Anxiety during COVID-19: The Lived Experience of Older Adults

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This dissertation is dedicated to my father, Simon. (1965-2016)

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Abstract

This study explored the lived experience of Maltese older adults with symptoms of anxiety during the COVID-19 pandemic. Research related to mental health in older adults is considered to be lacking locally. This qualitative study was carried out through an interpretative phenomenological analysis approach. 7 Maltese older adults (5 females and 2 males) were recruited through purposive and snowball sampling, and semi-structured interviews were utilised to collect data. The elicited themes highlighted the high levels of fear, as well as the different cognitive processes and attitudes that led to and maintained the experience of anxiety among participants. The challenges of living through the pandemic were also illustrated. This included isolation, the need to implement safety measures, the long-term living outcomes of the pandemic, as well as reflections on vulnerability. The resilience, coping strategies, and support systems of the participants were also highlighted. These results were framed within a *Dynamic Biopsychosocial Model*. The results indicated that biological, psychological and social factors were implicated in the experience of anxiety among the participants. However, these factors were not static but fluctuated as the pandemic progressed. This in turn impacted the experience of anxiety, and subsequently the participant's perceptions and attitudes towards anxiety as well as the pandemic. Recommendations for future research, clinical practice, and policymakers are also provided.

Keywords: COVID-19, anxiety, older adults, interpretative phenomenological analysis, lived experience

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Introduction

Preamble

The purpose of this chapter was to acquaint the reader with the topic explored in this research study, along with providing contextual knowledge regarding anxiety in older adults throughout the COVID-19 pandemic. This chapter covers the study's aims, objectives and conceptual framework. Furthermore, a synopsis of the chapters within the study will be provided.

Aims, Objectives and Research Question

The overall aim of this research study was to explore the lived experience of older adults who experienced symptoms of anxiety during the COVID-19 pandemic. Additionally, two objectives were set out to support the overall aim of the study by exploring:

- The different ways of how older adults with symptoms of anxiety coped during the pandemic;
- The meaning associated with the perceived risk factors and protective factors related to experiencing symptoms of anxiety during the pandemic.

The research question guiding this study is as follows:

- What is the lived experience of older adults who experienced symptoms of anxiety during the COVID-19 pandemic?

The study is qualitative in nature and utilises an interpretative phenomenological approach (IPA) in addition to conducting semi-structured interviews. The *Dynamic Biopsychosocial Model* (Lehman et al., 2017) was kept in mind during the drafting of the interview questions, the writing of the aim and objectives of this study, as well as during the subsequent analyses and discussion of the results. This meant that the lived experience of the

older adult participants was considered through a dynamic biological, psychological and social perspective.

Conceptual Framework

Over 40 years ago, the biomedical model was put up for discussion regarding its merits and position as a framework for viewing and understanding illness, and subsequently how illness and the individual are treated. This was as the supporters of the biomedical model felt that they should not tangle themselves with psychosocial issues as there were not considered to be related to the domain of medicine. On the other hand, the opposing school of thought felt that the biomedical model was too reductionist and was not sufficient enough to provide high-quality treatment. It was believed that to comprehensively understand disease and come to an encompassing treatment plan one cannot limit themselves to the biological aspect, but take into account the individual and their attitudes. Hence, the social and psychological world of the person needs to be considered. This became known as the *Biopsychosocial Model* (Engel, 1977). Therefore, the emphasis moved from focusing on the disease as the sole subject of interest to exploring what areas and factors have contributed to a person experiencing an illness in their life and what sort of changes are needed to restore their health. The terms ‘disease’ and ‘illness’ are reflections of these two different models, and how they are distinguished from one another. Disease refers to the malfunctioning of the physiology, regardless of the individual’s subjective views (Seidlein & Salloch, 2019). In other words, disease “removes the patient from the pathology” (Fleischman, 1999, p.7). Conversely, illness is the individual’s experience and perception of an unwanted state of health (Seidlein & Salloch, 2019).

To comprehensively understand how anxiety was experienced and how it impacted the different areas of the participant’s lives, the *Biopsychosocial Model* (Engel, 1977) was found to

be needed and adopted for this study. Additionally, a plethora of studies have contextualised anxiety and anxiety disorders within this model (Jokinen & Hartshorne, 2022; Narmandakh et al., 2021).

In addition to the above model, increased emphasis has been given to the word 'dynamic', indicating that the biological, psychological and social influences that impact an individual's health are not rigid but rather ebb and flow as time passes whilst simultaneously interacting together (Lehman et al., 2017). Hence in the context of the COVID-19 pandemic, anxiety is theorised to not have been a static experience, but rather one that fluctuated as the pandemic developed. This fluctuation also points to how these biological, psychological and social systems can vary in centrality over time, meaning that how impactful they are to a person's health is also dynamic (Lehman et al., 2017).

Several other theoretical models and conceptual frameworks were used to analyse the data collected from the semi-structured interviews. These included the *Transactional Model of Stress and Coping* by Lazarus and Folkman (1984), the *Health Belief Model* (Rosenstock et al., 1988), the *Transactional Model of Stress and Coping* by Lazarus and Folkman (1984), as well as the *Theory of Planned Behaviour* (Ajzen, 1991). These models and concepts were used to frame the behaviours and attitudes of the participants.

Background Information

Anxiety disorders are conditions that present with excessive and persistent fear and anxiety. Symptoms of anxiety include tension, sleep disturbances and excessive worry (American Psychiatric Association, 2022). Anxiety disorders are the most prevalent forms of mental illness in the world and affect millions of people each year (Yang et al., 2021). Prevalence

rates of anxiety within older adult populations range from 1.2% to 15% in the community, and up to 28% in clinical settings (Scinto & Wick, 2020; Welzel et al., 2021). Locally, around 10% of the older adult population experiences chronic anxiety (The Directorate for Health Information and Research, 2018).

The COVID-19 pandemic caused by the SARS-CoV-2 virus has emerged as a severe global health crisis with wide-ranging impacts (Shi et al., 2020). Older adults were particularly vulnerable during the COVID-19 pandemic due to a variety of reasons, which ultimately led to this particular population having the highest rates of mortality and COVID-19 cases (Centers for Disease Control and Prevention, 2021). The onset of the COVID-19 pandemic was also found to have had a direct impact on the increased prevalence rates of anxiety in older adults (Santomauro et al., 2021).

Several risk factors are implicated in the aetiology of anxiety in older adults during the COVID-19 pandemic. These included *Population Shocks* (Santomauro et al., 2021), being female (Lusida et al., 2022), genetics factors (Lee et al., 2016), complex physical illnesses (Jemal et al., 2021), loneliness (Robb et al., 2020), and socioeconomic factors such as having a low income (Koma et al., 2020).

On the other hand, research has also shown that protective factors were evident throughout the pandemic that were negatively associated with anxiety in older adults. Lifestyle and family-related factors such as socialising with other people, keeping a routine, family cohesion and being in a long-term relationship are commonly cited as being protective against anxiety (McKinlay et al., 2021; Yoon & Choi, 2021). Furthermore, having clear and concise information related to the pandemic was found to reduce the chance of anxiety in older adults (González-Sanguino et al., 2020). However, COVID-19 information and news also had the

potential to lead to or worsen symptoms of anxiety if the information was excessive and overwhelming (Cachicatari-Vargas et al., 2022). Additionally, resilience (McKinlay et al., 2021), wisdom (Jeste et al., 2019), and financial stability (Ciuffreda et al., 2021) are all factors that prevent or lessen symptoms of anxiety in older adults.

The pandemic has also seen a rise in ageist attitudes and behaviours against older adults, which in turn have led to negative social and psychological effects within this population (Silva et al., 2021). Different theories such as the *Terror Management Theory* have been utilised to explain the link between prejudice against older adults, COVID-19, and the rise of anxiety (Arcieri, 2021).

