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Walden University

College of Psychology and Community Services

This is to certify that the doctoral dissertation by

Heidi Beth Lubetkin

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2024

Abstract

Residential Older Adults' Experiences Related to Mental Health from COVID-19 Isolation

by

Heidi Beth Lubetkin

MA, Walden University, 2017

BS, Charter Oak State College, 2015

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human and Social Sciences

Gerontology Specialty

Walden University

August 2024

Abstract

The COVID-19 pandemic exacerbated many illnesses afflicting older adults in U.S. communities, including mental health wellness. Since 2020, at the inception of the pandemic, older adults living in residential settings, including assisted living and skilled nursing homes, experienced harsh limitations in their everyday lives. The conditions included prolonged periods of isolation and reduced interactions between caregivers and loved ones. Therefore, it is important to understand the experiences of older adults living in facilities and their ability to adapt to the environment. The research question addressed in this study gained insight into the effects of mandated isolation on older adults. Using the conceptual framework of selection, optimization, and compensation model, the research demonstrated the coping ability of older adults, and the theoretical framework of the sociological perspective of ecological theory helped to explain the interactions between the environment and the older adult. Using a qualitative study, seven residential older adults were interviewed using semistructured interviews, with data being analyzed through a six-step thematic process. There were 19 codes identified during the thematic analysis, and five categories were identified, including: (a) coping, (b) isolation, (c) support and response, (d) mental health, and (e) isolation. The positive social change impact of this research may help caregivers, practitioners, and policymakers increase their preparedness for future pandemics and determine the best mandates to impose, given the postpandemic effects of such decisions.

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Dedication

This dedication is for my loved ones who have entered my life and provided purpose to my journey. I want to honor in memory my only brother, Matthew, who took his own life while I was completing my dissertation. While he will not be here to see the finish line, I know he is proud. I want to thank my husband, Eduardo, and my beautiful children, Jeremy Paul, Alexander, Carter James, and Isabella, for taking on extra chores and providing unconditional love. Lastly, I want to dedicate this dissertation to the communities of older adults I am so grateful to serve every day.

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I want to acknowledge the amazing experts, academic professionals, practitioners, peers, and older adults who selflessly contributed to the success of my journey. My sincere appreciation for Dr. Kelly Chermack, my Committee Chair, who is truly a gift and relentless support. Dr. Chermack, you will forever be a part of my life, and I am grateful for your calls, texts, weekend emails, and Zoom calls. I would also like to acknowledge Dr. Andrea Holzner, my second Committee Chair, for mutually caring for a community so important to us both, providing her expertise in this journey, and believing in my topic.

Thank you to the old adults who shared their experiences coping with a once-in-a-lifetime experience, contributing their stories to history, my journey, and milestones.

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Chapter 1: Introduction to the Study

Introduction

The COVID-19 pandemic has exacerbated illnesses afflicting older adults in our communities, including mental health wellness. Since 2020, at the inception of the pandemic, older adults living in residential settings, including assisted living and skilled nursing homes, have faced harsh limitations and restrictions in their daily lives (Wong & Li, 2021). The conditions executed by regulators and administrators included prolonged isolation, mandated quarantine, and the reduction of interactions between caregivers and loved ones (Wong & Li, 2021). These mandates impacted the overall mental wellness of older adults. Therefore, it is important to understand the experiences of older adults living in these residential settings and their ability to adapt to the environment and develop coping mechanisms. As the older adult population grows over the next two decades, practitioners, older adult caregivers, and policymakers need to know about the collective impact of the pandemic to ensure that resources, programming, and funding are available to support the population in a post-pandemic era.

Background

Infectious diseases throughout history have impacted the world, yet our response and mitigation have adjusted over time (Novella, 2022). Global diseases, termed pandemics, affect populations without discrimination and include examples such as the Spanish Flu of 1918 and cholera (Piret & Boivin, 2021). Despite the historical presence of pandemics, the world was greatly affected by this century's pandemic, noted as SARS-CoV (Piret & Boivin, 2021). The sources of the SARS-CoV virus, also known as

COVID-19, are still unknown (National Institute of Allergy and Infectious Diseases, 2022). Despite being unsure of the cause, the first cases of confirmed COVID-19 were reported in Wuhan, China, on January 7, 2020, with the first confirmed case in the United States from Snohomish County, Washington, on January 20, 2020 (Holshue et al., 2020). On February 20, 2020, the United States recognized the first death caused by COVID-19 (World Health Organization, 2021). As of September 24, 2023, the death toll from COVID-19 was 1,127,152 in the United States and 6,958,486 globally (Coronavirus et al.). Further research is warranted that could explore mental health perceptions of COVID-19-mandated isolation from older adults living in assisted living and nursing homes in the United States to address the documented problem of mental health wellness due to COVID-19 mitigation in older adults living in a residential setting (Armitage & Nellums, 2020).

Problem Statement

The effects of the COVID-19 pandemic compounded many illnesses and comorbid illnesses, including mental health (World Health Organization, 2022). One of the more heavily afflicted populations was individuals diagnosed with mental health disorders, especially older adults. Before the pandemic, 15% of older adults were diagnosed with mental health conditions, such as depression and anxiety (National Institute of Mental Health, 2022). This is concerning as the population of older adults is rapidly growing and, based on the latest available information in 2023, will double in size, from 12% to 22% by 2050 (World Health Organization, 2017). Older adults experiencing mental health disorders are more likely to experience obstacles relative to

social determinants of health, including socioeconomic barriers and increased cognitive decline (Tan et al., 2022). This disparity within social determinants of health is more prevalent in impoverished populations, as 57% of impoverished individuals exhibit a correlation between barriers of social determinants and cognitive decline (Tan et al., 2022). Concern for the mental health of older adults and the experience of barriers contribute to an increased risk for suicide in older adults (Liang et al., 2022). Mental health concerns in older adults existed before the pandemic and were further worsened due to the enforced quarantine measures to mitigate COVID-19 (Ana Victoria et al., 2021; Borelli et al., 2022). The safety protocols mandated created social isolation, reduction of human interaction, limited in-person family support, and prolonged loneliness (Ana Victoria et al., 2021; Borelli et al., 2022), demonstrating increased challenges for the older adult population. Limited interaction and loneliness may cause triggering events that lead to increased mental health challenges, including anxiety, depression, suicide ideation, or attempts in older adults (Pulgar et al., 2022). In the United States, older adults die from suicide at a rate of 47.2% compared to their counterparts, demonstrating an alarming disparity (Pulgar et al., 2022).

According to Wong and Li (2021), physical distancing is one of the most effective mitigation strategies to prevent the spread of COVID-19, particularly in areas of great density. This strategy was used consistently as a form of mitigation in older adult residential settings such as assisted living and nursing home facilities. Additional mitigation strategies included stay-at-home orders, cancellation of group activities, and prohibiting visitation (Ana Victoria et al., 2021). While these strategies may have

reduced the spread of COVID-19, the consequences caused significant effects on the mental health of older adults (Ilgili & Gokce, 2020), particularly individuals living in residential settings (Perez-Rodriguez et al., 2021). Density in nursing homes and assisted living facilities caused COVID-19 outcomes to worsen for those living in those settings (Falvo et al., 2021; Wong & Li, 2021). The problem is that COVID-19 mandated isolation affected residential living older adults' mental health. The specific research problem that will be addressed through this study is the problem that older adults aged 60 years or older residing in assisted living or nursing homes were affected by the COVID-19 pandemic of mandated isolation.

Although researchers have investigated this issue of COVID-19 impact, the topic has not been explored in this way, and I have found no research that has explored residential living older adults' experiences related to mental health from COVID-19 isolation, including assisted living or nursing home facilities. Given such, further research is warranted that could explore mental health perceptions of COVID-19 mandated isolation from older adults living in assisted living or nursing homes in the United States to address the documented problem of mental health wellness due to COVID-19 mitigation in residential living older adults (Armitage & Nellums, 2020). The research could further benefit older adults living in a post-pandemic era, their caregivers, human services field practitioners, social services advocacy experts, and regulatory associations responsible for the care and services in residential settings for older adults.

Purpose of the Study

The purpose of the generic qualitative study is to explore how older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation.

The logical connections between the framework presented and the nature of my study include several components. The interpretation of the findings in this study have been looked at through the lens of the sociological perspective of the ecological theory (SPET) and the selection, optimization, and compensation model. Using the research question established, a thematic analysis has explored the findings from semistructured interviews of older adults and their experiences of COVID-19 isolation during the pandemic. The SPET provided the framework to explain the results as to why older adults living in assisted living or skilled nursing homes that had COVID-19 isolation restrictions had effects resulting in mental health. The selection, optimization, and compensation model helped to explain why mental health exists in some older adults and does not exist in others.

Research Question

How do older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation?

Theoretical Foundation

A theoretical and conceptual framework was used in this research study to fully explore how older adults aged 60 years or older residing in assisted living or nursing

homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation. These selected frameworks include the theoretical framework entitled the SPET (Bronfenbrenner, 1996) as the lens to understand further the relationship between COVID-19 isolation restrictions and the effects on the mental health of older adults living in a residential setting of an assisted living or skilled nursing facility. This theory provided a basis to explore the relationship between older adults, their facility environment of either an assisted living or skilled nursing home, and their ability to either succumb or succeed as the survivor of the fittest. The ability or inability to thrive is a foundational tenet of this theory. As the researcher, I analyzed the participants' responses to determine if they adapted to the environment, reported positive or negative feelings from the isolation, and how they responded to other interactions.

Conceptual Framework

The conceptual framework entitled selection, optimization, and compensation model further enhances the theoretical framework. This model was first established by researchers Baltes and Baltes (1993) to study the aging process. The framework further grounds this study as the isolation restrictions align with the three central tenets of the model. The first tenet, described as selection, is represented through the older adults' residential setting executed isolation. The optimization component is conveyed through the adaptability of the older adult, which can be positive or negative. The compensation component is observed through the types of adaptation of the older adult, such as increased emotional coping mechanisms or decompensation and feelings of mental health symptoms (Baltes & Baltes, 1993). Through the responses from the participants, this

model guides the analysis as to how the isolation affected the mental wellness of older adults, determine the coping mechanisms that may have been created, and the adaptability to thrive or succumb in an environment the participant(s) lived during their COVID-19 isolation.

Nature of the Study

Researchers conducting qualitative research have many options when designing the study's approach. One of the critical elements to determining the method is reviewing what will be studied, such as cultures, norms, daily lived experiences, or a new phenomenon (Patton, 2015). The characteristics of these approaches include their disciplinary roots, central research questions, unique terminology, data sources, sampling issues, and data analysis to indicate the best choice for the approach.

In this study, I have designed my research question using a qualitative approach. The qualitative design is aligned with the research, as I explored individual's experiences and not the relationship among variables implied in a quantitative design. This research study used a general qualitative inquiry, which allowed me to explore how older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation is broad to allow for adequate topic exploration (Patton, 2015). This study was exploratory in nature, and data was collected via semi-structured interviews of older adults living in assisted living or nursing home facilities aged 60 years or older. A general qualitative inquiry was the best for the nature of this study and research question (see Patton, 2015). This type of study was selected to thoroughly explore the perceptions, attitudes, and

opinions of the mandated COVID-19 isolation from the perspective of older adult individuals. The virus known as COVID-19 is a relatively new phenomenon, and grounded theory may have been applicable. However, I have selected a theory and framework; therefore, I did not select grounded theory.

Definitions

The following terms will be read throughout this research, and corresponding definitions will allow the reader to incorporate the meaning and understanding of key terms fully:

Activities of daily living (ADL): These are tasks or mobility of an individual that may be routine to most. The duties may include bathing, dressing, eating, and one's ability to be mobile (Edemekong et al., 2022).

Assisted living facility: A place whereby individuals live in apartment-type settings, in a dwelling that is not shared with others. Centers for Medicare and Medicaid Services do not govern these settings; they can be privately owned and sometimes privately paid for by residents or subsidized (National Institute of Aging, 2017).

C*ognitively intact:* Describes an individual who demonstrates insufficient judgment, planning, organization, or self-control within conducting activities of daily living or instrumental activities for daily living (National Institute on Aging, n.d.).

Institution: A place whereby individuals requiring a specific level of care live as a temporary or permanent residence and receive supportive living care with their activities of daily living; it can also be referred to as a skilled nursing facility in the context of older

adult care. The Centers for Medicare and Medicaid Services governs the residence (National Institute of Aging, 2017).

Nursing home facility: An example of a type of institution, also referred to as a skilled nursing facility, the focus of care is medically oriented (National Institute of Aging, 2017).

Older adults: The section of the population defined as aged 65 years or older; for purposes of this study, this definition was modified to be 60 years or older to incorporate the definition from the United States Older American Act (National Institutes of Health, 2022; Administration for Community Living, 2016).

Residential: A facility-based setting whereby older adults and/or others deemed eligible may live. (National Institute of Aging, 2017).

Assumptions

This study has several aspects that are believed to be facts. Therefore, I cannot demonstrate these facts to be true and are being referred to as assumptions. There are two assumptions associated with this study. First, I have assumed all participants provided truthful answers during my interaction(s). The older adults interviewed during this study have met participation eligibility, including age and residential setting, and their responses to the screening are assumed to be truthful answers. All older adults participating are cognitively intact and not conserved, assuming this will ensure the accuracy of their responses. In addition, older adults may embellish their perspectives to express their experiences. To promote accurate responses, I ensured to all participants that their answers are meaningful and important to the body of research, which in turn

validated their experience. The second assumption is that data saturation was reached based on the definition defined in the methodology section. A participant recruitment strategy was defined to promote data saturation, and thematic analysis was selected to ensure an ongoing review of themes until saturation was met.

Scope and Delimitations

The scope of this study is limited to exploring the experiences of older adults aged 60 years or older residing in an assisted living or nursing home during the COVID-19 pandemic and mandated isolation. As the researcher, I selected assisted living or skilled nursing homes and no other older adult settings, as these facilities mandated the harshest of mandates in their communities (Wong & Li, 2021). While older adults in independent living, individual homes, or other congregate settings coped with COVID-19, they had a choice regarding how they wanted to conform to public health recommendations. Those living in the contrast settings had to adjust to public health mandates such as prolonged restrictions of visitors, isolation, and decreased support with activities for daily living. The study is limited to those 60 years or older and did not include younger individuals or those deemed disabled (often a population living in skilled nursing homes). The characteristics of older adults align with the definition from the Older American Act (Administration for Community Living, 2016). It is limited to give a consistent approach to eligibility for the study. In addition, the scope of this study was limited to those deemed cognitively intact and competent to ensure historical experiences could be expressed with accuracy. There is no limitation on the gender of participants, which supports the complete exploratory nature of the research question. Lastly, this study was

limited to a six-step thematic analysis to ensure alignment with the research question, opportunity for clear themes and categories to be presented, and study saturation.

Limitations

This study has several limitations, barriers, or challenges for consideration. Based on the qualitative design of the research and selected population, there are internal validity threats, including (a) history, (b) mortality, (c) and illusory correlation. History is chosen as a threat based on the aging process of residential older adults and the selected periods, as it may have been challenging to identify a sufficient number of volunteers to provide historical information on their experiences during COVID-19-mandated isolation. Mortality is a potential challenge based on the age and medical status of those participating in the study. This challenge would have occurred if interviews were scheduled and the participant could no longer participate, or if follow-up interviews were required. If the person had passed, it would have caused the initial data to be invalid. To mitigate these challenges, a large group of participants was identified in the sample size to reach sample size saturation.

