no comment to make about the event.. I don´t know if it´s because of being isolated.." (Resident 11)

This category posed a major challenge that the older population typically face during the aging process: social isolation. This stage of life is often marked by a significant reduction in social interaction of the older individual with their family members, friends and/or society as a whole. Factors such as the presence of chronic diseases, social inequities and more restricted social network favor this isolation. However, ageism, characterized by stereotypes and prejudices against older adults, may explain the segregation of older citizens from society and their consequent social disengagement[23].

In the context of institutionalized older adults, allied with social stereotypes of aging, it follows that

institutionalization is accompanied by being more removed from the family and material things and social isolation even by LTCF workers[4].

Physical inactivity was another key point cited by the residents, with sedentary behavior within the facility, a ubiquitous feature of LTCF environments.

> "I was doing nothing, because it's true. As I did before, I didn´t have loads of things to do. […] Because we don´t do a lot anyway, sitting down all day." (Resident 4)

> "I did nothing. I hardly leave the room..[…]" (Resident 8)

This level of inactivity warrants attention given that, besides the fact that engaging in functional activities confers cognitive benefits in this population, it is also positive for strengthening the immune system, preserving musculature and regulating hormones[24,26].

Besides stimulating autonomy, the use of occupational therapy is believed to improve mood, where exercise associated with social interaction, healthy diet and good sleep hygiene are recommended. However, reducing sedentary behavior hinges on other factors, such as the motivation to do so[25,27].

COVID viewed as trivial

A number of participants demonstrated a lack of concern with the pandemic and, in some cases, no awareness of the seriousness of COVID-19, as illustrated in the statements below:

> "I even said it, I said it was rubbish. We had to remain confined, right? I said: no, that´s nonsense. God calls the shots. Did God not come here and say this? It´s he who sorts it out, God calls the shots." (Resident 5)

> "Ah me.. No, I didn´t like .. I didn´t like, give it much thought [..] I said it´s God´s will, right?" (Resident 9)

These accounts pertain to older adults residing in LTCFs, places with a high concentration of aged individuals and a higher level of frailty who are exposed to the entry and exit of people and materials on a daily basis, with a consequent substantially greater risk of exposure to the virus in this population. Furthermore, on both a national and global scale, institutionalized older adults were the main target of COVID-19, with a high number of infected residents who died as a result of the disease[8]

The findings for this category are consistent with a study of institutionalized older adults in a city located in Paraná State, where misinformation and a lack of interest regarding the impact of the pandemic were evident. These results highlighted that, although aware of the global crisis, little meaningful change was made in the daily routine of residents in response to the events involving COVID-19 outside the facilities. This poor response might be due to the low exposure to communication channels within the LTCFs[28].

Also, the COVID-19 "infodemic" to which the non-institutionalized older population was exposed meant they felt a much greater impact of the information conveyed, especially via social media platforms, triggering different negative psychological responses, such as depression, stress, anguish, anxiety, sadness and fear[28].

In this sense, the lack of concern over the pandemic exhibited by the residents proved a protective factor for the psychological response cited above. In these cases, religiosity served as a source of support amid the lack of concern with the disease and for coping with critical life events[29]. However, it is important to stress that there should be a balance between prophylaxis and lack of concern with the disease[8].

CONCLUSION

The reports of residents revealed that social isolation had a negative impact on the mental health of the older adults studied, exacerbating feelings of sadness, fear, loneliness, anxiety, concern, agitation, and upset experienced by these individuals.

In this context, the study showed that the period of isolation during the pandemic served to highlight the challenge faced by institutionalized older adults of living isolated lives, irrespective of the occurrence of the pandemic.

Amid this scenario, strategies for improving social interaction and preserving mental health were identified: engaging in spirituality, encouraging physical activity, ADLs and IADLs, digital inclusion of older adults, and practice of occupational therapy.

Limitations of this study include the fact that data collection was performed only for residents of two philanthropic LTCFs. This limitation precludes generalization of the study findings to other institutionalized older adults in the city. Future studies of this nature including private LTCFs are suggested.

Lastly, the results of the present study help further understanding on the impacts of social isolation on the lives and mental health of institutionalized older individuals. The findings also contribute to discussions and reflections on better strategies for managing the social and health needs arising from the pandemic. In the context of gerontological nursing, the study underscores the importance of providing better strategies for addressing mental health and social interaction among LTCF residents to mitigate the consequences of social isolation in this population.

AUTHOR CONTRIBUTIONS

- Iasmin Narciso – Conception, data collection, analysis, interpretation and writing.
- Flávia de Oliveira – Interpretation and critical review
- Silmara Nunes Andrade – Interpretation and critical review.
- Kellen Rosa Coelho – Conception, analysis, interpretation, writing and supervision.

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