Locally, several central sectors of society were impacted by the pandemic, such as those relating to healthcare, the economy and social activities (Grech & Grech, 2020). Whilst the quantitative impact of the pandemic in Malta has been extensively explored in literature, qualitative studies looking at the impact on mental health are less evident. Nonetheless, the few conducted studies have shown that older adults experienced increased levels of anxiety during the pandemic, and were particularly worried about their mental health and that of their loved ones (Richmond Foundation, 2022). Factors such as the closure of spiritual institutions were also found to be directly linked to the exacerbation of anxiety (Zammit, 2020). All in all, local studies have quantitatively shown that the mental health of older adults has been negatively impacted due to the pandemic. Nonetheless, additional qualitative studies are needed to more comprehensively understand the different impacted dimensions of mental health, including that of anxiety.

This study is being proposed for several reasons. As previously mentioned, anxiety disorders in older adults have been on the rise since the pandemic began, making this research

relevant to public health concerns. While literature on the topic is available internationally, there is a lack of local studies (Formosa, 2015). This study hopes to fill this gap and contribute to the literature on this topic. Cultural and social factors can influence anxiety, so it is important to explore this issue in different populations (Penninx et al., 2021). By understanding the experiences of Maltese older adults with anxiety during the pandemic, appropriate support and tailored interventions can be delivered to them. In the same vein, the results of this study can contribute to the field of health psychology by aiding future health campaigns. This is because data will be more readily available and such campaigns can accurately and systematically target the needs of this population and consequently aim for a specific behaviour change, such as the reduction of isolation. Similarly, the study can further highlight the specific risk factors in older adults during a pandemic or in similar situations of high stress. This, in conjunction with the improved understanding of the mental health needs of this cohort will support health psychologists and other professionals in developing evidence-based interventions to reduce anxiety and improve overall quality of life (QOL). Lastly, the results of this study can be utilised in other models and theories that serve to understand behaviour change in this population. Overall, investigating the experience of older adults with anxiety during the pandemic has important implications for improving mental health outcomes in this population, as well as contributing to the field of health psychology and mental health in general.

Conclusion

Following this introductory chapter, a review of pertinent literature relating to anxiety in older adults framed within the COVID-19 pandemic will be presented. The utilised methodology and research design for this study are then discussed. Following this, the themes and findings elicited from the 7 semi-structured interviews are presented. These findings are then discussed in

the context of literature in the fifth chapter. To conclude the study, the last chapter will include the pertinent findings whilst the limitations of the study and implications for future research, policymakers and clinical practice are put forward.

Literature Review

Introduction

This chapter provides an overview of pertinent information regarding the lived experience of older adults who experienced symptoms of anxiety during the pandemic, as well as the different ways how this population coped with anxiety during this period. Furthermore, this literature review will discuss risk factors and protective factors concerning older adults experiencing anxiety during the pandemic or similar circumstances.

What is Anxiety?

Anxiety has been considered to be a health issue which is distinct from fear and sadness for over 2000 years (Crocq, 2015). The word 'anxiety' is derived from the Latin word 'angor', which means to constrict or to tighten (Crocq, 2015). This in itself points to specific symptoms of anxiety, such as palpitations and the feeling of choking (Bandelow et al., 2017). By today's understanding, anxiety is considered to be a reactive state of fear brought upon by the anticipation of future scenarios which a person perceives to be dangerous or threatening (American Psychiatric Association, 2022). This state of anxiety impacts one's cognitive, behavioural, physiological, and emotional processes. This in turn results in avoidance behaviours as a way to evade situations that are perceived to be anxiety-inducing (Chand & Marwaha, 2022).

Prevalence

Anxiety-related disorders are considered to be some of the most commonly occurring mental health disorders in older adults, with prevalence rates ranging between 1.2% to 15% in the community, and up to 28% in clinical settings (Scinto & Wick, 2020; Welzel et al., 2021). A

nationwide survey conducted in Malta revealed that 9% of those aged 65-74 had chronic anxiety, which increased to 12% in those aged 75+ (The Directorate for Health Information and Research, 2018). As can be noted it is difficult to have a single figure, as prevalence rates vary according to numerous factors such as the sub-age groups in the older adult cohort (such as the oldest-old), socioeconomic status, type of anxiety disorder and gender. As a result, this may lead to inaccurate prevalence rates, meaning that rates may be different than what is being reported. Furthermore, these figures do not necessarily reflect the true prevalence rate of anxiety disorders and anxiety symptoms within the older adult population. Reasons for this include the fact that the oldest-old cohort is often underrepresented, under-researched, and excluded from studies (Cresswell-Smith et al., 2018; Marum, 2020; Prendki et al., 2020). Studies have also found that older adults tend to underreport their symptoms for numerous reasons, such as due to cognitive problems, previously existing conditions, and co-existing mental health issues (Bell et al., 2016; Loh et al., 2018; Skinner et al., 2016).

Anxiety in Older Adults

The 5th edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) provides several commonly occurring symptoms related to anxiety such as panic attacks, the fear of losing control, excessive worry, palpitations, sweating and nausea (American Psychiatric Association, 2022). However, specific symptom profiles for older adults with anxiety are not mentioned in the DSM, even though recent research is pointing to the possibility that older adults experience a different anxiety symptom profile from other age cohorts (Balsamo et al., 2018; Hellwig & Domschke, 2019). This means that certain anxiety symptoms occur less frequently, while others are expressed more often (Bui et al., 2019). Thus, if one symptom profile is applied for all age cohorts with anxiety, anxiety symptoms may be over, or under-detected.

Studies by Miloyan et al. (2014) and Nilsson et al. (2018) found that anxiety manifested differently according to age groups. Symptoms commonly associated with anxiety such as nausea, vomiting, and diarrhoea occurred less frequently in older adults, while others such as concentration difficulties, feeling dizzy and fainting were more common among this age group. These findings are also relevant and appropriate when considered in the context of depression in older adults, where symptomology is also different when compared to other age groups (Wuthrich et al., 2015).

The Relationship Between COVID-19, Anxiety, and Older Adults

The link between older adults, anxiety, and the COVID-19 pandemic has been made increasingly clear following the data that emerged from studies related to these three distinct, but also closely related topics. This relationship may be seen through the vulnerability of older adults during the pandemic, as well as the impact it had when compared to other age cohorts. Older adults are considered to be at the highest risk of contracting the virus and experiencing negative health outcomes such as death, hospitalisation, and requiring specialised equipment to aid with breathing (Centers for Disease Control and Prevention, 2021). One should also consider that the mortality rate of older adults with COVID-19 is higher when compared to all younger age groups (Dadras et al., 2022). As a result of this, of the 1,000,000+ deaths attributed to COVID-19 in the United States, 74.8% of these deaths occurred in older adults (Centers for Disease Control and Prevention, 2022).

However, there were not only more COVID-19-related deaths in older adults compared to other age cohorts, but other health-related implications too. The findings from the *International Health Policy Survey of Older Adults* by Williams et al. (2021) based on older adult participants indicated that during the pandemic, older adults were most likely to experience

financial problems as well as cancelled medical appointments by the hospital. However, data was collected from high-income countries with a majority of Caucasian participants, and it did not include Malta. Due to this, these findings may not apply to lower-income countries, people of different races, as well as to the local population.

A substantial increase in symptoms of anxiety as well as anxiety disorders has been noted in older adult populations on a global scale since the onset of the pandemic when compared to pre-pandemic times. These changes have been documented by numerous studies, such as that by Jemal et al. (2021) who assessed the prevalence of anxiety in older adults. Jemal et al. (2021) found that 68.7% of their participants developed symptoms of anxiety during the pandemic, which were previously not present. However, these results may be impacted by the specific culture of the participants since they were all selected from Ethiopia. Thus, the experience of anxiety symptoms may be interpreted differently due to ethnic, racial, and cultural factors (Zisberg, 2017).