The American Psychological Association (APA, 2022) publishes the ethical considerations required for research, and the IRB ensures compliance with these standards. Several components must be considered in this qualitative study, which includes: (a) consent, (b) solicitation, (c) debriefing, (d) confidentiality, (e) anonymity, and (f) storage of data. The first consideration is the population selected: older adults aged 60 years or older. The older adults who volunteered were all considered legally competent to participate and competent to provide consent, were not conserved by a

person or estate, and did not present during the interview with any symptoms that could be regarded as cognitively impaired. If the person had appeared for the interview and was no longer defined as competent, a discussion would have occurred with the participant and the participant would have been removed from the study. All participants were able to consent to participation in the study. Based on confirmed ability to consent, all individuals interviewed provided a verbal approval of informed consent to ensure documentation in the transcription of their consent to participate with a complete review of the study components.

Participants in the study were only solicited to participate based on allowable activities described in the procedure. Debriefing was conducted with all participants promptly after the interview to ensure the participants had a clear understanding of the research and were in a clear state of mind. The confidentiality of the older adult and the residing facility is an element of ethical consideration. Therefore, the participating facilities will be confidential and not published in the study; only the data collected will be used and shared based on unique identifying information. The voluntary design study also supports an ethical manner that complies with IRB standards. During the process, volunteer participants could have removed themselves from the research, and the data collected would be disqualified. Given participants' age, potentially vulnerable status, and questions that could trigger feelings or emotions, all participants were provided with a list of mental health providers. All documents used, collected, and analyzed for the study are secured in a locked area in my home office with the sole key in my possession to ensure confidentiality.

There are other avenues to ensure credibility in this qualitative study. Establishing credibility through internal validity will ensure that the accuracy of the respondent's answers is mirrored in the data reported in the study. This study also ensured the accuracy of the data and adherence to the practice of generalizability and transferability, which allows for the conclusions to be applied to the general public or afflicted populations studied. As the researcher, I also deployed several strategies to ensure compliance, including extended participation, which allows for adequate time to be within the culture studied, test for falsified information, build trust, and repeat the procedure several times. The continuous observation and data collection from participants allowed adequate time to identify findings, themes, or results that may evolve over the length of the study. The triangulation strategy was also used in this study, using several methods to draw conclusions, including a literature review and data collected from multiple types of dwellings in which older adults live, defined as assisted living and nursing home facilities. Lastly, audit trails were used to ensure compliance and credibility with the research.

Significance of the Study

This study has several areas of significance. This study is significant in that the results of this study provided much-needed insights into the consequences of COVID-19 lockdown measures on older adults living in assisted living or skilled nursing homes. Specifically, examining results from the experiences on the effects of the mandated isolation periods and feelings of mental health is important. Insights from this study provided essential information to key stakeholders in the human services and social

services or mental health fields, including resident services coordinators, mental health professionals, Executive Directors of older adult communities, and local and national trade organizations working with older adults. While many organizations fit within these categories, specific examples include the State of Connecticut Departments of Public Health, Department of Human and Social Services, Department of Mental Health and Addiction Services, Connecticut and National LeadingAge trade association, Connecticut Assisted Living Agency, New England Resident Services Coordinators, Inc., Community Renewal Team, Inc (local community action agency) and Connecticut Chapter of North Central Area Agency on Aging. As an example of such significance, a local skilled nursing or assisted living facility may review the research and evaluation of their residents' mental health screening results and decide on an individualized plan for mandated isolation measures for their older adults. Another example of significance relates to future practitioners looking at the research and determining if their community is at increased risk for exacerbated mental health or depression within their older adult population.

The social change significance of this study creates opportunities for an improved risk and benefits review before imposing harsh, isolating, and challenging mitigation efforts on older adults. The older adults may fare better based on changes in programming, evaluation, and assessment due, in part, to the results of this study, which improves their quality of life. The information delineating nursing homes and assisted living may also provide critical information on how one type of institution’s older adults will fare compared to the other. Of note, the specific organizations listed are in

Connecticut, as this is my residence; these organizations may exist in other states and allow for replication of significance.

Summary and Transition

Older adults living in residential communities require aligning support services in a post-pandemic era based on their COVID experiences. This research has helped to gain an understanding of how older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation. Using both the conceptual and theoretical frameworks as a lens to this identified problem, the research findings concluded themes that represent the mental wellness of older adults. As observed in Chapter 1, an introduction has ensued regarding the background, problem statement, purpose of study, and research question to address and learn more about the experiences. In Chapter 2, a comprehensive literature review will represent topics such as successful aging, isolation, mental health in older adults, the history of COVID, and mitigation efforts in residential settings. The third chapter will document the areas relative to this study's research design and rationale. This chapter includes sections for methodology, participant selection, procedure and recruitment, and the data analysis plan. The remaining chapters of this study, Chapters 4 and 5, will include the results, study discussion, conclusions, and recommendations to address social determinants of health factors and future studies. The overall expectation of this research study was that the findings contribute to the body of research while seeking more answers in the gaps in the literature.

Chapter 2: Literature Review

The specific research problem that will be addressed through this literature review is the problem that older adults aged 60 years or older residing in assisted living or nursing homes were affected by the COVID-19 pandemic of mandated isolation. The purpose of this generic qualitative study is to explore how older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation. The following literature review will provide a history of the pandemic, the effects of COVID-19 on the older adult communities, specifically those living in residential settings, a discussion of mental health concerns in older adults, and a contrasting discussion of successful aging.

Literature Search Strategy

There were several databases that I used in the literature review search, including:

1. Thoreau Multi-Data base,
2. SAGE Journal,
3. CINAHL Plus,
4. MEDLINE with Full Text,
5. APA PsycInfo,
6. Social Science Citation Index,
7. Journal of Gerontology Social Work,
8. JMIR Aging,
9. American Journal of Geriatric Psychiatry,
10. American Journal of Infection Control,

11. American Psychology,
12. PLoS One,
13. Lancet Global Health,
14. Research in Nursing and Health,
15. Ageing Society,
16. Journal Clinical Nursing,
17. International Journal of Environmental Research in Public Health,
18. Gerontologist,
19. Center for Medicare and Medicaid Services, and
20. Centers for Disease Control.

Important terms were selected when searching the above databases to ensure proper research was completed and saturated. The following key terms were used to search and include:

1. older adults,
2. skilled nursing facilities,
3. assisted living facilities,
4. covid
5. coronavirus/COVID-19/SARS-COV2,
6. personal protective equipment,
7. social isolation,
8. socioeconomic factors,
9. quantitative results,

10. qualitative results,

11. nutrition,

12. Weight,

13. communicable disease control,

14. Suicide,

15. Community-dwelling,

16. Depression,

17. Qualitative studies,

18. Quantitative studies,

19. Meta-Analysis,

20. Gerontology,

21. Centers for Disease Control [CDC],

22. Centers for Medicare and Medicaid Services,

23. Regulations of…[items #1-7],

24. Evidence-based tests for Mental Health,

25. Evidence-based tests for Falls,

26. Standardized testing,

27. PHQ-9, and

28. Successful aging.

All research selected were peer-reviewed articles, and publication was mostly limited to the last five years. In research whereby the information is cited to be more than five years, this is due to informational purposes, seminal authors, and or definition.

Theoretical Framework

The theoretical framework selected, Sociological Perspective of Ecological Theory, uses the seminal researcher Urie Bronfenbrenner, who is often chosen in similar human and social services studies. This theory aligns both with the population being studied and the methodology selected.

Sociological Perspective of Ecological Theory

This study uses the SPET as the lens to further explore the perspective of older adults during COVID-19 mandated isolation. This theory combines research from its original theorist, Urie Bronfenbrenner (1977), and the ecological systems theory, which looks at plausible relationships between human beings and their environment with work from Thomas Malthus and Charles Darwin (McPhearson, 2005). The sociological component of the theory dates to 1798 and a publication entitled “Essay on the Principles of Population” by theorist Thomas Malthus (McPhearson, 2005). Charles Darwin further enhanced the theory by establishing the theory of survival of the fittest. Several traits are present within the SPET, which include adaptation and selection, relating to an individual’s ability to adapt to challenges, obstacles, or threats within their environment and changes made to lessen the effects and adjust. The alignment persists between SPET and this study, recognizing the presence of the two main characteristics, adaptation, and selection.

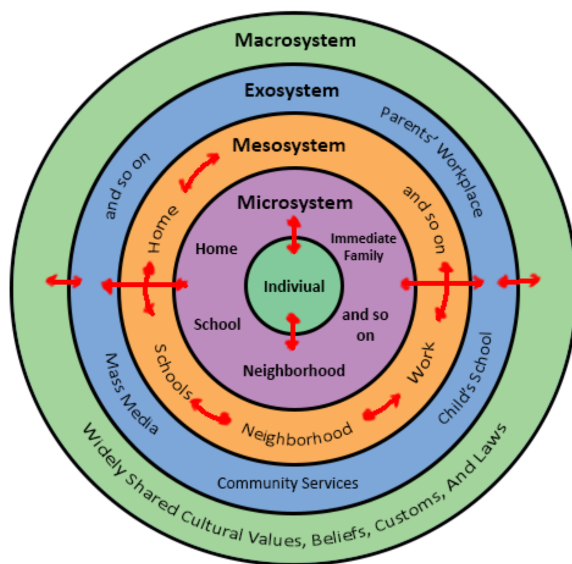
SPET is a theory frequently used in social and human services research. It is often used to explore elements affecting the lifespan and is considered a holistic approach (Bettis et al., 2020). Bronfenbrenner’s human ecological theory is broken down into five

individualized systems to define the meaning between an individual and their environment (Bronfenbrenner, 1996). These five systems included: (a) microsystem, (b) mesosystem, (c) exosystem, (d) macrosystem, and (e) chronosystem. The microsystem is driven by the group that has the most contact with the individual; this would include the person's family or household, while the mesosystem is defined as the relationship of the groups that occur, such as the relationship between one familial person and the other with the individual. The exosystem is the external relationship that may impact the individual from the familial group; in this case, it could be the family member's workplace related to the individual. The macrosystem indirectly influences the individual and includes cultural elements, values, or organized religion. The last system in Bronfenbrenner's human ecological theory is the chronosystem, which describes an individual's life stage during an event in their life. All these levels within the theory help to understand an individual and their relationship to the environment.

Bronfenbrenner's human ecological theory is often displayed in a circular depiction representing the levels of the systems; the description is noted in Figure 1. Specifically, an individual's interaction with these systems helps to describe the strengths or weaknesses within behavioral outcomes for those affected within the system during a particular event. For this study, the particular event is the mitigation strategy of mandated isolation in response to the COVID-19 pandemic.

Figure 1

Bronfenbrenner's human ecological theory



Conceptual Framework

The conceptual framework selected is documented by authors Baltes and Baltes. The model is synonymous with older adult content, and seminal authors Baltes and Baltes are considered experts in aging and Successful Aging.

Selection, Optimization, and Compensation Model

The study is further grounded by the conceptual framework model entitled selection, optimization, and compensation model (SOC). This model was first established by researchers Paul B. Baltes and Margaret M. Baltes (Baltes & Baltes, 1993) to study the aging process. Their research is significant to those studying older adults, as previously, many lifespan studies focused solely on infancy, adolescence, and middle life (Baltes & Baltes, 1993). The SOC model now allows for discovery through the lens of

developmental stages in any component of the lifespan, including early, middle, and older adults (Zajac-Lamparska, 2021). Based on an individual's responses in the lifespan, the SOC will demonstrate how the individual perceives life's goals, completes adjustments to adapt, and responds to setbacks. This self-assessment and an individual's monitoring of goals determines the person's perception of well-being and life management (Zajac-Lamparska, 2021).

The SOC framework further grounds this study as the mandated isolation restrictions align with the three central tenets of the model: selection, optimization, and compensation. The first tenant selection is expressed through mandated isolation. The next tenet, described as optimization, is observed by the older adult's ability or inability to adapt to the environment. The last tenant, compensation, is observed through the types of adaptation, such as increased emotional coping mechanisms or decompensation and feelings of mental health symptoms. This conceptual framework and interview responses from older adults supported an exploration of how the different components interact. The SOC model is appropriate for this study based on the population being studied and the ability to align the model with the research question and method described.

Literature Review

The literature review begins with discussing successful aging through the lens of practitioners, researchers, and older adults' perspectives. The literature on successful aging is pertinent to my research problem and purpose, as the experiences of isolation during COVID-19 may affect older adults' attitudes toward successful aging. Further, the ability of an older adult to adapt and develop coping strategies during isolation may also

impact their ability to continue to age in a successful, meaningful way. The remainder of the literature review will discuss the history of the pandemic, including the impact of isolation on an older adult's mental health and how one's environment may have influenced strategies and coping through the pandemic. These components demonstrate the importance of this study for older adults to thrive and, when this is not feasible, to ensure that social delivery systems provide safety nets to help those in need.

Successful Aging

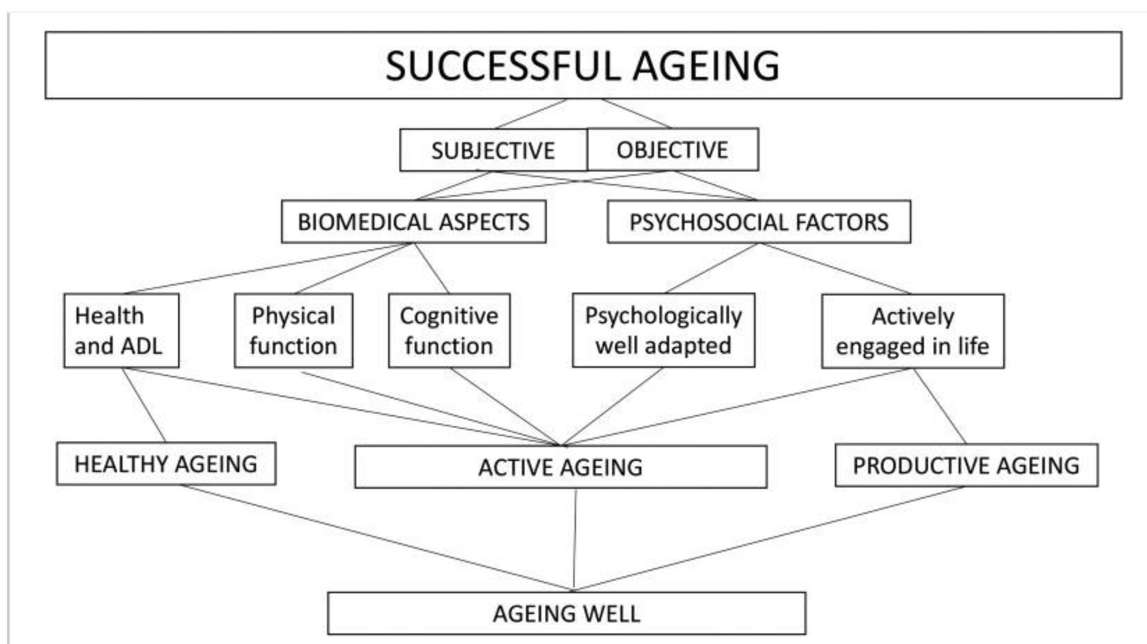
An individual's lifespan is finite and ranges from one's beginning or birth until death. As an individual grows older, they may eventually become an older adult and live through the ending years of their lifespan. Successful aging helps to describe the multifaceted concept of the individual's adaptability to thrive (Annele et al., 2019). This concept is not limited to medical components and includes social health determinants and emotional/mental wellness elements. The term has evolved, however, through many different iterations. First used by scholar Robert J. Havighurst in 1961, the term successful aging was used to describe the happiness and satisfaction of the older adults in their "old age" (Havighurst, 1961). A more commonly used definition was established in 1978 by scholars Rowe and Kahn, who added the medical component to assess successful aging (Calasanti, 2015). The modern expression of successful aging incorporates a multi-faceted definition from these seminal practitioners and others. The segments include, at minimum, satisfaction, happiness, medical/physical health, cognitive ability/decline, active social life, healthy relationships, and the ability to control decisions (Calasanti, 2015; Havighurst, 1961). An interesting caveat to these segments is the longevity

characteristic, which, according to Bhattacharyya et al. (2023), is not an older adult's perspective of successful aging. This may infer that older adults perceive quality of life as more important than quantity of years.