Similar results were found in the study conducted by Robb et al. (2020). The study found that compared to the base results observed a few months before the lockdown in Britain, a quarter of the older adult participants experienced higher levels of anxiety post-lockdown. However, as the baseline survey took place between May and July of 2020 when the COVID-19 pandemic was already present in the UK it is unclear what factors led to the increase in anxiety symptoms in the study. Due to this, the post-lockdown results may have been different to the baseline survey due to the restrictions brought about by the lockdown, rather than other psychological factors brought about by COVID-19. In fact, loneliness was considered to be the major influencing factor linked to higher symptoms of anxiety (Robb et al., 2020).

Mental health disorders are considered to be one of the leading causes of burden on a global scale, with anxiety being one of the top contributors (Ferrari et al., 2022). The onset of the COVID-19 pandemic served to provide a breeding ground that led to several factors which exacerbated mental health issues globally. The systematic review by Santomauro et al. (2021) served to quantify the impact of the pandemic by comparing the global prevalence of disorders such as anxiety disorders from pre-pandemic, to mid-pandemic times from over 200 countries. Santomauro et al. (2021) estimated that there were an additional 76.2 million cases of anxiety disorders in 2020 caused by the pandemic in all age groups. It is interesting to note that the study estimated that younger age groups were more affected by the pandemic than older age groups in terms of prevalence (Santomauro et al., 2021), however, the study fails to define the age range of the 'younger' and 'older' age groups. Furthermore, while the mean age of the total participant population was included (49.1), a clear breakdown showing the age group, with the number of participants in that group was not provided. Due to this, it is difficult to ascertain the impact on older adult participants.

Studies such as that by Wetherell et al. (2009) and Balsamo et al. (2018) have pointed to possible complications in identifying anxiety levels in older adults. One study found that older adult participants were less accurate in identifying their symptoms of anxiety, and less likely to realize that their symptoms were anxiety-related (Wetherell et al., 2009). Hence, since older adults are less likely to recognise symptoms of anxiety and anxiety is manifested differently in this age group, results on this specific age cohort may not be entirely correct. Nonetheless, the overall consensus supports the idea that there was a stark increase in anxiety symptoms within all age populations caused by the pandemic, including in older adults (Taquet et al., 2021; Wong et al., 2020).

The Impact of The Pandemic on Pre-existing Mental Health Conditions

As discussed throughout this chapter, the COVID-19 pandemic has left a multi-factorial impact on older adults, including economic, physical health, social, and mental health dimensions. One way that older adults were impacted by the pandemic was how pre-existing mental health issues tended to become more severe, with an increased chance of relapse (Chatterjee et al., 2020; McCarron et al., 2021).

Lewis et al. (2022) explored the exacerbation of pre-existing mental health issues during the pandemic through a survey completed by participants with a history of mental health issues. Their findings indicated that the majority of the participants felt that their mental health worsened upon the onset and duration of COVID-19, especially in those with a history of anxiety and depression. Pathways that contributed to worsening mental health conditions included difficulty in accessing mental health services, fear of contracting COVID-19, low income, and disrupted financial income (Lewis et al., 2022). These findings are also in line with studies conducted in the UK showing that mental health issues have increased during the pandemic (O'Connor et al., 2020; Pieh et al., 2020).

The systematic review by Neelam et al. (2021) explored the impact of the pandemic on pre-existing mental illness. Their results concluded that anxiety symptoms were higher in those who have a pre-existing mental illness than those without mental health issues during the pandemic. Studies have put forward possible reasons as to why pre-existing mental health issues and symptoms of anxiety increased during the pandemic. Factors include the stresses brought upon by long quarantine periods, the uncertainty and fear of a new global virus, decreased socialisation, job loss, social distancing, closed spiritual institutions and loneliness (Chatterjee et al., 2020; Webb & Chen, 2021).

Risk and Protective Factors

Risk and protective factors that impacted the experience of anxiety in older adults during the pandemic can be viewed within the *Dynamic Biopsychosocial Model* (Lehman et al., 2017). This model adds to the *Biopsychosocial Model* (Engel, 1977) by considering biological, psychological and social systems as being dynamic and thus changing over time, rather than being rigid elements in the lifespan of a person.

Risk Factors

The COVID-19 pandemic has prompted extensive research on the mental health implications for older adults. Subsequently, studies also identified several risk factors that contributed to heightened anxiety symptoms and other related conditions during this time.

Population Shocks. Santomauro et al. (2021) discuss the idea of *Population Shocks*, which are considered to be major unanticipated and unforeseen scenarios that negatively impact a population on numerous levels, such as those related to the environment, finances, socialisation, and well-being. Population shocks have also been found to be strong predictors of increasing levels of anxiety symptoms and disorders (Santomauro et al., 2021). Thus COVID-19 can be considered to be a population shock on a global scale, as well as acting as an overarching risk factor for anxiety in individuals (Santomauro et al., 2021).

Long COVID-19. Long COVID-19 refers to the continuation and development of COVID-19-related symptoms long after the onset of the infection (Koc et al., 2022). While symptoms of COVID-19 are primarily acute, long COVID-19 tend to be neuropsychiatric in nature and more severe (Kubota et al., 2022), thus impacting one's QOL. One of the most frequently occurring psychological symptoms associated with long COVID-19 is anxiety

(Houben-Wilke et al., 2022). While several psychosocial factors contribute to the experience of anxiety in those with long COVID-19 such as social isolation, there is also a physiological process. COVID-19 has been found to result in systemic neuroinflammation, which in turn leads to psychiatric and cognitive symptoms (Penninx, 2021). Due to this, long COVID-19 can also be considered a risk factor for anxiety in older adults during the pandemic.

Gender differences. Gender differences in anxiety were observed in older adults during the pandemic. Most studies have concluded that females are more prone to experiencing symptoms of anxiety during the pandemic than males. Hence, being a female is a risk factor for anxiety during this period (Hubbard et al., 2021; Yassin et al., 2022). However, the contrasting results of the study by Wu et al. (2021) concluded that male participants experienced higher rates of anxiety symptoms when compared to females. The reason for the opposing results of this study may have to do with cultural factors since the participants were chosen from a specific area of China and may contrast with Western hemisphere experiences of anxiety due to cultural and societal differences (Hofmann & Hinton, 2014; Khambaty & Parikh, 2017). These overall results indicating that being a female is a risk factor for anxiety during the pandemic is logical when considering that older females also had higher rates of anxiety in pre-pandemic times (Girgus et al., 2017; Grenier et al., 2018).

Genetic and Biological Factors. The biological component of the *Dynamic Biopsychosocial Model* (Lehman et al., 2017) refers to the physical aspect of the human body that subsequently affects our health and includes an individual's genetics. Older adults may be especially susceptible to experiencing symptoms of anxiety during the pandemic due to genetic factors. This can be seen in the longitudinal twin-based study by Lee et al. (2016) that aggregated data on older adult participants. This study aimed to explore the trajectory of anxiety in later life.

The findings indicated that genetic contributions related to anxiety peak in older adult life, resulting in higher levels of anxiety (Lee et al., 2016). Furthermore, as discussed earlier, gender has also been found to play a role in the relationship between anxiety and older adults. Older female adults tend to experience higher rates of anxiety than males (Grenier et al., 2018; Vasiliadis et al., 2020) due to several biological factors, such as hormonal fluctuations that increase the chance of experiencing anxiety and stress (Altemus et al., 2014; Hantsoo & Epperson, 2017). Similarly, testosterone is found in higher concentrations in males than females and is protective against anxiety (McHenry et al., 2014; Stanikova et al., 2019).