When studying successful aging, it is important to acknowledge the many terms that can be used to describe this phase of the lifespan. First and foremost, the term successful aging may imply that this phase only exists when an individual is thriving; therefore, other terms can be used interchangeably, such as healthy aging, productive aging, and aging well, to name a few (Annele et al., 2019). A common diagram used to express the relationship factors is published by Fernandez-Ballesteros and noted below (Rocío Fernández-Ballesteros et al., 2019):

Figure 2

Successful Aging Diagram



There are subjective and objective components in the facets of aging, as demonstrated in the figure. The elements are further broken down into areas that impact the older adult's ability to thrive or decline, such as health, activities of daily living, physical/cognitive functioning, activity, and psychological/mental fitness. As older adults age, researchers suggest successful aging occurs when these factors are positive. In contrast, older adults will not be considered aging well when the factors are negatively impacted or when decline is observed (Annele et al., 2019).

An older adult's aging process may also be impacted by their environment. For review purposes, the environment may include the older adult’s residence, neighborhood, community, and network (Yoshida et al., 2022). According to the World Health Organization (2020) and the International Classification of Function, Disability, and Health, an older adult’s health, and aging are determined by the interactions between environmental factors and other social determinant factors (Yoshida et al., 2022). This intersection between the older adult and the environment can be further illustrated by the model of selection, optimization, and compensation (Baltes & Baltes, 1993). In factors where intersectionality is positive, researchers suggest that older adults' perspectives are that of successful aging. In contrast, when there are adverse outcomes, a lack of successful aging persists (Low et al., 2023).

As noted, successful or healthy aging is an important component of the lifespan. As an older adult progresses through their life cycle, interacting positively with the environment and other elements will garner their perspective of quality of life. According to Low et al. (2023), older adults consider successful aging to occur when they meet

criteria including being healthy, maintaining family relationships, and having a caring social environment. This is important to the subject of this research paper, as well as the impact of mandated isolation periods in response to COVID-19. During isolation periods, older adults may have experienced a sense of loss, decreased ability to maintain a relationship, and/or experienced other negative outcomes. In contrast, the mandated isolation may also have provided opportunities for the older adult to report experiences whereby they developed or used coping strategies, learned new skills, or acquired new relationships. Researching the impact of isolation on older adults, particularly in community settings such as assisted living or skilled nursing homes, will provide supplemental information into these factors.

Older Adults and Restricted Environments

Older adults living in residential settings have encountered restricted environments, isolation, and physical inactivity due to COVID-19 mitigation efforts (Wong & Li, 2020). Strategies such as lockdown measures consisting of quarantine and isolation sought to decrease exposure to the virus, limiting illness and death (Falvo et al., 2021). Social distancing was also used to limit the spread of the virus (MacIntyre & Wang, 2020). In some settings, this would result in periods whereby older adults would not have the ability to leave their designated room, apartment, or home. While it is unclear what the total impact of COVID-19 will have on older adults after the pandemic, in May 2020, the World Health Organization reported that more than 95% of COVID-19 deaths were among those 60 years or older (WHO, 2022). These statistics are one explanation supporting the enforced restrictions, but there is another position to consider.

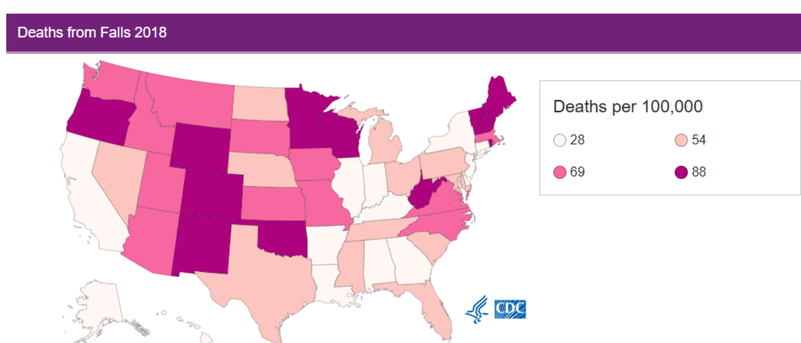
These mandates, while reducing exposure and decreasing deaths of older adults, created unintentional consequences (Wong & Li, 2020). The inability to move about freely, in turn, caused a reduction in physical activity, a more sedentary lifestyle, isolation, and negative changes in health behavior for this fragile population (Moro & Paoli, 2020). These health behaviors have impacted the overall quality of life for older adults, including aspects of mental health, increased fall risks, weight changes, and decreased muscle, to name a few (Moro & Paoli, 2020; Siegmund et al., 2021).

The lockdown mitigation efforts of COVID-19 severely impacted older adults. Due to the restrictions, physical inactivity, isolation, and a sedentary lifestyle ensued. Several themes were identified whereby these health behaviors should be addressed to improve the overall quality of life through the end stages of the lifespan. Based on the latest available information in 2023, as of July 2020, there were approximately 76 million older adults in the United States, defined as individuals aged 60 years or older, representing nearly 20 percent of the total population (Duffin, 2021). During the pandemic, this population faced grave outcomes, including the most significant percentage of mortality (Statista, 2022). According to June 14, 2023, mortality statistics, there have been 858,323 older adults defined as 65 years or older who have succumbed to death with a primary diagnosis of COVID-19 (Statista, 2022). While this statistic is tragic within itself, the consequences are also essential to comprehend, including effects on mental health, with 20% of older adults diagnosed with some mental health effects (SAMSHA, 2022; Stival et al., 2022), changes in weight and nutritional status (Nakayama, 2020), and increased falls (Centers for Disease Control, 2020). Falls are a

severe consequence of physical inactivity and are detrimental to older adults. According to the Centers for Disease Control, falls cause severe injury; one out of five falls in older adults, with over 800,000 resulting in a hospital stay for treatment of a head injury or hip fracture (Centers for Disease Control, 2020). These injuries can lead to mortality in older adults. Figure 3 depicts the deaths per 100,000 people in the United States.

Figure 3

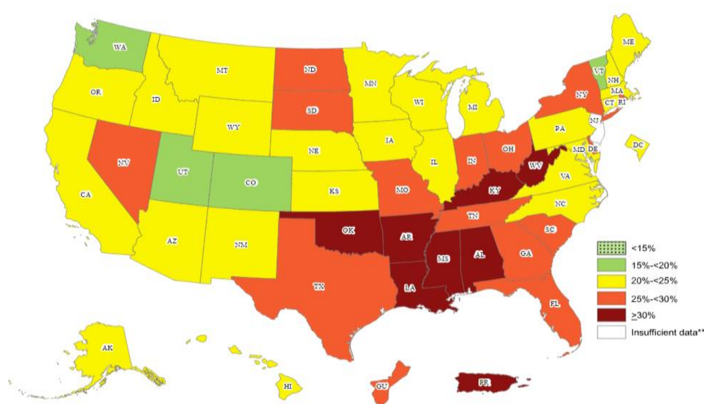
Deaths Caused by Fall in Older Adults in the United States



Before the pandemic, older adults were already affected by a sedentary lifestyle, and the restrictions on activity and enforced isolation worsened this characteristic. Physical inactivity among older adults is prevalent throughout the United States. The physical inactivity of older adults is displayed in Figure 4, which demonstrates a high number of states that have reduced inactivity at or above 20%, with 7 of the states reporting 30% or more significance of 30% or more of inactivity (Centers for Disease Control, 2020). The location for the proposed program is in Connecticut, showing a 20-25% level of inactivity.

Figure 4

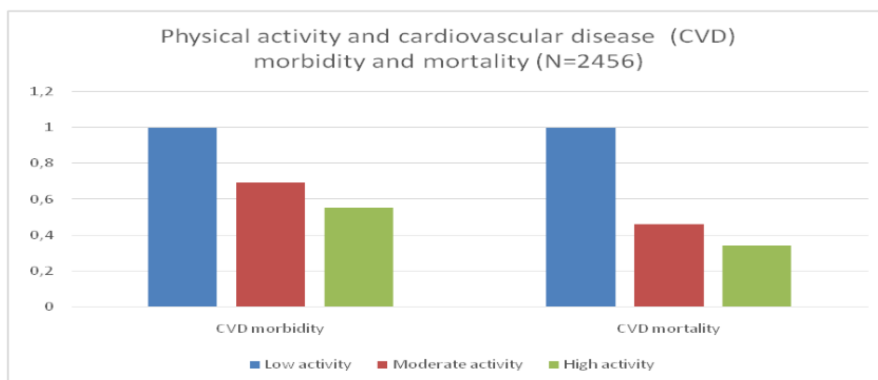
Prevalence of Physical Inactivity Self-Reported by US Adults 2017-2020



There is a strong correlation between the impact of physical inactivity and the likelihood of disease. Cardiovascular disease or heart disease is one condition whereby a connection has been noted. According to the National Institute of Health, the prevalence of heart disease increases based on the effort of physical activity of an individual (Heart Health and Aging, n.d.) The following chart demonstrates the prevalence of heart disease and activity levels, showing low, moderate, and high activity levels and the relationship between comorbidity and mortality.

Figure 5

Physical activity and cardiovascular disease



Understanding the impact of disease and its correlation to the restrictions from COVID-19 demonstrates a potential inability for older adults to age successfully. An older adult's perception of disease or aging in an unhealthy manner enforces a poor quality of life.

Another example of restriction and its impact on older adults is found in a longitudinal diabetic study. Published in *BMC Geriatrics*, authors Li Ai Tai et al. (2023) demonstrate a correlation between activity limitations and restrictions with outcomes from diabetes. A collective of 110 older adults aged 65 years or older participated in the study, with multiple evidence-based assessments conducted, including the Mini-Mental State Examination, Geriatric Depression Scale, and Perceived Stress Scale (2023). The study documents a perception of change in the quality of life for those with diabetes due to restrictions, environmental limitations, and perceived stress. This study adds to the current literature review discussion, as diabetes is the most prevalent illness among older adults, and the impact of restrictions is higher for diabetics at 14 % over their non-diabetic counterparts at 5 %. The inability to have physical activity causes further disability in 32% of people with diabetes. These characteristics contribute to the discussion of healthy aging and environmental elements' impact on the older adult.

Restrictions for older adults impact fall risk and depressive symptoms as well. A study published in *Psychogeriatrics* reports findings from a quantitative, longitudinal study of older adults in Korea. There were 2933 older adult participants, with data collected from 2006 to 2018. The data focused on responses from the participants regarding falls, fear of falling, self-induced restrictions, and the correlation to depression symptoms. This study was significant to Korean older adults as depressive symptoms

have proven to lead to suicide, impacting their population at a rate of 23 deaths per 100,000 individuals, the highest rate of suicide in South Korea. An interesting conclusion from the study is that the fear of falling was the strongest indicator of an adverse health outcome, whereby older adults self-restrict their movement and avoid activity. This change in activity leads to changes in dependence, decreased muscle loss, social isolation, and inevitably poorer quality of life. The social isolation component will further lead to the older adults' perception of successful aging, wellness, and overall mental health.

Older Adults with Loneliness and Isolation

Many factors affect an older adult’s successful aging. Two examples of these factors are the feeling of loneliness and physical isolation. Both examples may cause an older adult to become more vulnerable (National Institute of Aging, 2021). For discussion purposes, these terms should not be used interchangeably; instead, the definitions must be reviewed. According to the Centers for Disease Control and Prevention (2021), “loneliness is the feeling of being alone,” while isolation is the physical separation from others or the lack of physical and social connectedness. It is important to note that individuals may report physical and social connectedness but still feel lonely (CDC, 2021). These elements affect older adults more often than their younger counterparts due to social determinants of health such as housing (living alone), chronic illness, socioeconomic status, and changes to familial relationships (Tran, 2022).

The effects of physical and social isolation for older adults are debilitating. When observing the effects of isolation, 24% of community-living older adults report being

isolated and having challenges with completing basic functions of living; this, in turn, leads to increased fragility, critical care events, and mortality (Tran, 2022). In a study published in *Critical Care Alert,* older adults with moderate and severe social isolation have an increased risk between 48% and 119% for mortality one year post hospitalization (Tran, 2022). This research leads to a connection that the event of hospitalization may be a critical intervention for those largely affected by isolation. Hospitalization offers an opportunity for human and social services to be referred and accessed for those older adults afflicted.

Frailty is a concept intertwined with the discussion of feelings of loneliness and physical and social isolation. Frailty affects at least 10% of the older adult population and may lead to decreased disability and mortality (Davies et al., 2021). Published in *The Lancet Health Longevity,* a longitudinal study conducted in London sampled 9171 older adults related to frailty (Davies et al., 2021). The characteristics of frailty within this study consisted of several criteria, including low speed of movement, decreased physical activity, weight loss without intent, weak grip strength, and reporting feelings of exhaustion. Other factors contributing to the decline from this criterion include the socioeconomic status of the older adult, gender, healthy eating, and the prevalence of other diseases (Davies et al., 2021). The study further supports other literature in this review by demonstrating that feelings of loneliness and forms of isolation are compounded due to older adults having a smaller social network, dwindling finances, and changes to mobility. Lastly, increased frailty, loneliness, and isolation all contribute to the overall mental wellness of an older adult (Nakagomi et al., 2023).

Older adults with feelings of loneliness may report other negative concerns or decline. Individuals in this category often have increased emergency room visits, admission to the hospital, and placement into long-term care facilities such as assisted living or skilled nursing homes (National Institute of Aging, 2021). Additionally, older adults identified as socially isolated are at high risk for high blood pressure, depression, anxiety, cognitive decline, and substance use issues (National Institute of Aging, 2021). Solomonov et al. (2023) noted that a feeling of loneliness, attributing social determinants of health factors and prevalence of illness, leads to increased social isolation, further contributing to high thoughts of suicide among older adults.

A relatively new phenomenon affecting older adults and isolation was the imposed mandates of isolation occurring during the COVID-19 pandemic. The isolation was used as a mitigation strategy to prevent exposure and possible mortality to the virus. At times, the isolation may have existed for weeks due to quarantine standards set forth by the Centers for Disease Control and Prevention (CDC, 2022). This isolation decreased the connectedness of caregivers to their older adult loved ones, created restrictions on physical movement, and increased feelings of loneliness (Falvo et al., 2021). A study published in the *Journal of the American Geriatric Society* further supports the impact of COVID-19 and the isolation of older adults (Kotwal et al., 2020). The study conducted by Kotwal et al. (2020) was a mixed-method longitudinal phone survey that occurred every two weeks. In total, 151 older adults living in community settings were surveyed, with the average age being 75 years old, with disabilities including 50% hearing or vision impairment, 64% lived alone, and 26% had difficulty bathing. Conclusions from the

Kotwal et al. (2020) study reported older adults had worsened loneliness at 54% of participants, worsened depression at 62% of participants, and 52% worsened anxiety, respectively. Based on the study's findings, it can be concluded that the COVID-19 mitigation strategy of isolation further contributed to already prevalent feelings of loneliness for older adults.