Socioeconomic Factors. Older adults coming from a lower-income household, experienced job loss or were financially impacted have also been highlighted as being at risk of increased levels of anxiety symptoms during the pandemic. This risk factor was particularly highlighted by Koma et al. (2020), who found that older adults with a low salary had a higher chance of anxiety, which was close to double the rate when compared to those older adults with a high annual income. Furthermore, their analysis yielded that those older adults who lived in a household where job loss was evident experienced higher rates of anxiety or depression compared to those that did not (Koma et al., 2020). Additionally, job loss was found to be disproportionally present among older adults compared to other age groups during the pandemic (Goda et al., 2022; Jiskrova et al., 2021), which is linked to higher rates of anxiety during the pandemic (de Miquel et al., 2022; McDowell et al., 2021). Similar results by other studies have also found that negative economic factors such as having a lower income, high health-related expenses and not managing to save up money were additional risk factors (Mani et al., 2022; Yassin et al., 2022). However, due to the devastatingly negative economic impact that the pandemic had on a global scale (Belitski et al., 2021; Nicola et al., 2020), anxiety levels have

been exacerbated (Santomauro et al., 2021). Socioeconomic factors acting as a risk factor for anxiety in older adults can further be explained through the *Social Determinants of Health Model* (Shokouh et al., 2017), as it explains how one's social situation impacts a person's QOL and overall health. This is because factors such as food, economic resources, housing and social relationships shape and determine how effective health care and support are (Centers for Disease Control and Prevention, 2008). Thus, if the social situation of older adults was negatively impacted throughout the pandemic, then this will in turn influence health outcomes such as those related to the management of a health condition (Sulley & Bayssie, 2021). This can be further understood through an intersectionality approach, which refers to how a person's characteristics such as gender, age and race are intertwined with systems of power and inequity and thus impact QOL and wellbeing (Gustafsson et al., 2022). Old age itself can be considered a status of disadvantage due to the combination of increased chronic conditions in conjunction with higher healthcare costs. This is problematic as older adults tend to retire, which impacts their financial stability. When considered together, these factors stemming from the characteristic of being an older adult can negatively impact healthcare access, perceptions of healthcare, and the utilisation of healthcare services (Cohen, 2021).

Isolation and Loneliness. A commonly mentioned risk factor for anxiety during the pandemic in older adults is the combination of isolation, loneliness and the restrictions that amplified loneliness, such as social distancing, shutdowns, and quarantining. Social isolation is present in up to 40% of the older adult population in the USA (Chen & Schulz, 2016), and has only worsened since the onset of the COVID-19 pandemic (MacLeod et al., 2021; Su et al., 2022). This was also the case in Malta, where those aged 65+ felt the most socially isolated throughout the pandemic (Richmond Foundation, 2022).

Loneliness in older adults was also found to be higher during the pandemic compared to pre-pandemic levels (Seifert & Hassler, 2020; Su et al., 2022), and is linked to increased rates of anxiety in this cohort (Dziedzic et al., 2021). The study by Robb et al. (2020) looked at older adults in Britain and concluded that participants living alone and those who felt lonely experienced more anxiety. In fact, the strongest association linked to higher rates of anxiety from a list of components was perceived loneliness (Robb et al., 2020). This risk factor was particularly highlighted in the study by Falvo et al. (2021), whose participants felt scared and anxious about leaving their homes due to the virus, but were simultaneously feeling worse off when remaining inside their homes. This confinement left them feeling safer, but also lonelier and more reclusive. Even though the participants were aware that this behaviour led to decreased socialisation and communication, the fear of the pandemic was stronger than their feelings of loneliness (Falvo et al., 2021).

The pandemic has been recognised as a traumatic experience for some and is acknowledged to be a psychological factor that can lead to heightened levels of anxiety (Kira et al., 2021; Sanchez-Gomez et al., 2021). The pandemic is also considered to be a traumatic trigger and stressor due to the traumatic stress response seen in individuals and the general psychological distress it has caused (Ali et al., 2022; Bridgland et al., 2021). Older adults in particular are at increased risk of COVID-19-related trauma symptoms, as found in the study by Armitage et al. (2022). The study found that around a third of the sample experienced trauma-related symptoms, and estimated that part of this sample has the potential to experience post-traumatic stress disorder (Armitage et al., 2022). These COVID-19-related traumatic stressors are especially relevant to older adults experiencing symptoms of anxiety during the pandemic as this population seems to be at a higher risk (Sarangi et al., 2021). This is also because traumatic

stressors were predictors of anxiety, among other mental health related issues (Kira et al., 2021). Furthermore, other risk factors related to anxiety in older adults during the pandemic have been noted, such as having lower perceived physical health and physical comorbidities (Ciuffreda et al., 2021; Koma et al., 2020).

To conclude, several risk factors have been found to contribute to higher levels of anxiety in older adults during the pandemic, some of which carried over from pre-pandemic times. However, other risk factors emerged or were more prominent with the onset of the pandemic.

Protective Factors

While several risk factors have been found to be associated with anxiety in older adults during the COVID-19 pandemic, there were also protective factors identified in studies that were found to mitigate anxiety and promote mental well-being in this population.

Lifestyle and Family. The study by McKinlay et al. (2021) explored the risk and protective factors related to the mental health well-being of older adults in the UK during COVID-19. McKinlay et al. (2021) identified several protective factors and behaviours utilised by the older adult participants to protect their mental health wellbeing, such as keep to a routine, maintaining a positive outlook, keeping in contact with people, and drawing on their resilience. In this particular case, the participants proactively used behaviours to protect themselves from negative outcomes on their mental health. However, the study focused on mental health in general, rather than anxiety. Nonetheless, the study by Yoon and Choi (2021) looked at the effects of psychological stress related to COVID-19 and anxiety in middle-aged and older adult participants and found similar protective factors to the previously discussed study. Resilience, family cohesion and being married were common factors identified in both studies.

Having the correct amount and type of information regarding public health measures such as COVID-19 restrictions during the pandemic was found to be protective in older adults against anxiety (González-Sanguino et al., 2020; Kim & Hwang, 2022). Nonetheless, such information can also exacerbate or lead to symptoms of anxiety, especially if excessive information is given to older adults (Cachicatari-Vargas et al., 2022; González-Sanguino et al., 2020) as they become overwhelmed. This is also the case when there is a proliferation of fake and inaccurate news, as well as constant exposure to crisis-related news (Garfin et al., 2020; Ko et al., 2020).

Resilience. Psychological resilience refers to the ability for one to adapt and survive negative life events, such as the COVID-19 pandemic through different avenues, including emotional and behavioural processes (American Psychological Association, 2022). Studies have found that high resilience was a protective factor that reduced the negative effects of the pandemic, as well as decreased the chance of experiencing symptoms of anxiety in older adults (McKinlay et al., 2021; Yoon and Choi, 2021). Keeping in mind the psychological aspect of the *Dynamic Biopsychosocial Model* (Lehman et al., 2017), studies indicate that older adults with the psychological trait of resilience experience less anxiety (Miller et al., 2021). Several studies have indicated that the older one gets, the more resilient one becomes, in part due to surviving negative experiences and losses endured throughout life (Gooding et al., 2011; Perez-Rojo et al., 2022). Thus, while some research has shown that older adults experienced an increase in anxiety during the pandemic, other research has indicated that resilience can be a buffer and lead to fewer negative outcomes. The study by Weitzel et al. (2021) found that the older adult participants with a higher level of resilience felt less impacted and threatened by the pandemic, resulting in increased levels of adaptability, and fewer negative outcomes. Perez-Rojo et al. (2022) explored the topic in greater detail and found that increased levels of resilience decrease

stress brought about by the pandemic in older adults, however they expanded on what leads to higher levels of resilience. Their results found that the older adult participants with a higher level of gratitude and personal growth, and those with a meaningful life purpose had higher levels of resilience.

Resilience can also be observed through the *Theory of Positive Psychology*, as this model highlights the importance of resilience and similar positive psychology constructs such as positive emotion and coping self-efficacy. These aspects are directly related to psychological wellbeing and optimal functioning, as well as reduced anxiety (Lasota & Mróz, 2021).

Financial Stability, Social Interaction and Wisdom. Unsurprisingly, when the risk factors previously discussed in this chapter were not present in the lives of older adults, they acted as protective factors instead. This included one's financial situation, and how having financial stability and a relatively high income was protective against anxiety for older adults during the pandemic (Ciuffreda et al., 2021). Similarly, social interaction in older adults can also have a dual role in experiencing anxiety. Strong and meaningful social networks were crucial in dampening anxiety in older adults brought upon by the pandemic (Pascut et al., 2022; van Tilburg et al., 2020).

Another protective factor is wisdom, which is considered to be a complex trait made up of several aspects such as empathy, compassion, and having a diverse perspective (Jeste et al., 2019). The systematic review by Lee et al. (2020) concluded that those older adult participants who displayed higher levels of wisdom resulted in having increased socialising behaviour. Thus, as quality socialising was found to be protective against anxiety (Pascut et al., 2022; van Tilburg et al., 2020), then wisdom may also act as a protective factor against anxiety.

Ageism as a Mechanism of Anxiety During the Pandemic

Ageism is defined as using prejudice and stereotyping against older adults because of their age (Donizzetti, 2019). This can result in negative attitudes and behaviours towards older adults on different societal levels. Such ageist practices included how older adults were not given value or a voice when it came to decision making practices that impacted them, the lack of preparation in residential care homes in tackling the virus, as well as how some members of the public considered the pandemic to be an older adult problem rather than a collective one (Fraser et al., 2020). Ageism has been experienced by this cohort for a while; however this has only worsened with the arrival of the COVID-19 pandemic (Arcieri, 2021; Fraser et al., 2020). This idea was also supported by the literature review conducted by Silva et al. (2021), who concluded that ageism against older adults has become more apparent following the pandemic, which caused negative social and psychological effects within this population. Ageism occurred during the pandemic in part due to the ageist practices carried out, such as those used by healthcare institutions, basing lockdown measures according to age (Formosa, 2021), as well as ageist ideas pushed on social media (Fraser et al., 2020). Ageist ideas included the introduction of the hashtag 'BoomerRemover', referring to how the high death rate of older adults caused by the pandemic is normal and thus nothing should be done to prevent this (Fraser et al., 2020). Ageist healthcare practices were also seen to take place throughout the pandemic. The Italian Society of Anaesthesia, Analgesia, and Intensive Care set out healthcare guidelines throughout the pandemic, in case of extremely limited healthcare resources. They stated that an age limit should be set for admission to intensive care, as younger people will have more years of life saved (Cesari & Proietti, 2020).

The *Terror Management Theory* serves to explain prejudice during periods of high mortality and was used by Arcieri (2021) to explore the link between ageism against older adults,

anxiety and the COVID-19 pandemic. The author concluded that the pandemic resulted in increased anxiety in older adults as younger cohorts made use of ageism towards older adults as a coping mechanism to decrease their death anxiety, which ultimately had a negative effect on older adults. This possible prejudice and ageism has important implications in relation to healthcare given to older adults, considering that they are part of the most vulnerable groups (Arcieri, 2021).

Bergman et al. (2020) further expanded on the link between ageism, COVID-19 health fears, and anxiety in older adults and found that both ageism and COVID-19 fears are associated with higher levels of anxiety symptoms in this age group. This result was viewed through the *Stereotype Embodiment Theory* (Levy, 2009), in that the older adult participants with higher self-ageism levels may consider their health to be worse off than it is, and thus increases their levels of anxiety and fear (Bergman et al., 2020).

The Local Scenario

While Malta was affected by the COVID-19 pandemic in a similar way to other countries, it seems that comparatively, the negative impact throughout the first wave was noticeably lower as regards to mortality rates and overall control of the virus (Cuschieri, 2021; Micallef et al., 2020). However, as time went by and the virus continued to spread around the island, the situation changed and began to have a more "devastating impact on health, economies, and other societal pillars" (Grech & Grech, 2020 p. 534), with post-acute care also being impacted (Cuschieri et al., 2021).

Nonetheless, while the quantitative nature of the pandemic in regards to admission rates, infection rate and mortality rates have been comprehensively studied within the local scenario

(Cuschieri, 2021; Grech & Grech, 2020; Micallef et al., 2020), the impact on mental health was not as thoroughly studied on a qualitative level, and even more so in regards to the mental health of Maltese older adults specifically. This leaves a gap in literature of comprehensive and high-quality studies exploring the impact of COVID-19 on the mental health of the local population, most particularly on Maltese older adults since this cohort was repeatedly found to be the most devastated by the pandemic globally (Bartleson et al., 2021; Cocuzzo et al., 2022). To date, there are no local systematic reviews or meta-analyses regarding the mental health of this cohort following the COVID-19 pandemic. This is problematic as these are the highest quality research designs (Ranganathan & Aggarwal, 2020), and are currently not available locally.

Whilst no lockdown was implemented locally during the pandemic several restrictions were set in place such as quarantine, restrictions regarding residential care facilities and social distancing (Government of Malta, 2021; The Malta Independent, 2021). Nonetheless, an impact on local mental health was evident (Bonello et al., 2021; Scerri et al., 2021), including that of older adults (Formosa, 2021).

The closest study related to older adults living with anxiety during the pandemic is the quantitative study conducted by Richmond Foundation (2022), which aimed to assess the psychological wellbeing of the general population throughout the pandemic. The key results of the study indicated that the majority of the older adult participants felt anxious when they were around other people due to the increased risk of infection, as well as experienced an overall low mood throughout the pandemic. Additionally, older adult participants were particularly worried about the mental wellbeing of their loved ones, over their own wellbeing. The overwhelming majority of older adult participants also avoided social interactions where possible, leading to feelings of social isolation. Furthermore, the 65+ participant group experienced the highest

amount of fear and hopelessness when compared to all other participant age groups. Lastly, to cope with the negative impact of the pandemic, the participants mostly made use of prayer, avoided contact with other people, and tried to have a more positive outlook.

The study by Cuschieri (2021b) specifically explored anxiety levels in Maltese adults throughout the pandemic by utilising an online survey. Results indicated that 41% of participants experienced mild anxiety, with the highest levels experienced in students (Cuschieri, 2021b). However, it is difficult to assess how much these levels of anxiety are attributed towards the pandemic, as no data was collected pre-pandemic and so a comparison is not possible. Furthermore, results are presented regarding adults in general, and thus may not necessarily be transferable to Maltese older adults.

Additionally, a factor that may have contributed to the worsening of pre-existing mental issues in Malta such as anxiety was the closure of spiritual institutions, and thus masses and other religious services could not take place or were greatly disrupted during the pandemic (Zammit, 2020). This had negative implications on church-going citizens as it disrupted their spirituality and daily routine. Furthermore, the census conducted by the Institute for Research on the Sign of Times (2018) for the Maltese Diocese concluded that 33% of all mass attendees are 65 years or older, indicating a large proportion of church-goers are older adults. Thus, the closure of churches may have possibly led to a worsening of pre-existing mental health issues and contributed to higher levels of anxiety symptoms and loneliness in local older adults. This may have occurred because attending religious activities such as mass is protective for older adults against both physical conditions and mental health issues, including anxiety (Akerman et al., 2020; Coelho-Júnior et al., 2022). These results make sense when considering that more than 82% of Maltese are Catholic (National Statistics Office, 2021). Additionally, religious

institutions have been found to play an active role in supporting their members and offering practices that are akin to being psychologically therapeutic and thus contribute to better health outcomes (Satariano & Curtis, 2018). In fact, the qualitative study by Baldacchino and Bonello (2013) found that spiritual activities such as attending mass and prayer led to decreased levels of anxiety and fear in the participants.

Overall, quantitative local studies have indicated that general mental health in Malta has been negatively impacted by the onset of the COVID-19 pandemic. However, qualitative studies are needed to assess the different dimensions of mental health in greater depth, especially regarding anxiety levels in older adults.

The Lived Experience of Older Adults With Anxiety Symptoms During COVID-19

As discussed above, extensive research has been conducted in different countries, but was found to be lacking within the local scenario. As several international studies closely align with the title and aim of this dissertation, they will be discussed hereunder.