Older Adults and Mental Health

This literature review has thus far demonstrated a substantial prevalence of elements relative to decline in older adults, thus affecting successful aging. As documented, the preponderance of characteristics such as restriction, physical and social isolation, and loneliness lead to increased mental wellness symptoms. According to Mental Health America’s (2023) *The State of Mental Health in America 2023* report, mental health illness affects 20.78% of the United States population. Conditions such as anxiety and depression are contributing risk factors to mental health decline and suicidality in older adults (Mental Health America, 2023); further disparity exists in minority populations. A Morbidity and Mortality Weekly report published by the Centers for Disease Control and Prevention on August 14, 2020, documented an elevated risk for older adults due to the COVID-19 pandemic (Czeisler, 2020). This report cites mitigation factors, changes to physical distancing, and stay-at-home orders as links to the cause of the elevated risk of mental health decline. The vulnerability of older adults, coupled with these factors, demonstrates concern for this population's overall mental health and well-being.

Researchers Burke Garcia et al. (2021) conducted a study entitled *How Right Now* to understand mental health resilience. The researchers surveyed 731 participants, of which 33% were 65 years or older, to understand better an individual's ability to respond to stressors such as isolation, physical distancing, and economic changes during the COVID-19 pandemic. Embedded in the study was the concept of resilience and the ability to cope with feelings of grief, worry, and stress mandated by mitigation strategies. Several conclusions from the study indicated that an individual's resilience is important in manifesting mental health symptoms and illness. Further, Burke Garcia et al. (2021) document that one's ability to "bounce back" from stressors is impacted by the individual's perceived ability and confidence to cope and adapt. For older adults, the lack of confidence in bouncing back leads to disorders such as anxiety and depression, which will cause coping and adapting to take longer (Burke Garcia et al., 2021). The authors of the *How Right Now* study publication recommend culturally responsive messaging, practicing self-care, and learning coping strategies as all potential prevention strategies to reduce the incidence of mental health disorders.

The presence of mental health symptoms or diagnosis for an older adult is debilitating. A high incidence of depression persists in older adults and affects their ability to manage tasks associated with activities for daily living (Zenebe et al., 2021). In a meta-analysis and systematic review of older adult depression, Zenebe et al. (2021) report findings that 31.78% of older adults have depression, further documenting the likelihood of the illness should be a "warning sign" to healthcare professionals, policymakers, and stakeholders. Zenebe et al. (2021) suggests various factors of

prevalence, including the rapid growth of the older adult population due to decreased mortality rates and improved quality of life. Despite the positive reports of longevity, debilitation, physical disabilities, functional decline, and increased risk of suicide are significant factors impacting older adults.

Another mental health disorder affecting older adults is anxiety. This illness is also as debilitating as depression and is common among older adults (Erickson & Rector, 2022). In a cross-sectional observational study by Kumar et al. (2021) during the COVID-19 pandemic, 106 participants aged 60 years or older were studied. The results indicated that anxiety prevalence existed among 22.6% of older adult respondents. Kuman et al. (2021) report several characteristics that increased the anxiety of older adults during the pandemic, including fear of being exposed or infected by the virus, financial hardships, and experience losses of loved ones from the infection. This study had similar conclusions to the *How Right Now* (Burke Garcia et al., 2021) recommendations, encouraging trusted messengers, policymakers, and advocates to ensure a prevention model is in place to temper the effects of the pandemic on mental health disorders in older adults.

The frequency of mental health illness affecting older adults is particularly concerning as it relates to the rates of suicide in this population. In a 50-state survey conducted by Solomonov et al. (2023) from February to December 2021, findings report a prevalence of 7.1% of older adults having thoughts of suicide. Further, Solomonov et al. (2023) document an increased risk and disproportionate effect of suicide for older adults due to loss of connectedness and isolation, which are reported risk factors for

suicide. Thoughts of suicide are a concerning risk factor in older adult communities, as this population is more likely to complete suicide than any other age group; lethal means is the most common form (Cai et al., 2022). To prevent the high-risk elements of older adult suicide, researchers Solomonov et al. (2023) suggest a multipronged approach that includes psychotherapy and increased psychosocial interventions.

The concern for older adult suicide is not restricted to the United States. In an article published in the *Asian Journal of Psychiatry,* Chattun et al. (2022) report older adult suicide as a global concern, particularly in a post-pandemic era. Chattun et al. (2022) document several elements for consideration, including a study of risk factors, increasing protective factors, and identifying resilience characteristics. As it relates to risk factors, this research is consistent with previous literature and documents, previous mental illnesses such as depression or anxiety, social isolation, loneliness, and financial stress as factors; a new risk factor identified, however, was the prevalence of a completed suicide of any first degree relative. Chattun et al. (2022) report protective factors and resilience as potential means to decrease suicidality in older adults. Examples of such factors include good physical health, the ability to meet basic needs, religion, positive relationships, and an overall healthy perspective of life. Further, the researchers could not suggest one leading element as a prevention. Instead, they offered a combination of all positive components as a mitigation model to prevent older adult suicide.

Several studies documented in this literature review have suggested intervention models to fight the effects of mental health illness in older adults. A healthcare intervention is an example. For older adults affected by depression, treatment as early as

possible is recommended and may include services such as clinical therapy and medication (Lee, 2023); all models require careful consideration of culturally acceptable adaptations. Another example of an intervention for depression is documented by authors Gilbody et al. (2021), whereby they used behavioral adaptation (BA). The BA was in the form of telephone reassurance calls. Gilbody et al. (2023) focused their BA program on older adults living in long-term care facilities, as the COVID-19 pandemic more socially impacted them. Using psychosocial intervention, older adults who participated in regular calls reported a decreased feeling of social isolation or loneliness, a risk for depression. An interesting component of the BA intervention is the report from researchers that this can be replicated and scaled, offering an opportunity to impact the older adult population significantly.

Telehealth services are a widely used intervention for mental health illness. During the COVID-19 pandemic, the use of a telehealth platform increased to deploy social and psychiatric interventions for those who required services (Weldon & Hagemann, 2022). During the pandemic, older adults initially struggled with the technology components of telehealth services; issues such as connectivity, lack of internet, and general technology literacy were obstacles (Powers et al., 2023). In a study of older adult veterans, Weldon and Hagemann (2022) studied the effectiveness of telehealth services. The study consisted of veterans aged 65 years or older, with results documented via questionnaire asking about overall acceptance of the platform, accessibility, and ability to decrease mental health symptoms effectively; there were 70 completed responses from the 200 questionnaires mailed. Overall, the older adults

reported positive outcomes from the telehealth services, with moderate satisfaction; however, respondents also reported they wanted telehealth services to supplement the opportunity for in-person services in a geriatric outpatient setting. Based on this study, telehealth services may be a continued intervention model to help prevent mental health illness in older adults.

Social Determinants of Health and Older Adults

There is a strong intersectionality among the elements of mental health, social determinants of health, and older adults. A study in 2022 conducted by Ma et al. (2022) examined the impact of social determinants of health and COVID-19 mitigation behaviors in older adults. Using the National Institute of Health's All of Us dataset, statistics from characteristics such as race, employment, housing, gender, and age were examined against compliance with COVID-19 mitigation mandates. Ma et al. (2022) demonstrated that African American older adults were more likely to be compliant than their White counterparts when avoiding large social gatherings, adhering to stay-at-home orders, and following sanitary practices. Employment was also an indicator of adherence, with those with a job being less likely to avoid social gatherings or participate in events outside the home. Overall, Ma et al. (2022) documented a linkage between social determinants of health and poor COVID-19 outcomes and a more considerable disparity in treatment for older adults.

Health equity is a prevalent concern when researching the elements of older adults and social determinants of health. Public health researchers Guerrero and Wallace (2021) examined data from the World Health Organization's Health Inequity Casual Model.

They found several social determinants of health factors leading to adverse outcomes for older adults. Specifically analyzing data relative to COVID-19 outcomes, Guerrero and Wallace (2021) reported that older adults of color are the most at risk for adverse outcomes, with the effects of racism and financial hardship leading the way. Income was the basis for most of the discussion in this study, as the poverty level of participant data leads to disparity in areas such as housing, food insecurity, and basic needs. Reflection on the data demonstrated that older adults of color were disproportionately affected in all categories over their white counterparts. An interesting connection in this study is the housing factor and how older adults of color experienced increased exposure to COVID-19 due to their living arrangements. Older adults of color often live in overcrowded housing (Guerrero & Wallace, 2021), and as previously documented by Wong and Li (2020), density is a risk factor for COVID-19. Older adults of color may live in skilled nursing facilities when they reach a need or disability, increasing the disparity and effects of social determinants. Those living in institutional housing have increased exposure to the virus (Wong & Li, 2021). For older adults of color living with family, the disparity is still present as family members in these communities are often essential workers (Guerrero & Wallace, 2021), and the exposure is high. The impact of social determinants of health and older adults represents a disparity.

Social determinants of health risk factors also translate into increased concern for mental health disparity. In a cross-sectional analysis, researchers examined the intersectionality of depression, social risk factors, and older adults (Omary & Chamber, 2022). Published in the *Journal of Evidence-Based Social Work,* researchers documented

five key risk factors that affect older adults and an increased rate of suicidal ideation. These risk factors are social determinants of health, including race, sex, education, poverty, and overall health. Based on the data examined from the National Survey on Drug Use and Health, a strong correlation was found as a predictor in all categories except for marital status and showed a linkage between major depressive episodes and suicidal ideation. Based on the connections in this study, an intervention model incorporating clinical treatment and case management was recommended.

Summary and Conclusions

This literature review shall be considered exhaustive. The information documented and shared contributes to this research study. The topics reviewed include successful aging, older adults and health behaviors, residential living environments, older adults and mental health, the impact of COVID-19, and mitigation strategies in older adults. These topics intersect as an opportunity to learn more about components that affect an older adult, which may lead to positive outcomes such as successful aging or adverse outcomes such as depression or suicide. The literature review provides a foundation for this study's research method and design, which will be outlined in the next chapter.

Chapter 3: Research

By way of a qualitative method, this research study helped to gain a better understanding of how older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation. The first two chapters of this study demonstrated the background and history of the problem of mental health experiences of older adults and the impact of mandated isolation on their ability to age successfully. Chapter 3 will further explore this older adult problem through the methodology, individual participation, recruitment, and thematic data analysis. All components of this research study adhere to the qualitative research method and include a review of issues of trustworthiness, ethical procedures, sampling methods, and data collection/storage.

Research Design and Rationale

The purpose of the generic qualitative study was to explore how older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation. The research question in this study is: How do older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation? Unique to this research question is the intent to gain a better understanding of the impact of mandated isolation on older adults during the COVID-19 pandemic.

To address the research question in this general qualitative inquiry study, the specific research design included semistructured questions of institutionalized older

adults living in assisted living and nursing home facilities aged 60 years or older. This type of study was selected to thoroughly explore the perceptions, attitudes, and opinions of the mandated COVID-19 isolation from the perspective of older adults. According to Patton (2015), a general qualitative study is best selected when this type of exploration and population is established.

This design study was ideal as it allowed for an in-depth exploration of the topic from those directly impacted by the COVID-19 isolation during the pandemic. The qualitative design was further aligned with the research, as the study explored individual responses and was not based on a numerical or quantitative design method (Maxwell, 2009). A generic qualitative study was selected to allow for the ebbs and flows of the research study. It did not include a case study, exploration of a phenomenon, or individual narrative inquiry. In summary, the study explored how institutionalized older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation.

Role of the Researcher

As a researcher, I have several roles in completing this research study. First, I am the data collection instrument (Patton, 2015), a content expert, interviewer, transcriber, analyst, and coder. As the interviewer, I conducted the interviews with the participants to collect the data, and as the transcriber, I transcribed the information taken from the interviews. As my role pivoted, I was responsible for coding the information collected to identify themes and relevant categories and then analyzing them in alignment with the research design and study. The final role of the researcher is to document the conclusion

and findings in a credible, meaningful way that will contribute to the scientific community.

In addition to the role described above, I am also a practitioner in the field of gerontology. I have worked with older adults from various backgrounds, cultures, generations, and mental health needs for over twenty years. During the pandemic, I was a practitioner, an administrator, and a caregiver in a subsidized assisted living facility. While my relationship with the participant population and topic is close, I removed my bias and mitigated issues in advance. First and foremost, I have excluded participants that experienced COVID-19 isolation under my guidance. There were no instances of an older adult being referred to the study that would be defined this way. If the occasion had occurred, I would have excluded them from participating. In addition, my experience in the subject matter will only be used as a strength because I know how to communicate effectively with the older adult population.

Methodology

This section reviews several elements, including participant selection, identified instruments for the study, data analysis plan, issues of trustworthiness, and the ethical procedures adhered including informed consent.

Participant Selection Logic

This study consisted of individuals defined as older adults aged 60 years or older who lived in an assisted living or nursing home facility during COVID-19 and experienced mandated isolation. The questions were formatted and used to conduct one-to-one interviews with older adults based on the inclusion and exclusion criteria in this

study. The questions were intended to be thought-provoking and with follow-up probing questions used, as needed. All were designed to be open-ended, with the ability to respond with a yes or no response being limited. The initial question was an "opener" to establish a rapport with the older adult. In contrast, the last question allowed the participant to add additional information to the survey that may not have been thoroughly explored (Patton, 2015). As the researcher, I ensured a sufficient schedule for the participants to exit the interview, sharing whatever pertinent information they felt was necessary.

The use of debriefing is an essential component of this study design and ensured safeguarding for the participants. Debriefing was a benefit provided to the participant after the interview was completed; this is often used when the subject matter is considered sensitive (Burkholder et al., 2020). Benefits of use included establishing trust between the researcher and participant, informing the participant of the entire research study, including the purpose, and providing appropriate resources for the participant if they choose to access (Patton, 2015). Debriefing was conducted with all participants at the commencement of the interview and promptly after the interview to ensure the participants had no misunderstandings from the research and are in a clear state of mind before exiting the interview process. Resources were provided in a resource pamphlet to include my contact information and the onsite social worker at the facility. The confidentiality of the older adult and the residing facility is an element of ethical consideration. Therefore, the participating facilities are confidential and not published in the study; only the data collected was used and shared based on unique identifying

information. The voluntary design study also supports an ethical manner that complies with IRB standards. During the process, volunteer participants could have elected to remove themselves from the research, and the data collected would be disqualified. Given participants' age, potentially vulnerable status, and questions that could trigger feelings or emotions, all participants and facilities were provided with a list of mental health providers. All documents used, collected, and analyzed for the study are all secured in a locked area in my home office with the sole key in my possession to ensure confidentiality.

Instrument

The instrument used in this research study was a prescribed list of ten open-ended questions, with additional follow-up questions listed (See Appendix B.1.2- Interview Guide). The interview questions were created using the established theoretical and conceptual framework as a guide. The questions sought to understand the participants' experiences and determine their relationship to the environment during the mandated isolation, potential coping mechanisms, adaptability, and the effects of the isolation on the older adults' mental health. As a practitioner, I incorporated and aligned my experiences with the research. The drafted questions were read several times to ensure the flow allowed for an opener question and built up to more complex questions. At the end of the interview, a question was asked for the participant to report any additional comments if there were items they still want to disclose. As a trained practitioner in motivational interviewing, the technique was used along with the instrument.

Procedure for Recruitment, Participation, and Data Collection

This research study aligns with a generic qualitative approach, with participants meeting the criteria defined and established within. Several nonprobability sampling methods were used in this study. The first method was purposive sampling, a technique used to select specific individuals with similar characteristics (Saldana, 2021). This method aligns with this research study as the population studied is finite and specific, such as being an older adult 60 years or older and having resided in an assisted living or skilled nursing home. In addition, the snowball method of sampling was used, which is a method whereby a group of participants will share information regarding the study and make referrals to participate (Saldana, 2021). The strengths of this sampling method allowed the selection of the participants to align with the criteria and meet saturation results efficiently.