The theme of COVID-19 anxiety in older adults was evident and became a central theme in the qualitative study by Aboh et al. (2022). COVID-19 anxiety was especially high in the older adult participants whenever they received pandemic-related news about how older adults such as themselves were at the most risk of dying from the virus. Indeed, some of the participants decided to self-isolate rather than go out of their homes and risk becoming infected (Aboh et al., 2022). Thus, the fear of threat to self was closely associated with the experience of anxiety. A sub-theme of coping with COVID-19 anxiety also emerged in the same study. Participants made use of different strategies such as prayer and educating themselves about the virus (Aboh et al., 2022). Support was also felt to be a crucial aspect in coping with their anxiety,

with participants feeling more able to cope when they had support from their family, friends and professionals. In cases where participants felt that they did not have ways to cope, they suffered considerably (Aboh et al., 2022).

Similar experiences to the above study were also elicited in the qualitative study by Sit et al. (2022), who explored the psychosocial impact of COVID-19. A theme named "The Vicious Cycle of Media Consumption and Distress" was put forward, as the participants began to see more social media and news since they were restricted to their homes, which resulted in a new avenue of anxiety (Sit et al., 2022 p. 7). This anxiety led them to consume even more media, leading to even more distress, anxiety, and worry. Nonetheless, the participants coped with this distress and anxiety in various ways, such as through online communication (Sit et al., 2022).

Interestingly enough, participants of the study conducted by Finlay et al. (2021) used online technology and screen time as a way of coping and keeping their minds off the pandemic situation. However, others within the same study felt the need to limit such online interaction and that was their way of coping. This is because any time spent online exposed them to constant news related to the pandemic and quickly overwhelmed them, causing anxiety. They also stressed that the amount of news and the source of the news affected whether they felt more, or less anxious. In cases where news sources regarding the pandemic were reliable, they felt more in control and informed (Finlay et al., 2021).

The studies by Bundy et al. (2021) and Fiocco et al. (2021) found two similar themes in their older adult participants related to concerns and feelings of anxiety about others, rather than for themselves. While interviewees in the study by Bundy et al. (2021) felt relatively at ease, their anxiety was related to their loved ones. They voiced concerns about how their family members mix with other people, and thus are more at risk of contracting the virus. Others were

worried about the general state of the world, and how something as terrible as COVID-19 has happened in their lifetimes. This was compounded as they felt that people around them were irresponsible and did not take precautions seriously. Similarly, the older adult participants of the study conducted by Fiocco et al. (2021) were greatly worried about their children losing their jobs or contracting the virus since they were frontliners. Additionally, other participants were aware of how they can potentially pass on the virus to others, especially to vulnerable spouses who had pre-existing conditions.

Starkly contrasting experiences were found in a study that explored the perspective of older adults in New Zealand on anxiety during their COVID-19 lockdown (Stephens & Breheny, 2021). Initially, participants were anxious and worried about the pandemic due to the vulnerability of their age, as well as due to the isolation following restrictions. However, a main theme titled 'Enjoyment' emerged when they reflected on their time in the lockdown. This came about as the majority of the participant enjoyed the lockdown as it allowed them to reflect, catch up with family, and re-engage with their hobbies (Stephens & Breheny, 2021). The authors put forward this positive experience as being due to strong support from the government, as measures such as wage and heating subsidies and work-from-home programmes were implemented, coupled with strong government leadership (Stephens & Breheny, 2021). Thus, the results of this study may be divergent from other similar studies due to the consistent and cohesive support from their specific government.

A previously unmentioned theme in similar studies is the use of substances or drugs throughout the pandemic. The majority of the older adult participants in the qualitative study by Von Humboldt et al. (2022) increased their alcohol and drug use to forget about negative emotions such as fear, anxiety, and anger related to the pandemic. Similarly, Roberts et al.

(2021) also found that alcohol use increased in older populations as a way of coping with the anxiety and social isolation caused by the pandemic.

Feelings of loss were a central theme in the results found by Fauk et al. (2022). Participants shared how loved ones and family members passed away due to the pandemic, which added an added element of loss as they were unable to say goodbye or grieve as they were unable to attend their funerals due to restrictions. Loss was also related to losing out on meaningful activities as a result of COVID-19 precautions. This left participants feeling that they had something missing in their lives, as the lost activities were a big part of their daily routines.

Rationale for the Study

The overall aim of this research study was to explore the lived experience of older adults who experienced symptoms of anxiety during the COVID-19 pandemic. Additionally, two objectives were set out to support the overall aim of the study by exploring:

- The different ways of how older adults with symptoms of anxiety coped during the pandemic.
- The meaning associated with the perceived risk factors and protective factors related to experiencing symptoms of anxiety during the pandemic.

The research question guiding this study is as follows:

- What is the lived experience of older adults who experienced symptoms of anxiety during the COVID-19 pandemic?

This study, with its specific aim and objectives is being proposed due to several reasons. The first being that the pandemic had a devastating impact on older adults, both in terms of death toll (Centers for Disease Control and Prevention, 2022), and emotional repercussions. Specifically, a substantial rise in anxiety disorders was seen due to the pandemic within this age

cohort (Santomauro et al., 2021). This makes this research relevant to this current public health concern.

Furthermore, research on older adults tends to be lacking when compared to other age groups, especially in Malta (Formosa, 2015). Whilst it is evident as seen in this chapter that both quantitative and qualitative literature is available internationally concerning the topic at hand, the same cannot be said for local studies. To the best of the author's knowledge and after thoroughly exploring the available literature, there were no qualitative studies that explored the lived experience of Maltese older adults living with anxiety during the pandemic. Due to this, it is hoped that this study will aid in contributing further literature on this topic and filling the lacuna of local knowledge about it. A local study is needed to explore anxiety during the pandemic for several reasons. Anxiety is a complex mental health condition that can be influenced by various factors, including cultural, social, and environmental factors (Penninx et al., 2021). Therefore, it is possible that anxiety may manifest differently in Maltese people compared to individuals from other nationalities. Due to this, it is important to consider cultural and social factors when exploring anxiety in different populations, including Maltese individuals, and thus why a topic that has been internationally studied is needed locally.

By identifying and understanding the experiences of older adults who lived with anxiety, the system can then provide appropriate support and tailored interventions according to their needs. This research can also provide insights into how the pandemic has affected mental health, with a focus on anxiety and thus inform future strategies for supporting individuals who experience anxiety in times of crisis. Furthermore, carrying out interviews with participants on their lived experience, who were often in a state of isolation, gave them a voice that would have otherwise gone unheard. Overall, investigating the experiences of older adults with anxiety

during the pandemic has important implications for improving mental health outcomes and promoting resilience in this population.

Conclusion

This chapter presented an overview of the literature regarding the different ways in which the COVID-19 pandemic impacted older adults, with a focus on anxiety. This pandemic led to the creation of a "perfect storm" (Whitehead & Torossian, 2021 p.36), as it brought about the cumulative negative effects of anxiety caused by the virus, restrictions that caused further isolation and loneliness, as well as an overall disruption of daily life. However, the arrival of the pandemic also highlighted the resilience and adaptation shown by older adults. The following chapter will present the research design and methodology.

Methodology

Introduction

Within this chapter, the rationale for choosing a qualitative approach and IPA to analyse the data will be provided. Additionally, the methodological approach utilised throughout this study will be put forward, followed by a description of the data collection and analysis process. This chapter also includes the philosophical underpinnings of the chosen approach and the ethical considerations of the study.

Aims and Objectives

The overall aim of this research study was to explore the lived experience of older adults who experienced symptoms of anxiety during the COVID-19 pandemic. Additionally, two objectives were set out to support the overall aim of the study. The *Dynamic Biopsychosocial Model* (Lehman et al., 2017) was kept in mind during the writing of the aim and objectives of this study, as well as during the subsequent analyses. This means that the lived experience of the older adult participants was considered through a biological, psychological and social perspective. These objectives were as follows:

- The different ways of how older adults with symptoms of anxiety coped during the pandemic.
- The meaning associated with the perceived risk factors and protective factors related to experiencing symptoms of anxiety during the pandemic.