The sample size in a qualitative study design is best met when saturation occurs. To determine saturation, the diversity of the population and the amount of potentially varying information should be considered. This study does not have a large, diverse group of participants, and the research question is not complex; therefore, a small group of participants is justified. Qualitative studies generally have less participation than their quantitative design counterparts (Saldana, 2021). In conducting an environmental scan of similar studies (Saunders et al., 2017), considering the targeted population and complexity of the research question, a saturation level will occur with a limited or smaller group of participants. Additional findings documented in an article written by O'Reilly & Parker (2013) further support this sample size, in which the notion of sample quantity is

sufficient as long as sample responses are adequate from the participants. Given this information, the sample size was expected to be 12 participants from either an assisted living or nursing home facility, to ensure saturation and sample adequacy.

Participant recruitment adhered to the following procedure and incorporated several components. A one-page flyer was created to announce the study, targeted population, participation criteria, and researcher contact information, including a cellular phone number and Walden University email address. A query was conducted from the Department of Public Health website for the State of Connecticut to gather contact information for all registered and eligible facilities, as well as a query with 211 (a local resource organization). A list was created based on the completed query of email/mailing addresses, phone numbers, and administrators for all identified facilities. Once the flyer was approved, a request for volunteer participation was sent via email to all nursing homes and assisted living facilities registered through the Department of Public Health in Connecticut. If this didn’t garner sufficient results, phone calls would have been made to all eligible facilities to ask if the flyer was received and determine if there is interest in participation.

I also pursued participants online. The approved flyer was posted on social media, including LinkedIn and Facebook, and sent to older adult supporting organizations, including LeadingAge Connecticut and Connecticut Assisted Living Agency. The request was for the facility to volunteer to participate in the study by allowing the flyer to be shared among their older adults meeting the criteria of aged 60 years or older, considered legally competent to participate (all older adults participating in the study will be

regarded as cognitively intact, not conserved of a person or estate, and able to make decisions independently) and having lived in a facility during the pandemic period of COVID-19 imposed isolation.

Once the facility agreed to allowing for the flyer to be shared, a scheduled meet and greet discussion would have been scheduled at the facility for the researcher to meet with staff and potential individuals to discuss the research from a general perspective. Individuals would have an opportunity to sign up to participate at that time. The meet and greet sessions were to be conducted based on the availability of the facility, and the facility would select the location and time. The researcher would bring food and drink if permission was granted. Individuals could have volunteered to participate at any time by calling the researcher's phone number or emailing; all were disclosed on the flyer. At the time of contact and once the older adult requests to participate, the inclusion criteria verification was completed by asking yes/no screening questions.

The interviews were conducted in the most convenient and comfortable format for the older adult, including telephone, virtual platform (zoom, Microsoft Teams), or in person. The individual selected the timing of the interview, and a reminder call was made the day before the interview as a courtesy to the participant. The information from the interview was confidential, with data collection only identified through a unique identifier throughout the study. Before the start of the interview, the participant provided verbal Informed Consent Form, as required by the IRB. A debriefing document was provided to each participant at the end of the interview and included, at minimum, a

thank you statement, title of the research study, purpose of the study, confidentiality statement, contact information for a final report, and my contact information.

Data Analysis Plan

This research study used a six-step thematic analysis plan. Data was collected and analyzed to identify themes and patterns to gain an understanding of how institutionalized older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation. Interviews with the participants occurred using a semi-structured process with open-ended questions. There are ten total questions prescribed, with additional probing follow-up questions available.

The six-step thematic analysis was initially created and used in psychology and then evolved for application in other subjects, making this an aligned analysis for the study (Clark & Braun, 2017). The tenets of the phases are prescribed and include six phases to ensure adequate time to analyze the information and allow for the themes, patterns, and categories to evolve organically. The first phase involves familiarization with the data; this is completed by transcribing the information collected from the interviews while taking notes based on the participants' responses. The generation of initial and relevant codes is completed in the second Phase. The researcher will search for and document themes in Phase Three, including coding for common themes according to familial features from the responses. Phase Four includes the review of potential themes and an analysis completed to determine if the generation of the themes reflects the data in its entirety. During Phase Five, the researcher continues to develop the overarching

themes, labels the themes with uniformity, and groups the responses. In the last step, Phase Six, the researcher will complete the final written analytical report.

Applying this six-step approach to my interview questions, I included color coding in like responses and potential coding of themes to highlight commonalities between participant interviews (Clark & Braun, 2017). A summary worksheet was used to keep the data collected organized by the participant responses and assist with the analysis to observe themes. As a generic qualitative study, I selected the theory and conceptual framework to ground this study; therefore, the linkages between the responses and the frameworks was noted in the worksheet. This provided an excellent opportunity to develop themes early in the phases and see the connection(s) between the responses and how it applies to both the sociological perspective of ecological theory (Bronfenbrenner, 1977) and the selection, optimization, and compensation model (Baltes & Baltes, 1993). While software products are available to support this type of coding and analysis, I used the hand-coded method. The identified themes generated answers to the research question regarding how institutionalized older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation.

Issues of Trustworthiness

Researcher bias must be considered when evaluating the credibility of the study. While there is no way to eliminate bias entirely, a mitigation plan throughout the study was imperative. Several mitigation strategies were used in this study, with the first being the methodology (Patton, 2015). Alignment in the areas of the qualitative method,

purpose, research design, and research question mitigates the bias to meet the objectives set forth. Participation management was used to provide mitigation, whereby the researcher ensured follow-up with any participant that may have withdrawn. The follow-up would have allowed the researcher to determine if there are causes relative to bias and make a plan of correction. Participant questions are asked in a neutral and non-judgmental tone to ensure no leading of the answers provided. Lastly, triangulation will enhance the validity and credibility of the findings (Korstjens & Moser, 2018). Triangulation requires the use of multiple sources of data in the research. In application to this research study, I used participant interviews, an extensive literature review, and thematic analysis.

Credibility

Credibility is the most critical factor in establishing trustworthiness in this study. Credibility is the component of research that demonstrates that it is accurate, unemotional, subjective, and responsible (Patton, 2015). This is similarly referred to as internal validity in quantitative research. Further, credibility is demonstrated in qualitative research when the conclusions are documented in a clear reflection or meaning from the participants (Korstjens & Moser, 2018). Researcher bias must be considered when evaluating the credibility of this study. While there is no way to eliminate bias entirely, a mitigation plan throughout the study was imperative. Several mitigation strategies were used in this study, with the first being the methodology (Patton, 2015). An alignment in the areas of the qualitative method, purpose, research design, and research question mitigates the bias. Using the conceptual lens and theoretical

framework removed bias from the conclusions, as the analysis was based solely on the alignment of answers and the established framework.

Participation management will also provide credibility. Participant questions were asked in a neutral and non-judgmental tone to ensure no leading of the answers provided. Triangulation will enhance the credibility and validity of the findings (Korstjens &Mosher, 2018). Triangulation requires the use of multiple sources of data in the research. In application to this study, I used participant interviews, an extensive literature review, and thematic analysis.

As the researcher conducting this study, it is essential to establish credibility within the targeted population and with the future audience reading the research findings. As a practitioner in the field of gerontology, I have the skill set to approach older adults and associated facilities. The credentials and honors that I have acquired as a practitioner has established credibility within both populations, including my Executive Director certification, Leading Age Innovative Leader award in 2022, Certification as a Community Health Worker, and Community Renewal Team's President Award in 2017 and 2018 for best practices in a community action agency. With this said, safeguarding biases was pivotal while conducting the study. To ensure no bias is present, I did not directly recruit participation from any assisted living, nursing home, or individual. I also excluded any older adults I may have provided services to during my career.

Transferability

This study also ensures the accuracy of the data adheres to the practice of transferability (Korstjens & Moser, 2018), which allows for the conclusions to be applied

to the general public or other populations studied. This application is similar to generalizability or external validation in a quantitative study (Patton, 2015). The data collected provided evidence of a qualified and accurate set of information to ensure judgment of transferability. This will be further expressed in sections of the study specific to how the research can be applied to future research and how the findings can contribute to services provided within the older adult community. The use of fidelity (Feely et al., 2017) supports transferability in this research study. Fidelity is documented by consistently applying the same set of approved interview questions for the participants. These selected examples of transferability ensure compliance of trustworthiness in the research.

Dependability

Dependability in qualitative research was demonstrated by the degree to which the finding remains stable over time (Korstjens & Moser, 2018). Dependability was proven when the study participants evaluated the findings to be reflective and interpretive of their responses. In a quantitative study, this is defined as reliability, which refers to the degree to which the study is consistent and replicable (Korstjens & Moser, 2018). This study's data collection process, findings, and documentation will demonstrate dependability. Triangulation also ensured that multiple data resources were selected for thematic analysis (Patton, 2015). An audit trail and transcripts are available to demonstrate alignment between the data collected and the final conclusions reported. According to Ravitch and Carl (2021), consistent practice in data collection and the ability to replicate the research also demonstrate dependability. This research study has

ensured compliance in all these elements, including the alignment, analysis, instrument, and data collection methods.

Confirmability

The last component of trustworthiness in this research study is confirmability. Confirmability is assured when other researchers can confirm the data collected and only reflect responses and experiences from the participants, a critical component of this element of trustworthiness (Ravitch & Carl, 2021). In a quantitative study, confirmability is referred to as objectivity, which refers to unbiased findings that do not involve the researcher's opinions. Confirmability occurs through the practice of neutrality and the researchers' use of reflexivity (Ravitch & Carl, 2021). The findings of this research study has demonstrated neutrality as the conclusions were based on the participant's own words and responses; there was no researcher bias present. Using a transcript from the interviews also helped to ensure the findings were only implied by the respondents' responses. Reflexivity was used, as I maintained a journal to reflect on the interviews and any components of bias that occurred during the data collection. The efforts of corroboration between the participant responses and conclusions, along with the exclusions of research bias, aligns with confirmability.

Ethical Procedures

The research conducted in this study has met the rigorous requirements set forth by Walden University’s Institutional Review Board (IRB). As required by Walden University’s IRB, this proposal has been assigned a unique approval, 02-09-24-0660533. Additional ethical considerations were applied as published by The American

Psychological Association (APA, 2022). Several components were considered in this qualitative study, which include: (a) consent, (b) solicitation, (c) debriefing, (d) confidentiality, (e) anonymity, and (f) storage of data. The first consideration is the population selected: older adults aged 60 years or older. The older adults who volunteered were all considered to be legally competent to participate, competent to provide consent, not conserved of person or estate, and did not present during the scheduled interview with any symptoms that could be regarded as cognitively impaired. If the person appeared to have suffered from a cognitive impairment or was no longer competent, a discussion with the participant will ensue, and the participant will be removed from the study. All participants will be able to consent to participation in the study. Based on confirmed ability to consent, all individuals interviewed will sign an informed consent to ensure documentation of their consent is complete. A review of the study components will also be completed. Participants in the study will only be invited to participate based on allowable activities described in the procedure.

The confidentiality of the older adult and the residing facility is an element of ethical consideration. Therefore, the participating facilities will be confidential and not published in the study; only the data collected will be used and shared based on unique identifying information. The voluntary design study also supports an ethical manner that complies with IRB standards. During the process, volunteer participants can remove themselves from the research, and the data collected would be disqualified. All documents used, organized, and analyzed for the study will be secured in a locked area in

my home office with the sole key in my possession to ensure confidentiality and data protection.

Summary

This chapter reviewed the research method selected, which is qualitative. A thorough discussion ensued regarding important elements of this study, which seeks to explore how older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation. Essential elements within the design of this study ensure the fidelity of the method selected, including the type of instrument used in semi-structured interviews. This procedure will support the needs of the older adult population and an adequate sample size for data saturation. Next, Chapter 4 will document the data collection, including participant information such as the number of participants, location, and recording. The data analysis section will report on the process and describe the specific codes, categories, and themes identified from the participant responses. Lastly, sections on evidence of trustworthiness and the results of the study will be shared.

Chapter 4: Results

Introduction

The purpose of this generic qualitative study was to explore how older adults aged 60 years or older residing in assisted living or nursing homes described their experience of mental health during the COVID-19 pandemic of mandated isolation. I interviewed seven older adults who historically or currently live in a residential setting of an assisted living or nursing home and experienced a COVID-19 isolation period. All participants met inclusion criteria for age, residence, and no self-attested memory impairment.

Research Question

How do older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation?

In this Chapter 4, the results of the study will be explored. The organization of the chapter will start with the setting of the study, including location, frequency, and duration, followed by the participant demographic information. The data collection process will be reviewed, including the number of participants, how the data was recorded, and variations in the data collection process. The data analysis will be discussed, including the thematic coding, categories, and emerging themes. Issues of trustworthiness will be reviewed, including the components of credibility, transferability, dependability, and confirmability. Lastly, the study's results will be reviewed, including patterns and themes from the participants' responses.

Setting

In this generic qualitative study, I focused on exploring the lived experiences of older adults who experienced COVID-19 isolation while living in a residential setting such as an assisted living or skilled nursing facility. I recruited older adults by posting a flyer in three residential facilities (two skilled nursing homes and one assisted living facility) and postings online through Facebook and LinkedIn; I also presented to the Connecticut Leading Age Trade Association monthly meeting of Assisted Living and Skilled Nursing facilities. Nine older adults from two different locations replied to my flier. The older adult participants 60 years or older responded to 10 semistructured interview questions. The interviews were conducted in person, on the phone and online videoconferencing platform Zoom (https://zoom.us) was used as a recording application. During each interview, I used a pre-selected community space chosen by the participant. The spaces were private, and each interview was conducted in the same format.

The older adult participants shared their experiences through responses about coping, isolation, and adaptability. The participants also shared about their overall mental wellness and strategies that were helpful in successfully or unsuccessfully adapting to the challenge of isolation. Overall, the setting proposed in Chapter 3 remained consistent throughout the data collection process; the only adaptation was a change for one of the interviews to be over the phone. There were no additional adaptations required.

Demographics

The participants in this study were all 60 years or older and experienced at least one COVID-19 period of isolation or quarantine while living in a residential setting such

as an assisted living or nursing home facility. Each participant was screened to meet research inclusion criteria, including the following:

- 60 years or older
- Experienced an isolation or quarantine period as a result of the COVID-19
- No memory issues, impairment, and/or diagnosis of a memory disorder
- Does not have an appointed Conservator of Estate or Person.

The following, Table 1, Participant Demographics, outlines the participant demographic information aligning with the inclusion criteria. I have used letters to represent the Participant ID and maintain confidentiality. Additional information, including gender, race, and religion, is included as this information was presented during the interview.

Table 1.

Participant Demographics

	Participant ID	Age	Type of Facility	Gender	Race	Religion
1	RZ	90	Assisted Living	Female	Black	Jehovah Witness
2	DG	67	Skilled Nursing	Female	Black	Christian
3	AL	82	Assisted Living	Male	Caucasian	Jewish
4	LS	67	Assisted Living	Female	Caucasian	Christian
5	DE	94	Assisted Living	Female	Black	Catholic
6	AK	95	Assisted Living	Female	Caucasian	Jewish
7	JP	92	Assisted Living	Female	Caucasian	Jewish

Data Collection

This study's data were collected by asking 10 semistructured, open-ended interview questions. The participants were recruited through posted flyers in local residential facilities. In addition, social media was used to recruit participants through LinkedIn and Facebook. The social media announcement and recruitment flyer were used once final approval was provided by the Walden University Institutional Review Board (IRB Approval # 02-09-24-0660533). Lastly, participant recruitment occurred through networking with existing older adult networks, including presenting at the monthly Connecticut Chapter of Leading Age Connecticut meetings for skilled nursing homes and assisted living facilities. A mailing list was created through the Connecticut Department of Public Health residential facility listing, which includes all residential facilities to send the flyer to participants; however, saturation was completed before this mailing list; therefore, it was not used. Interested participants contacted me through the Walden University contact information posted on the approved flyer. Once alerted by a participant of their interest, the eligibility screening questions were asked, and a verbal reading of the consent form was performed. The participant verbally consented to the study through their statement of “I Consent.” I reviewed the consent form again at the interview to confirm consent from the participants.

The interviews were scheduled during the initial screening conversation with the participant. I would call the participant the day before the scheduled interview as a reminder of the appointment. When completing the reminder calls, two individuals initially scheduled for interviews declined the visits due to illness. All interviews were

conducted from March 1st, 2024 – May 3rd, 2024, during which I drove to the facilities, met with the participants in person in a private community space of their choosing and one interview that was conducted over the phone.

The interviews were in-person and recorded through Zoom's online videoconferencing platform (https://zoom.us). The audio recordings were transcribed using the app iTranscribe (https://itranscribe.co/). The transcripts were sent to the participants via mail, requesting them to notify me within ten days to note any inaccuracies in the transcript or if they would like any information changed. The participants made no requests during this period to change the transcriptions.

Data Analysis

There were seven participants in this study, which allowed for data saturation (Patton, 2015). Data saturation was met at six participants; however, to ensure there were no additional opportunities to find new information, a seventh interview was completed. At the completion of the seventh interview, the data collection process ceased as no new codes, categories, or themes were identified. A six-step thematic analysis process occurred, adhering to each step described by Clark and Braun (2015). Data analysis began at the start of the interview, whereby participants were asked a series of semistructured questions. This first phase allowed for the familiarization of the responses, as well as note taking during the interviews and transcribing the information from iTranscribe (https://itranscribe.co/) into a Microsoft Word document. The second step was completed by generating initial and relevant codes by combing through the interview transcriptions and looking for relative information that would aid in answering the

overarching research question. Phases three and four consisted of further review of the information, following an iterative process, and the categories and themes started to evolve. During phase five, I grouped the categories and confirmed the labels and themes. The last component, phase six, was completed by summarizing the information into a worksheet, organized by Participant ID, frequency of response, code, category, and themes; this was used as the final written analytical report.

Emerging Codes, Categories, and Themes

As mentioned, I coded these data for emergent themes. I had many codes, roughly 19, and grouped those into six categories. There were 19 codes identified during the thematic analysis, and five categories were identified, including: (a) coping, (b) isolation, (c) support and response, (d) mental health, and (e) isolation. From there, five themes emerged.

Table 2

Codes, Categories, and Themes

	Codes	Categories	Themes
1.	Adapting Adaptability Coping of Others Resilience Reflection Spirituality	Coping	Mechanisms to cope with isolation included watching TV, reading, walking, texting with families, and participating in spiritual services (church and synagogue).
2.	Social Isolation Response	Isolation	Responses to being isolated included sadness, loneliness, and distress, all leading to perceptions of the effects of mental health during isolation.
3.	Facility Response Family Connections	Facility	Facilities provided formal and informal support during isolation, but not seeing family continued to weigh on the older adults, contributing to their overall mental health wellness.
4.	Mental Health Mental Health of Others Changes to Independence Changes to Emotions Changes to Reflections Changes to Freedom	Mental Health	Older adults reported both positive and negative responses as it relates to their mental health during isolation.
5.	Pre-COVID Response Post-COVID Response	COVID Response	The transition from the pre-COVID to post-COVID period contributed to an awareness that positive

			mental health wellness may only occur with proper support and/or intervention.
6.	Access Caregiver	Support and Response	There were many barriers to access that also seemed to impact mental health and wellness.

Evidence of Trustworthiness

This research study consistently aligned with the selected qualitative method, including the research design and question. This alignment is evidence of the study's trustworthiness. Participant management was also a critical factor in ensuring the trustworthiness of this study, whereby questions were asked neutrally, with no judgment, bias, or leading. Triangulation (Korstjens & Moser, 2018) was used to further enhance the study by using multiple data sources, including participant interviews, a literature review, and a six-step thematic analysis. Additional components of trustworthiness ensued, including credibility, transferability, dependability, and confirmability.

Credibility

According to Patton (2015), credibility is established when the researcher demonstrates accuracy and truth in the findings. For this study, credibility was established based on the accuracy of the testimonials from the participants, as each older adult verified the content of their interviews, a process also referred to as “member checking” (Moran, 2021). In addition, the research is accurate as it was conducted in an unemotional, subjective, and responsible manner. The results have been reported with

transparency, accuracy, and clear reflection based on the responses of the participants (Korstjens & Moser, 2018). The last component in credibility and evidence of trustworthiness for this research study is mitigating researcher bias. As the researcher, I used a conceptual lens and theoretical framework to analyze the results. This lens and framework helped to align the results with the qualitative method and remove bias from the conclusions.

Transferability

Trustworthiness is also established in this study through adherence to transferability (Korstjens & Moser, 2018). In a quantitative study, this element would be expressed through generalization or external validation (Patton, 2015). For this qualitative study, transferability is represented by an understanding that the findings can be applied to the general public or other populations. The narration of results and conclusions contributes to the older adult community. This contribution will also support future research on the subject to expand the knowledge of the results. Lastly, the use of fidelity (Feely et al., 2017) supports transferability. As the researcher, I applied a consistent and methodical method of asking questions to the participants. I ensured that the format remained the same throughout the seven interviews, thus ensuring fidelity to the process.

Dependability

This research study demonstrates dependability in support and adherence to trustworthiness, ensuring the findings remain stable (Korstjens & Moser, 2018). The older adult participants in this study have reviewed the transcripts for accuracy and

dependability, verifying that the results are reflective and interpretative. Other components of dependability demonstrated in this study include the data collection process, findings, and analysis. According to Ravitch and Carl (2021), consistent practice in data collection and the ability to replicate the research also demonstrate dependability. As the researcher, I used bracketing (Thomas & Sohn, 2023) during my interviewing process. Using this method, I maintained a journal to catalog my internal processing regarding the subject, participant, and interview to remove any bias. This was particularly helpful to allow for moments of pause and reflection during the data collection process.

Confirmability

The last element of trustworthiness in this study is confirmability. This component was followed by ensuring the experiences the participants reported were verified and confirmed (Ravitch & Carl, 2021). By demonstrating neutrality and documenting the results based on the older adults' own words and responses, this study further adheres to confirmability. The journaling process also supported trustworthiness, allowing for time to reflect on the information shared; this is also referred to as reflexivity (Ravitch & Carl, 2021). The combined use of these techniques ensured confirmability in the research study.

Results

The research question for the study was, how do older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation. Seven individuals

volunteered to share their experiences and participate in the study. Six emerging themes were identified to better understand older adults' experiences during the pandemic.

Theme 1: Mechanisms To Cope With Isolation Included Watching TV, Reading, Walking, Texting With Families, and Participating in Spiritual Services (Church and Synagogue)

In this research study, all participants responded to their abilities to cope with the mandated and imposed isolation periods due to COVID. According to Popescu (2023), there is a strong relationship between an older adult’s ability to cope during stressful occasions and their perspective on successful aging. This is particularly important in terms of the responses from the participants. All seven participants reported coping mechanisms such as watching television, reading books and magazines, and listening to music or religious scripture. Participants also reported that walking both in the facility and outside was helpful, along with connecting with family through telephone and/or texting. Lastly, participants reported a successful coping strategy through spiritual connectedness. The older adults came from several religions, including Jehovah's Witness, Catholicism, Christianity, and Judaism.

During the interview, Participant DE shared several coping strategies. When asked about a typical day during COVID isolation, Participant DE said, “Well, it was not too bad for me because I like to read; I love the newspapers.” Participant DE reported that music, especially from the big band era, was also helpful in coping with the isolation. Participant DE noted that it helped “pass the time,” specifically on “the weekends when there was less staff at the facility.” When asked what to share with future generations to

prepare for coping during a pandemic, Participant DE said, "Keep the faith […] And if they are church people, get to know your church or whatever you do religiously. Pray, pray." This comment from Participant DE was similar to other participants, noting many forms of spiritual activities were essential to coping, including reading scripture, attending virtual services during the "lockdown", praying, and watching services on television.

During interviews with the older adults, responses also represented information that coping mechanisms were not as successful. Regardless of coping strategies, the older adults sometimes reported being unable to adapt during isolation periods. It is essential for older adults to adapt to stressful situations to maintain a healthy emotional level and overall mental wellness. In the absence of adaptive strategies, mental health symptoms or a diagnosis may ensue (Popescu, 2023). Participants reported several responses representing a poor coping strategy to their response to how they spent a typical day during COVID-19. In total, 4 of the 7 participants shared poor coping. Participant DE stated, "It was kind of difficult because I lost my freedom."

When Participant LS shared about her typical isolation day, she said, "I ate a lot of junk and tons of chips, and I ate myself back into being in a funk." Participant LS shared that she was a bariatric patient years before COVID-19, with stress being a trigger, which led to poor nutrition habits as a coping strategy. Participant LS further shared, "My kids did all my shopping for me and brought me all the food that I really was not supposed to eat […] Everything that was wrong. I was very depressed." When asked to share more about this specific experience, Participant LS shared that her loss of freedom

decreased her independence and, in turn, decreased her ability to cope with a typical day during isolation periods.

During my interview with Participant AK, it was shared that historically, she would pass the time and enjoy playing cards with friends before the pandemic. When asked about her typical day, Participant AK reported, “There was nothing else to do. I had nothing else to do. I could not play bridge because we were not allowed to get together.” The inability to participate in activities and the reduction to roam freely in the facility removed traditional coping mechanisms for Participant AK; this, in turn, created unsuccessful coping during isolation. For Participant AK, the programming that previously provided her joy was prohibited.

In addition to the older adults’ sharing about their coping during isolation periods of the pandemic, they also provided unsolicited information regarding their perspective of others ability to cope. This is noted as unsolicited, as no specific questions were asked of the participants regarding other individuals’ ability to cope. Many participants were concerned for their neighbors and others living in the shared facility. During the interview, Participant AK shared, “Not everybody copes in the same ways, and there are a lot of people here who have not coped well with it, and it has really done a job on them, unfortunately.” Further stating, “Since COVID, half of the people do not come down anymore and are isolated in their rooms.” The report of older adults remaining in their apartments even after COVID-19 isolation periods is significant as this may demonstrate a lack of coping mechanisms and adaptability. These episodes of self-isolation indicate poor adaptability in older adults. According to Silva et al. (2023), factors such as

limitations of daily functioning and limiting physical activity may lead to depression in older adults aged 60 years or older. This finding will be further discussed in Themes 2 and 5.

Theme 2: Responses To Being Isolated Included Sadness, Loneliness, and Distress, All Leading to Perceptions of the Effects of Mental Health During Isolation

All seven participants responded to their feelings of sadness, loneliness, and distress during the data collection process. These characteristics are important as they indicate the potential effects of mental health and wellness. Participants used words such as sad, frightened, lonely, alone, and fear when asked about their feelings during isolation. One participant shared that she was initially unsure how to describe her feeling of loneliness, noting she felt different. However, gradually, years later, she recognized that she had sadness and depression from the isolation. Participant AK noted that during the isolation, it was especially [lonely], referring to the weekends as more challenging as fewer staff were available and present. The word lonely was used most frequently to describe feelings of isolation by the participants, reflecting that, at times, it would make them feel frightened, scared, and fearful.

Participant DG reflected on a time of isolation when she had an increase in her feelings of loneliness as she was also COVID-positive. Participant DG shared that she felt ashamed, embarrassed, and humiliated because the caregivers acted “funny” towards her. When asked what was meant by the word “funny,” she said she felt they were afraid of her and did not want to be her caregiver because of her COVID status. These feelings

shared by Participant DG and others demonstrate that they experienced a variety of characteristics that may lead to negative mental health wellness.

Another component of loneliness was discovered through the interviews, which were related to loneliness due to social distancing, prohibiting family visits, and changing visiting protocol. Many participants shared the importance of their family; Participant DG shared about her grandson, Participant LS shared about her relationship with her daughter, sons, and grandchildren, and Participant AL shared about his son. When asked about loneliness, there were times when the participants reflected on the isolation causing loneliness from the change in family visits. Participant LS said she was “lonely for my family,” reflecting on her inability to hug and kiss her grandkids. Participant LS shared an experience when the facility started to have visits with social distancing. She stated that her family was allowed to drive by and blow kisses from the car, but it was not the same. While sharing about this visit, Participant LS became teary-eyed, stating that the time she “lost with family will never come back” and that she was devastated by the separation of people [referring to her children and grandkids]. These reflections demonstrate how the experiences of isolation negatively affect older adults' emotions. In summary, Theme 2 shares the participants' experiences as they share their feelings of sadness, loneliness, and distress. This, in turn, leads to the perceptions of mental health wellness during the pandemic.

Theme 3: Facilities Provided Formal and Informal Support During Isolation, but Not Seeing Family, Friends, Or Neighbors Continued to Weigh on the Older Adults, Contributing to Their Overall Mental Health Wellness

Participants in this research study were from several types of residential facilities: a skilled nursing facility or an assisted living facility. To the participants, the facility represented their home, and for some, the staff at the facility were referred to as their family. The theme refers to formal and informal support, with formal support being an element that the facility must provide or the paid caregivers (aide and nursing staff) and informal support such as activities (sewing, playing cards, etc.). Overall, participants reflected on both positive and negative components of the facility support.

Participants were asked about what went well during the COVID isolation. There were several responses regarding the facility. Participant AK responded that the facility helped her maintain and keep her apartment clean, specifically mentioning the housekeeping she appreciated. She mentioned that, at times, it was difficult as they (Participant K and the housekeeper) both wore masks, and she is hard of hearing, reads lips, and struggled with communication when the housekeeper used her mask. When asked if the housekeeping service helped her with the effects of isolation, Participant AK reported that keeping her apartment clean was important to her overall well-being, and she looked forward to the housekeeping staff coming to the apartment. Another support at the facility where Participant AK lived was the library. She shared, “We have a wonderful library here, and when I buy books, I put them in the library […] there are a lot of people who have eye problems, and they can't read, but they do have the talking

books." In contrast, Participant AK reported that the facility required the residents to stay in their apartments for an extended time during the isolation periods, reporting that she could not play bridge "because we were not allowed to get together." During this sharing, Participant AK appeared to be sad based on her facial expressions, reflecting that it was "difficult" not to be able to see her friends and neighbors and freely move around the facility as she did during a typical day prior to the pandemic.

Participant LS also shared about facility support. When asked about a typical day during COVID isolation, she first mentioned the change in the facility. Participant LS reflected that the residents had to stay in their apartments for long periods. In the community spaces, Participant LS shared that all the furniture on the ground floor was removed entirely. She referred to it as "a ghost town." The changes in the facility were emotionally challenging for Participant LS, sharing on a typical day before the pandemic, "We used to come down and walk for everything, but when COVID came, meals were delivered," and little interactions occurred among people. Participant LS described herself as an "old-fashioned Italian," very social, and a people person; therefore, these reflections regarding the changes in the facility affected her overall mental health due to the limited interaction with people.

The caregiver staff at the participants' facility played an important role in supporting their needs during the isolation period. When asked about important people during COVID isolation, Participant RZ shared about the caregiver staff. She shared, "The aides, they would come in, and that would give me company, you know, and they would give me my breakfast and make sure I take my medicine." The comment from

Participant RZ, “would give me company,” was particularly important as she reflected on missing her family, and the facility's caregivers helped to fill some of that void during their scheduled visits.