The research question guiding this study is as follows:

- What is the lived experience of older adults who experienced symptoms of anxiety during the COVID-19 pandemic?

Rationale for Qualitative Research

At its core, qualitative research explores the nature of real-life experiences of people and excels in eliciting comprehensive information that may expand on the understanding of these lived experiences by considering the context, behaviour, perspective and attitudes in which these occur (Busetto et al., 2020). Furthermore, a qualitative approach may more effectively capture the essence of a complex situation through open-ended questions such as ‘how’ and ‘why’ when compared to a quantitative approach (Terry et al., 2022). Utilising a quantitative approach to the aims and objectives above may be difficult as quantitative research is generally used to explore a topic in a statistical manner (Guetterman et al., 2015), rather than to find meaning. Since this study aims to gain a deeper understanding of the lived experience of older adults who experienced symptoms of anxiety during the COVID-19 pandemic, it was felt that a qualitative approach would accurately align itself with these aims. Qualitative research has been extensively utilised for healthcare research and is effective in uncovering further depth on the experiences and decisions of people (Renjith et al., 2021).

Rationale for Using IPA

Several reasons guided the process of choosing IPA as the qualitative methodology for this study. Firstly, IPA has been applied to both anxiety (Baker et al., 2022; Moser et al., 2018) and older adults (Forward et al., 2023; Viftrup et al., 2021) in research, and thus already has a basis of being an effective medium in eliciting the lived experience of older adults living with symptoms of anxiety. Nonetheless, other methodologies were considered such as grounded theory for its ability to develop a theory from data (Tie et al., 2019) as well as narrative analyses for being able to give importance to the narrative put forward by the participants (Wong & Breheny, 2018). However, IPA differs from these methodologies and others such as thematic analysis as it is idiographic in nature and places importance on the collective understanding of a

phenomenon and the individualistic experience of each participant (Smith & Osborn, 2014). Additionally, the double hermeneutic is a central characteristic of IPA and allows for the active involvement of the researcher as the results of the study are reached through a co-creation between the lived experience of the participant and the interpretation of the researcher (Willig & Rogers, 2017). Thus, as the overall aim of this study was to explore the lived experience of older adults who experienced anxiety during the pandemic and the individual meaning of these experiences, IPA was eventually chosen.

The Philosophical Underpinnings of IPA

IPA can be understood and explored through three philosophical ways of thinking, which are phenomenology, hermeneutics, and ideography (Anderson et al., 2022). Edmund Husserl, one of the main contributors to phenomenology, put forward the idea that to correctly adopt a phenomenological way of thinking, one must disengage themselves from their attitude towards everyday experiences. Rather, one can adopt a different process by giving more importance towards being reflexive and aware of one's consciousness towards a particular experience (Smith et al., 2022). It is for this reason that phenomenology is also referred to as the study of consciousness, with the aim "to explore the intentionality of consciousness, the fact that our perception, thinking, judging, etc. is about or of something" (Zahavi, 2018, p.7). Subsequently, Husserl constructed a phenomenological method to arrive at the essential pieces that make up an experience (Smith et al., 2022). This is carried out by 'bracketing' off our instinctual perception of what the world is and letting consciousness be the main focal point by which we see an experience (Smith et al., 2022).

Another prominent thinker in the world of phenomenology is Martin Heidegger, who built on the work of his teacher, Husserl. While Husserl was mostly drawn to an epistemological

approach, Heidegger pursued an ontological one (Zahavi, 2018). This meant that Heidegger gave more importance to interpretation over describing a world experience. Additionally, Heidegger also took an opposing stance concerning bracketing, as he felt that pre-existing knowledge enhanced rather than hampered the interpretation of meaning (McConnell-Henry et al., 2009). The researcher concluded that as the topic of study was something meaningful to him, it would be quasi-impossible to completely bracket off all feelings, assumptions, thoughts and ideas about the subject matter. Additionally, the biases of the researcher may not make themselves known until the point of interpretation (Willig & Rogers, 2017), thus making bracketing a complex pursuit. Due to this, the research has taken the position of Heidegger's view of phenomenology.

The second branch of the theory that makes up phenomenology is hermeneutics, which is the theory of interpretation (Smith et al., 2022). This concept can be further understood through the hermeneutic circle which puts forward the idea that to understand the whole one must look at the individual parts that make up the whole, and vice versa (Smith et al., 2022). This same concept can be applied to the dynamics between the research and the participant (the parts), who are contributing to the wholeness of an experiential phenomenon (the whole) (Montague et al., 2020). Thus, the importance of context and the meaning attributed to the words used is highlighted. The concept of hermeneutics, especially as construed by Schleiermacher and discussed by Montague et al. (2020) will aid the researcher to engage in a deeper and more comprehensive understanding of the phenomenon in question by not solely considering the text within a vacuum, but rather by also recognising cultural and social factors involved.

Idiography is another major influence of IPA and is concerned with the uniqueness, detail, and individuality of a person, rather than the interpretation of a whole group of people or the prediction of their behaviour (Willig & Rogers, 2017). As a result of this, the utilisation of

IPA allows for the unique understanding of a group of people within a particular context of a specific phenomenon (Smith et al., 2022). It is for this specific reason that IPA encourages small sample sizes with specific criteria so that importance and focus can be given to each case.

Research Design

Data Collection

As discussed above, the main aim of IPA is to explore and examine in detail a unique phenomenon as experienced by a person, and the meaning they attribute to their lived experience (Willig & Rogers, 2017). Subsequently, a data collection tool that flowed well with the philosophical underpinnings of IPA and allowed for in-depth information gathering was needed to have a cohesive framework throughout the study. Keeping these criteria in mind, interviews were chosen to collect data for their ability to accurately encompass the lived experience of the participant in a way that allows the expression of emotions, perceptions, facts, and cultural aspects related to the phenomenon in question. Smith et al., (2022) also propose the use of interviews, among others, as a tool that coincides well with the aims of IPA. Additionally, semi-structured interviews were specifically chosen as they allow for the core phenomenon to be explored systematically, while still having the flexibility for unplanned but nonetheless essential data to emerge (Busetto et al., 2020).

Interview Guide

The interview guide (Appendix A) was based on literature related to older adults who experienced anxiety throughout the pandemic, reflections carried out with the supervisor of the study, as well as on interview guides previously developed for similar phenomena (Ayalon et al., 2021; Hossain et al., 2020). Secondly, the *Biopsychosocial Model* by Engel (1977) was used as a framework for developing the questions asked, thus giving importance to the biological,

psychological and social experience of anxiety during the pandemic. The aim of the study was also kept in mind during the development of the interview guide. Lastly, several elements of the interview guide were amended following the pilot interview, which resulted in more easily understandable and fewer leading questions.

The Data Analysis Process

After each interview with the participants, the researcher engaged in a period of reflection, followed by the writing of field notes. The notes emerged from being attentive to what the participants had to say concerning the topic being investigated, the emotions that remained with the researcher, as well as his initial thoughts. At the same time, this process also allowed for a self-debriefing process.

With the written consent of every participant, each interview was audio-recorded and transcribed verbatim by the researcher. The overarching analysis process was carried out as per the recommended steps by Smith et al. (2022). As time passed from when the interviews were conducted, the researcher re-engaged with the life story of each participant by reading the transcripts several times until fully immersed in the data (Jeziorek & Riazi, 2022). This process was aided by listening to the audio recordings. Through the audio, the researcher was able to re-familiarise himself with the emotional aspects of the words used, as well as to notice any pauses and vocal intonations. This process allowed the researcher to note down comments on the left margin of the printed passage. These exploratory comments were used to construct the experiential statements and were noted in the right margin. Experiential statements relevant to the study were clustered, thus resulting in the personal experiential themes (PETs). Finally, these PETs were assimilated into the group experiential themes (GETs) (Smith et al., 2022). An excerpt showcasing the different stages of the analysis process can be found in Appendix B.