Participant DG also reflected on the caregiver staff of the facility as being positive during the isolation period. When asked if there were any persons important to you, Participant DG replied by saying an evening nurse. She shared that the nurse was “nice to me” and brought her extra food from the kitchen. She said the nurse made her “feel special” during a challenging time. In summary, Participants shared many aspects of living in a residential facility during COVID isolation. While many responses led to positive components, such as the facility caregivers, there were also adverse components, such as facility living being challenging and possibly contributing to the isolation effects of older adults.

Theme 4: Older Adults Reported Both Positive and Negative Responses as it Relates to Their Mental Health During Isolation

Older adult participants provided answers to several questions to help gain an understanding of their mental health during isolation. An interesting discovery during the analysis process demonstrated that many of the participants recognized post-COVID feelings of mental health, such as sadness, loneliness, and depression. Several participants said they were unsure of what was happening and how to describe their feelings or emotions. They shared that after introspection to determine what was causing these feelings, they concluded it was feelings of depression. Participant DE shared, “I’ve been going downhill a bit [and asked] what’s happening, and I came to the conclusion it

was from COVID, I was depressed." When asked why she made this conclusion, Participant DE shared that it was time away from her family, the isolation, and the overall pandemic experience. Participant DE reflected on the feelings of depression again, sharing, "You know, that little depression that COVID put on people came upon me." When asked how this affects her typical day, Participant DE reports she is not as motivated to organize her apartment, leave her apartment, or participate in programming.

Participant AK also shared about the impact of COVID isolation on her overall mental wellness. While Participant AK did not intently express that she had depression like Participant DE, she shared in multiple responses that she was no longer happy, stating the isolation periods caused this and reflecting on others in the facility being impacted. When asked about the experience of isolation, Participant AK stated, "It was very distressing. It was not a good time. It was very sad." Participant AK shared an interesting observation about her neighbors and said, "Those that were okay when I moved in, I could see the dementia starting. Some just did not do well [from COVID isolation]." Participant AK shared that before COVID isolation, residents at the facility were friendly, said hello, and would be cordial; in contrast to now, she stated, "they are reticent to get into a conversation." While not explicitly stated, it appeared that Participant AK was saying the residents were withdrawn.

Participant DG also shared her experiences and feelings as they related to mental health wellness during isolation. When asked about the impact of COVID and her overall mental wellness, Participant DG stated, "It played with it, it messed with me and, and I couldn't forget it, and I can't forget it. And I hope nobody ever go through that. It's an

awful feeling to be locked up in a room." When asked about her feelings of hopelessness during isolation, Participant DG stated, "I thought it was the end of the world." These responses from Participant DG demonstrated a difficult experience for her during isolation and the impact of the seclusion on her mental wellness. In Theme 4, the exploration of mental health wellness is explored from the perspective of the older adults impacted. They shared experiences of their mental wellness and provided remarkable insight into how others living in the facility were also experiencing possible effects.

Theme 5: The Transition From the Pre-COVID to Post-COVID Period Contributed to an Awareness That Positive Mental Health Wellness May Only Occur With Proper Support and/or Intervention

Participants were asked to share a typical day pre-COVID and post-COVID as part of the semistructured questions. During her pre-COVID reflection, Participant AK shared about her ability to go out, drive, and maintain her freedom and independence. Participant AK shared about participating in facility-sponsored groups, like playing bridge, exercising, and attending social activities. In contrast to the isolation period and post-COVID, Participant AK shared that she attempted to pass the time by reading, talking with friends on the telephone, and doing her best to "keep busy." Participant AK shared that reading was "something that made me feel complete when asked about coping. It seemed to fill in time. But if I really thought about it, I think I would have gone, I don't know, I don't think I would have made it through as well as I did [without the reading]." Participant AK reflected on the facility trying to keep residents engaged; they would call them, send note cards with positive messages, and check in with them.

Participant LS also shared a contrasting experience between her pre and post-COVID typical days. Participant LS shared that she would spend much of her time with her grandkids pre-COVID. She was their primary caregiver, especially before and after school. Participant LS described pre-COVID at her facility as “life was beautiful here,” and post-COVID, “they changed a lot of stuff.” Participant LS also shared about the current period, sharing,

“Life has gone back to almost normal around here, but I believe with all my heart that there is still PTSD. Definitely, there's still a lingering problem […] there's still a cloud it's back here somewhere. I still have a cloud, life changed. and it was very distressing; even though we moved on, it's like anything else, it comes back.”

Similar to Participant LS, other older adults reflected on the post-COVID period as trying to find a new normal in their typical day. Several participants said they would continue using the same coping mechanisms, such as watching television, reading spiritual connectedness, and listening to music as interventions. Participant RZ shared that she was adopting a cat to help provide her companionship [this was interesting, as it was the only time a pet was identified as a coping mechanism].

Theme 5 represents the contrast between the study participants' typical pre and post-COVID days. In a pre-COVID typical day, participants shared about activities of independence, a sense of being able to go anywhere, anytime, and being with friends and family. The post-COVID responses contributed to an understanding of a “new normal” whereby older adults have used coping techniques, support from informal and formal

caregivers, and an attempt to find a path forward after the isolation periods of the pandemic.

Theme 6: There Were Many Barriers to Access That Also Seemed to Impact Mental Health and Wellness

Participants shared a wide range of barriers relative to access in their responses during the interviews. In terms of access, this varied from access to medical treatment, doctors, and caregivers to access to family and spiritual services. During the pandemic's beginning, stay at home orders required residents to remain in their facility, even more specifically in their rooms or apartments. Due to the isolation, access to doctor appointments and medical treatments caused a barrier for the residents to receive services. Participant DE shared that she was unable to see a doctor for an extended period to treat extreme pains in her neck. When sharing this experience, Participant DE stated that this delay in services was very upsetting and uncomfortable and affected her mental wellness. Similarly, Participant LS shared her experience with access as she required surgery during COVID and the stay-at-home orders that prohibited her family from seeing her in the rehabilitation, as well as when she returned to the facility. While sharing this experience, Participant LS became teary-eyed as she was sad that she could not have her family present to support her during her healing.

Participants also shared that access to spiritual services was an important support during isolation. While none of my interview questions specifically solicited answers regarding religion, it was fascinating to hear some spiritual responses to access and support from all participants. The participants came from various religions, including

Jehovah's Witness, Catholic, Christian, and Jewish, and all shared the importance of faith. When asked what you would tell future generations about your experience during the pandemic, Participant DE said, “To keep the faith okay. Stay in touch with the family. And if they are church people, get to know your church or whatever you do religiously. Pray, pray.” This response indicated other participants' responses to the importance of spiritual connectedness. Participant AK shared that synagogue services were first stopped, but eventually, they went virtual, and she would attend every Friday. The access was important to all the participants through several platforms, including in-person, virtual, Facebook Live, and an app through the cellular phone.

Participants shared throughout their interviews regarding access to family and how the inability to have in-person visits was distressing. As many shared, family was important to the typical day to the participants, some sharing that they were caregivers to grandchildren or regularly visited with their daughter daily. As stay at home orders and isolations were imposed, many participants were prohibited from visitors at their designated facilities. Participants shared that this was distressing, sad, and lonely; Participant LS shared that she feels like she will never see “ages 6-8” of her grandson and will never get that time back. Over time, facilities adjusted to social distancing orders changed access permissions and allowed non-traditional visiting. Participant LS shared about a family visiting day, where she “blew kisses from the driveway” while her family drove through the parking lot. Participant LS shared that being unable to hug, kiss, and touch her family was very sad. Theme 6 represents findings that barriers to access afflicted older adults in various ways. The older adults reflected on the barriers causing

distressing times and barriers to accessing important elements such as family, caregiving, and medical care.

Summary

In Chapter Four, the study's results explored several answers to better understand older adults' experience during the COVID-19 pandemic of mandated isolation. There were six themes identified and included the following:

- **Theme 1**: Mechanisms to cope with isolation included watching TV, reading, walking, texting with families, and participating in spiritual services (church and synagogue);
- **Theme 2**: Responses to being isolated included sadness, loneliness, and distress, all leading to perceptions of effects on mental health during isolation;
- **Theme 3**: Facilities provided formal and informal support during isolation, but not seeing family continued to weigh on them;
- **Theme 4**: Older individuals reported both positive and negative responses as it relates to their mental health during isolation;
- **Theme 5:** The transition from the Pre-COVID to Post-COVID period contributed to an awareness that positive mental health wellness may only occur with proper support and/or intervention;
- **Theme 6:** There were many barriers to access that also seemed to impact mental health and wellness.

The following chapter will conclude this dissertation and include a thorough, meaningful discussion of the impact of social change from this study. In addition, the interpretation of the findings, limitations, and recommendations will be reviewed.

Chapter 5: Discussion, Conclusions, and Recommendations

The purpose of the generic qualitative study was to explore how older adults aged 60 years or older residing in assisted living or nursing homes describe their experience of mental health during the COVID-19 pandemic of mandated isolation. Older adults in several facilities shared their experiences, and the findings, in turn, will add to the current body of literature previously reported. There were 19 codes identified during the thematic analysis, and five categories were identified, including: (a) coping, (b) isolation, (c) support and response, (d) mental health, and (e) isolation. From these categories, six overarching themes were identified based on responses from the participants and shall be noted as follows:

- **Theme 1**: Mechanisms to cope with isolation included watching TV, reading, walking, texting with families, and participating in spiritual services (church and synagogue);
- **Theme 2**: Responses to being isolated included sadness, loneliness, and distress, all leading to perceptions of effects on mental health during isolation;
- **Theme 3**: Facilities provided formal and informal support during isolation, but not seeing family continued to weigh on them;
- **Theme 4**: Older individuals reported both positive and negative responses as it relates to their mental health during isolation;
- **Theme 5:** The transition from the Pre-COVID to Post-COVID period contributed to an awareness that positive mental health wellness may only occur with proper support and/or intervention;

- **Theme 6:** There were many barriers to access that also seemed to impact mental health and wellness.

This study used a conceptual lens and theoretical framework to provide an opportunity to process the participant responses in a meaningful manner with particular application to successful aging and mental wellness. The conceptual framework founded by Baltes and Baltes entitled Selection, Optimization, Compensation (Baltes & Baltes, 1993) allows for further explanation of the older adults' experiences related to the pandemic. The selection component was represented through the COVID-19-mandated isolation, the optimization component was the older adults' ability or inability to adapt to the environment, and the compensation was the emotional adaptation. The theoretical framework founded by Bronfenbrenner (1996) entitled Sociological Perspective of Ecological Theory provided an additional foundation to explore the relationship of the older adult with multiple systems: microsystem, mesosystem, exosystem, and macrosystem. All these tenets will be further discussed in the upcoming section. This final chapter will provide further interpretations of the findings, limitations of the study, recommendations for further research, and the implications for positive social change.

Interpretation of the Findings

For this study, seven participants shared their experiences concerning COVID-19 isolation and its impact on their mental wellness. The participants were descriptive in their responses concerning a typical day pre and post the COVID-19 pandemic at their respective residential settings. In addition, the participants shared their feelings, coping mechanisms, and important people during the isolation. The perspectives offered both

positive experiences and challenging times for the older adults. The findings from this study were consistent with previously documented literature from Armitage and Nellums (2020), Ilgili and Gokce (2020), and Wong and Li (2021), which demonstrated mitigation efforts for older adults and the effects of isolation on mental wellness.

Older adults are particularly afflicted with mental health disorders, including depression, at a rate of 15% of the population (National Institute of Mental Health, 2022). This is alarming, as the older adults in the study reported feelings of sadness, loneliness, and hopelessness, which are consistent with characteristics of depression. An alignment exists when compounding the literature reported by the National Institute of Mental Health (2022) with the participants' experiences. Several of the participants shared an observation that their neighbors appeared to have the presence of dementia after many months of staying in their apartments. This observation is consistent with the literature from Tan et al. (2022), suggesting that older adults experiencing mental health will have an increased cognitive decline. According to Ana Victoria et al. (2021), the presence of mental health in older adults prior to the pandemic was exacerbated by mitigation efforts such as isolation and quarantine.

While it is unclear if the participants in this study had the presence of mental health prior to the pandemic, it would appear, based on their responses, that the isolation affected their overall mental wellness. Ana Victoria et al. (2021) document the limited interactions, changes in family support, and prolonged loneliness as causes for these adverse effects. This previous research is further supported by the participants’ responses of sadness, hopelessness, loneliness, changes in family visits, and periods without human

interaction. The findings from this study are consistent with the knowledge of older adults explored during the Chapter 2 literature review and extend the knowledge in the discipline of gerontology.

Successful Aging

The concept of successful aging is multi-faceted and includes characteristics of medical components along with social determinants of health and mental wellness. According to seminal researchers of the concept (Havighurst, 1961; Calasanti, 2015), older adults will express successful aging by measuring many areas of their life, including overall satisfaction, happiness, medical health, mental health, and ability to control decisions. Successful aging is further broken down by an older adult's ability to thrive or decline, health, and activities of daily living (Rocío Fernández-Ballesteros et al., 2019). These elements are specifically important to the study as many of the participants' responses indicated a decrease in coping with their mental health, changes in their activities for daily living, or overall changes in their ability to thrive or decline. This leads to an interpretation that the older adults in the study reporting negative outcomes of the isolation may, in turn, consider successful aging as a challenge given the experience of COVID-19 isolation.

In contrast, the adverse effects of isolation may not lead to poor perceptions of successful aging in situations where older adults use coping strategies. Participants shared various activities that provided positive coping strategies. The positive coping mechanisms were discovered and identified in Theme 1: Mechanisms to cope with isolation included watching TV, reading, walking, texting with families, and participating

in spiritual services (church and synagogue). All participants shared their ability to pass time through reading, watching television, walking, and finding new ways to connect with families, such as texting and Facetime. Participants used these coping strategies positively, which, in turn, aided in their adaptability. Those who reported a positive adaptation may report better perceptions of successful aging.

Older Adults and Restricted Environments

The mitigation efforts during COVID-19 included many restrictions within the physical environment, known to many as lockdown, quarantine, or isolation. This mitigation was used to decrease older adults' exposure to the virus (Falvo et al., 2021). The restrictions within the environment facilitated long periods of isolation for the older adults to remain in their designated rooms or apartments. While the mandates reduced exposure, there were also other consequences (Wong & Li, 2020). These restrictions in mobility indicate potential adverse outcomes in mental health, increased fall risks, and weight changes, to name a few (Moro & Paoli, 2020; Siegmund et al., 2021). This research regarding older adults and their environment aligns with the findings of this study in several themes, including Theme 2 and Theme 3.

The finding for Theme 2 is stated as follows: Responses to being isolated included sadness, loneliness, and distress, all leading to perceptions of effects on mental health during isolation. As Wong and Li (2020) suggest, the consequences of COVID-19 isolation impacted other areas aside from the movement restrictions. The participants in this study shared their experiences of sadness, loneliness, hopelessness, and despair. At times, the participants expressed they did not know how they got through the isolation

times, with some sharing regret that they missed years from their families, growth of their grandchildren, and distress. Of the seven participants, three mentioned the feeling of being depressed during COVID or currently feeling this way at the time of the interview while correlating it with the isolation. The participant reports align with the research from Wong and Li (2020), which states that prolonged isolation has adverse consequences.

Another theme in this study illuminating older adults and their environment is Theme 3: Facilities provided formal and informal support during isolation, but not seeing family, friends, or neighbors continued to weigh on them, contributing to their overall mental health wellness. While the facility imposed the isolation, there were other roles the participants shared about the facility. Participant RZ shared, "company (facility staff) was important since family could not visit." Overall, participants reflected on the facility as their home, and at the time, staff became their informal family as they were the only human interactions for long periods. Participants shared that caregivers in the facility were essential in maintaining the physical environment and providing personal care. These interactions were critical to the health behaviors of older adults. Positive health behaviors promoted by the facility were interventions to prevent the negative consequences of a sedentary lifestyle (Moro & Paoli, 2020).

Participants shared about additional supportive means from the facilities. They reported that these supports helped them adapt during their isolation. These supports include having an onsite library, sending cards, making engagement calls, and allowing social distancing visits when permitted. The facility engagement efforts promoted

positive health behaviors to increase healthy mental wellness. The findings within this study and previous literature review align particularly with how facility restrictions impact the mental health wellness of older adults.

Older Adults with Loneliness and Isolation

Many attributes may lead to the vulnerability of older adults, and according to the National Institute of Aging (2021), feelings of loneliness and physical isolation are both examples. Loneliness and isolation affect older adults more frequently than other populations (Tran, 2022) and impact social determinants of health, including housing, illness, and relationships. For some, the impact of these changes can be challenging and, at worst, lead to increased hospitalization and mortality (Tran, 2022). The findings documented in the following themes are supportive of the literature reviews:

- Theme 4: Older individuals reported both positive and negative responses as it relates to their mental health during isolation.
- Theme 5: The transition from the pre-and post-COVID period contributed to an awareness that positive mental health wellness may only occur with proper support and/or intervention.

The participants in this study reported several negative responses to the isolations, which in turn afflicted their mental health. When asked about loneliness, Participant LS shared her experiences of being lonely and sad. Participant LS reflected on missing her family, stating that the years she missed “will never come back” and became teary-eyed when sharing. Participant LS said she had times of being in a “funk” and feeling depressed due to the isolation. The responses from this participant were similar to others in the study

who shared their overall feelings of loneliness, isolation, depression, and hopelessness. Based on the literature and experiences of the older adults in this study, an alignment persists among the experiences of loneliness caused by isolation.

Social Determinants of Health and Older Adults

A strong linkage persists between social determinants of health for older adults and poor COVID-19 outcomes (Mat et al., 2022). Social determinants of health represent many components for older adults, including health, mental health, socioeconomic status, and housing, to name a few. Within elements of social determinations, the participants in this study shared experiences regarding barriers to access leading to an overall impact on their mental health wellness. The findings identified as Theme 6: There were many barriers to access that also seemed to impact mental health and wellness, representing the alignment with the experiences of the participants and the literature review.

One of the most significant barriers to access shared by the participants was access to medical professionals. One of the participants shared that she waited several months to be able to see a doctor for the pain in her neck. She shared that the pain in the neck was causing her discomfort and affected her overall mental health. Another participant shared about access during a medical procedure in which she was unable to have her family come to the rehabilitation center during recovery. The inability of the family to provide support during her medical event was distressing to Participant LS. She shared that during her recovery time, she was sad, lonely, and struggled due to the isolation. The participants correlated these barriers to the COVID-19 mitigation efforts.

In contrast, participants reported access to religious services as a positive resource for social health determinations relative to mental wellness. Participants reported that there was initially no access to traditional religious services, such as attendance at synagogue or church services, due to the isolation mandates. Over time, however, Participants gained access to these services from non-traditional means such as virtual religious services, Facebook Live, and television. Participants shared that access to religious services was a coping mechanism that helped with isolation effects and mental health wellness. According to Omary and Chamber (2022), an intersection exists among depression, social risk factors, and older adults. Given this information and the coping mechanism reported by the Participants, the interpretation of these findings positively impacts the mental health of older adults.

Conceptual Lens and Theoretical Framework

This study used the conceptual lens of Selection, Optimization, and Compensation (Baltes & Baltes, 1993) and the theoretical framework of the Sociological Perspective of Ecological Theory (Bronfenbrenner, 1996). These perspectives were selected based on their application to older adult studies, sociological applications, and successful aging. Baltes and Baltes's (1993) Selection, Optimization, and Compensation (SOC) lens provided a roadmap to understanding the impact of COVID-19 isolation in older adults and its impact on successful aging. In this lens, Baltes and Baltes (1993) document that the selection component is the achievable goal; for this study, it is represented as adherence to isolation. The optimization component in this study is represented by the older adults' response, ability, and adaptation to the environment of the pandemic. The

compensation component is the older adults' emotional response and adaptation. The experiences shared by the older adults are further enhanced by this model, demonstrating how they adhered to isolation and created adaptations through their coping mechanisms and the effects on their emotional well-being. The tenants of SOC provided an application of the responses from the participants and their coping. While some of the participants shared that they had positive coping adaptations, many expressed emotions that aligned with symptoms of sadness and despair. As Baltes and Baltes (1993) teach, older adults' perspectives on their ability to age successfully correlate to their emotional well-being. Given the participants' experiences during COVID-19 isolation in their residential settings and the framework from SOC, the older adults may perceive themselves as having barriers to successfully aging.

The theoretical framework founded by Bronfenbrenner (1996) entitled Sociological Perspective of Ecological Theory (SPET) provided an additional foundation to explore the relationship of the older adult with multiple systems: microsystem, mesosystem, exosystem, and macrosystem. The SPET specifies the alignment between these systems and how the individuals' behavior interacts with the specific system with positive and adverse outcomes. At the microsystem level, the SPET offered an opportunity to consider how the participants experienced COVID-19 isolation. The microsystem level represents the closest contact opportunity for the older adult. During isolation, the older adults had minimal interactions at a microsystem level; the isolation, stay at home orders, and prolonged mandates to stay isolated limited and prohibited

interactions. These limitations created feelings of the participants of loneliness, isolation, and distress.

The SPET's mesosystem level represents the older adults' relationship in a slightly larger community for interaction. The mesosystem is demonstrated through the older adult's relationship with one familial person. Based on the experiences shared by the participants, the mesosystem level was critical for coping with emotional distress. These familial relationships were often between the older adult and their caregivers, referred to as informal family. The older adults could not see their family, friends, and neighbors during isolation. However, they were able to have caregivers come to their apartments. The interactions between the older adults and the caregivers were reported as a positive coping mechanism for the isolation. The ability to see family for older adults did not occur for several months into the pandemic when social distancing recommendations were provided.

The third system from SPET is the exosystem, defined as the individual's interactions with the external community. The exosystem for the older adult participants in this study is represented by the larger community in the residential setting and connections to community engagement, such as churches or synagogues. Participants shared both positive and adverse outcomes when applied to this system level. Participants could not interact in their residential settings during isolation periods as they were required to remain in their rooms or apartments, and programming ceased. Participant LS shared that the furniture was removed for the community spaces, and the residential setting was described as a ghost town. The limited interactions for the older adults within

their larger community affected their mental health, as they reported sadness, loneliness, and hopelessness. In contrast, the interactions between the older adults and religious community engagement were reported as a positive outcome. Participants reported a strong connection to spiritual and religious services as a coping mechanism during the isolation.

The last system of the SPET is the macrosystem, represented by the older adults' cultural belief system, norms, and customs. The older adults reported strong connections between their belief system and spiritual activities as a supportive coping mechanism to cope with the isolation. However, the cultural norm was an area where participants reported adverse effects. For example, Participant LS shared about her inability to be an active grandparent during isolation, sharing strong feelings of sadness, anger, and regret that she missed many years of her grandchildren. Participant LS also shared about her struggle as being an "Italian" and struggling not to be able to touch and kiss her family. Participants also reported sadness relative to changes in how holidays and particular customs were honored during the isolation. In summary, the SOC and the SPET provided a lens to further understand the experiences of older adults during COVID-19 isolation, representing both positive and adverse outcomes of mental health wellness.

Limitation of the Study

There are several limitations to this study. The first is that respondents were predominantly female, with only one of the seven participants identifying as male. While the study did meet data saturation requirements, there remains a limitation in determining if males responded differently to the COVID-19-mandated isolation at the designated

facility. Given that the nature of the research questions did not include a gender component, it was unnecessary to continue interviewing to ensure the male perspective. According to Xu et al. (2024), there are gender differences as they relate to mental health in older adults, especially concerning the COVID-19 pandemic. Therefore, gender responsiveness will remain a limitation of the study.

Another limitation of the study is the exclusion criteria. Based on IRB's definition of vulnerability for older adults, those with dementia or other memory impairments would have been considered high risk. Due to the nature of my experience conducting research and understanding the vulnerability of memory impaired older adults, they were excluded from this study. Cognitive decline is a characteristic of post COVID-19 health concerns (National Institute of Aging, 2021; Tan et al., 2022); therefore, learning more about their experiences is important. The exclusion of older adults with memory impairment limits this study, as they experienced isolation mitigation during the pandemic, and I could not capture their experiences through the study design.

Another limitation noted in this study is the geographical location. All participants in this study came from Connecticut. While the COVID-19 pandemic was a global phenomenon, the United States provided federal recommendations, and states could interpret the guidance. Given this variance and the ability to interpret mitigation efforts, states did not have a unified approach (Lurie & Sharfstein, 2023). Considering this limitation, participants may have different experiences based on the states they lived in during isolation.

The last limitation of this study is the type of residential settings related to economic funding sources. The participants from this study came from residential settings, including skilled nursing homes and assisted living facilities. Within these settings, they could have various funding means, including federal (Medicare), state (Medicaid), proprietary, and subsidized housing. The variance in these funding sources also leads to different economic backgrounds of the older adults. Based on the knowledge of social determinants, older adults could be differently impacted by their housing experiences, health, economics, and access to care. Given this limitation, older adults from varying economic backgrounds may report different experiences during the isolation periods.

Recommendations

Several recommendations are identified considering the limitations described, including gender, diagnosis, geographical location, and economic resources for future research. The first recommendation is regarding gender. As noted in the limitations, most participants were female, with only one identifying as male. To add to the current literature, additional studies are warranted to determine if males responded differently to the COVID-19 mitigation effort of isolation.

The following recommendation for future studies is to learn more about the experiences of older adults with memory impairment. Future studies should incorporate older adults with memory impairments who may still be able to share historical experiences of the pandemic. It is important to note that older adults who presently share about memory impairments may not have had the diagnosis during the pandemic;

therefore, it would be essential to learn about the discovery of the memory changes and the perspective if it was based on the decline from the isolation during the pandemic. The experiences of older adults with memory impairments will add to the current research.

Older adults' geographical and economic background is recommended for future research in this discipline. It would be necessary to interview older adults from states other than Connecticut to learn more about the experiences of COVID-19 isolation in residential settings. Given the limitation of the study and the variance of interpretation of guidance, future research in this area will help to learn about the experiences from a geographical perspective. The economic background or funding source of the older adults is a recommendation as well to learn more about the socioeconomic background of the older adults. Studies that compare the economical definition of the housing in relation to those that are privately funded versus subsidized. All of the recommendations for future research would aid in learning about the experiences of older adults and contribute knowledge to the discipline.

Implications

This study has several implications for positive social change at many levels, including individual, organizational, practitioner, and policy. The older adult population will grow over the next twenty years, and this study is important to have an understanding of the impact of COVID-19 isolation and mental health wellness. Practitioners, policymakers, and caregivers will gain critical insight into the collective impact of isolation. A comprehensive understanding of the consequences of isolation on adults will ensure that resources, programming, and funding are made available to

support older adults in a post-pandemic period. Practitioners should consider the isolation and mitigation efforts related to the effects, such as loneliness, sadness, and mental wellness. The impact of the change will occur when interventions are made available to older adults to further their coping mechanisms. In addition, given the experiences shared by older adults, it is critical for practitioners to screen for mental health and ensure treatment modalities are aligned with older adult complexity and needs. Lastly, positive change persists from this study by sharing the experiences of the participants with policymakers who must consider the mitigation recommendations and unintended consequences demonstrated. While the literature documents mitigation efforts such as isolation were effective in dense settings such as the settings for which the participants lived, the outcomes of mental health wellness must be addressed for the older adults to live a successful quality of life post-pandemic.

Conclusion

The collective impact of COVID-19 was harsh for the older adult communities studied in this dissertation. Participants shared experiences of contrasting outcomes, both positive and adverse. While the older adults in this study shared coping mechanisms such as watching television, reading, and spiritual activities, all reported some effects of negative mental health. Older adults shared feelings of distress, loneliness, hopelessness, and sadness when sharing their isolation experiences. It is imperative that efforts for positive social change occur to support the older adult community in specialized, tailored post-pandemic programming. This study and its findings will add to the previous

literature on COVID-19 isolation for older adult communities and offer great insight into the experiences of older adults, 60 years or older, living in residential settings.

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Appendix A: Interview Questions

Research Question #1:

Let us begin with what you would like to share with me about your experience living at (name of residential setting) during the COVID-19 pandemic.

Research Question #2:

Tell me about a typical day before COVID-19 imposed isolation.

Tell me about a typical day during COVID-19 imposed isolation.

Research Question #3:

What part of COVID isolation when well? What part of post-COVID-19 is going well?

From these experiences, how did it affect your overall mental wellness?

Research Question #4:

What was the most difficult part of the isolation?

Research Question #5:

Can you tell me if you have noticed a difference in your emotions and mental health pre-, during, and post-pandemic?

Research Question #6:

If you could share your experience with your mental health and emotions during quarantine, what would you share?

Research Question #7:

During the imposed isolation, were there times that you felt hopeless, isolated, or alone?

If so, how do you describe your experiences facing this?

Do you still carry those feelings post-COVID-19 isolation?

Research Question #8:

What is the most important thing you did during isolation to mitigate the feelings of negative mental wellness? Do you still use these tools post COVID-19?

Research Question #9:

Tell me about the role(s) of important people during COVID-19. Was there any person(s) who was particularly important during this time? Why?

Research Question #10:

What did this experience mean to you regarding your coping mechanism and ability to adapt to a barrier or challenge imposed by others?

Supplemental Questions:

What would you share with your future generations about COVID-19 imposed isolation?

Is there anything else you would like to share with me before we end our interview?

Appendix B: Recruitment Flyer

Interviewing Adults Aged 60 and Older

There is a new study about the experiences of adults aged 60 years or older who encountered COVID-19 Isolation to better understand the impact of the isolation.

Interviews begin March 2024
$10 Thank you gift card for all completed interviews

For this study, you are invited to describe your experiences during the pandemic isolation.

About the study:

- One 30–60-minute phone or in person interview that will be audio recorded.
- The published study will not share any names or details that identify you. Your privacy will always be protected.

Volunteers must meet these requirements:

- Aged 60 or older
- Resided in a skilled nursing home or assisted living facility
- Experienced COVID-19 Isolation/Quarantine while living in a facility

This interview is part of the doctoral study for Heidi Lubetkin, a Ph.D. student at Walden University.

Please email **Heidi.Lubetkin@Waldenu.edu** to let the researcher know of your interest. You are welcome to forward to others who might be interested.

Appendix C: Social Media Recruitment

Interviewing Older Adults aged 60 years or older ($10 Thank you Gift Card)

There is a new study about the experiences of Older Adults, aged 60 years or older who encountered a COVID-19 isolation to better understand the impact of the isolation. For this study, you are invited to describe your experiences during the pandemic isolation.

About the study:

- One 30–60-minute phone or in person interview that will be audio recorded (no videorecording)
- You would receive a $10 Visa gift card as a thank you
- To protect your privacy, the published study will not share any names or details that identify you

Volunteers must meet these requirements:

- 60 years old or older
- Resided in a skilled nursing home or assisted living facility
- Experienced a COVID-19 isolation/quarantine while living in the facility

This interview is part of the doctoral study for Heidi Lubetkin, a Ph.D. student at Walden University. Interviews will take place during January.

Please email Heidi.Lubetkin@Waldenu.edu to let the researcher know of your interest. You are welcome to forward it to others who might be interested.