The Recruitment Process

Purposive homogenous sampling was used to choose potential participants. Additionally, purposive sampling was implemented since this allows for an in-depth study into a specific and information-rich phenomenon and facilitates the generation of novel conceptual insights rather than a focus on generalisability (Benoot et al., 2016). While generalisability in the classic sense is not the aim nor is it reached within the study, theoretical generalisability as put forward by Smith et al., (2022) is reached as the results of the study are considered within the context of existent literature and links are made to other closely related studies. Additionally, the homogenous characteristics of the participants enabled their different unique perspectives and emotions to be highlighted (Smith et al., 2022). However, as difficulty in accessing the older adult population is well documented (Anzuoni et al., 2020; Biegus et al., 2022), snowball sampling was also utilised by asking each participant to disseminate the researcher's information sheet to possible candidates if they were comfortable doing so.

Initial access to the participants was gained through a gatekeeper. The gatekeeper was recruited to make contact with older adults living within the general population to provide them with the information sheet of the study. Specifically, the non-government organisation ‘Fondazzjoni Nanniet Malta’ was approached to act as a gatekeeper (Appendix C) for the study by passing on the information sheet to potential participants who fulfil the criteria of eligibility. Interested participants then made contact with the researcher via the contact information found in the information sheet. At this point, the potential participants were asked a series of questions to confirm that they fulfilled the inclusion criteria. This included verbally carrying out the Coronavirus Anxiety Scale (found within the public domain, with 5 brief items) (Lee, 2020; Silva et al., 2020). Following this, a time and place was set at their convenience to conduct the

semi-structured interview. 7 Maltese older adults took part in this study and all met the inclusion criteria. Interviews took place in the private homes of the participants and lasted between 45 and 60 minutes.

Inclusion Criteria

Several inclusion criteria were required for participants to be accepted within the study, both to be in line with the overall aim of the research, and also for the protection of the older adults themselves. The first criterion is that participants must be over the age of 65, as per the definition of older adults by the World Health Organisation (Sabharwal et al., 2015) and that of Malta (Government of Malta, n.d.). As per the primary research objective, the study requires participants to have experienced symptoms of anxiety during the COVID-19 pandemic to have uniformity within the participant group (Smith et al., 2022). Taking the recommendation of Patino and Ferreira (2018), individuals experiencing serious mental health problems were excluded to minimise the bias of these other experiences. In addition to this point, as well as to increase homogeneity, individuals must reside in the community rather than in a care home or a residential facility where the experience of anxiety may differ significantly. This is due to other anxiety provoking situations, such as the residents being unable to see family members due to COVID-19 restrictions. The last criterion is that participants must possess mental capacity and be able to provide informed consent.

Personal Reflexivity

Reflexivity in the context of qualitative research is the awareness and consciousness of the researcher's impact on the research process. However, as per the teachings of Heidegger, reaching this state of reflexivity is not an automatic process and requires dedication for it to manifest by being comfortable in ‘living’ with the data (Engward & Goldspink, 2020). This is in

part reached through unearthing that which is disguised (Smith et al., 2022). Working on being reflexive through writing in a personal journal allowed for the improved ethical quality of the research, as I became more aware of my pre-conceptions about older adults living with anxiety during the pandemic, and how such biases may have impacted the research procedure and my interpretation (Peat et al., 2018). I also reflected on my personal feelings, ideas and attitudes when it comes to older adults in general, as well as living with mental health issues such as anxiety. Specifically, I reflected on how older adults in general seem to be excluded from society to a certain extent, and how the participants were so eager to share their thoughts, feelings and experiences. This sense of exclusion may be even stronger when it comes to older adults living with mental issues such as anxiety due to stigma. This is in part why I chose older adults specifically, in order to give them a voice that would otherwise may have gone unheard. Additionally, I considered how my perception has been shaped in part through undergoing a Masters in Health Psychology, as well as completing a Master of Gerontology and Geriatrics where my view on older adults became substantially more comprehensive.

Part of how I strived for this reflective position was by considering the similarities and differences between myself and the participants. The disparity was highlighted in the different life stage I was in when compared to the older adults. This is as I am a young adult male, whilst the majority of the participants were older female adults. At the same time, this distance was reduced as I reflected on how I have an older adult family member living with a serious medical condition and subsequently brought out the theme of mortality. While older age does not equate to death, it nonetheless is a transitional area where death becomes more of a reality (Erikson, 1968) and where losses become commonplace (Netzer & Ovadia, 2019).

Trustworthiness & Credibility

To aim for a research study that placed importance on validity and quality, the researcher was informed by the work of Yardley (2000) who offers ways of assessing qualitative work and suggests how such criteria can be met. Yardley's (2000) work was in part chosen due to its focus on health psychology.

Yardley's (2000) first criterion, sensitivity to context, was met by utilising current literature relevant to the study as well as through interpreting data in conjunction with relevant theories. Additionally, data was not only interpreted through the use of theories but was also considered within the socio-cultural setting of Malta.

A clear rationale was given for the sampling process and participant selection was discussed in terms of inclusion criteria. Member checking was carried out with the supervisor of the study by discussing the findings of the interviews, as well as the process that led to the chosen themes. Lastly, transcript extracts were reviewed by the relevant participants when they opted for this to be done in the consent form, to ensure that they are reflective of their experience and what they wished to say. These conducted practices increase the study's commitment and rigour, as recommended by Yardley (2000).

Transference and coherence (Yardley, 2000) were met through the importance given to the process of the researcher's reflexivity, which was discussed in greater depth in the 'Personal Reflexivity' section and included the researcher's motivation for investigating this specific topic. This continuous reflexive process resulted in increased transparency between the author and the readers of the study. Coherence was also met by having a continuously intertwined relationship throughout the study between the methodology of choice, the data collection tools, as well as the aim of the study.

The impact and importance (Yardley, 2000) of this research study are hoped to be achieved on two levels. The first is that the topic will contribute further to a relatively new phenomenon, COVID-19, concerning the experience of anxiety in older adults. Thus, data is being added through this study and can be utilised by other researchers exploring this topic. Secondly, to the researcher's knowledge, this is the first study to explore the lived experience of older adults that experienced anxiety during the pandemic in Malta. It was important for this lacuna of literature to be filled as older adults were found to be the most negatively impacted cohort by the pandemic (Bartleson et al., 2021; Cocuzzo et al., 2022; Galea et al., 2022).

Ethical Considerations

The first step in ensuring that the research study in question was ethically sensitive and considerate was by submitting a research proposal to the Department of Psychology at the University of Malta, which was accepted. Furthermore, ethical clearance was given from both the Health Ethics Committee, as well as the Faculty Research Ethics Committee (Appendix D).

Before the start of the interview, participants were presented with the consent form (Appendix E) and the researcher verbally reiterated the salient points found in the information sheet (Appendix F) and consent form (Altawalbeh et al., 2019). The researcher also kept in mind that it is encouraged that more time is dedicated than usual in explaining the consent form when working with older adults in a research capacity (Altawalbeh et al., 2019). Keeping this point in mind, the researcher also adapted the forms to be printed with a larger and more easily legible font (Altawalbeh et al., 2019). The participants were also free to refrain from answering questions if they felt uncomfortable, and were welcome to ask for a break. Participants were also reminded that they are not forced to take part in the study and that they were free to stop the interview or stop participating without any repercussions. Lastly, in case the participants felt

distressed or felt the need to process the experience of the interview, they were given information regarding free-of-charge services that offer psychological support.

Conclusion

This chapter presented the different methodology aspects of the study. Specifically, the philosophical tenets of the chosen methodology were explored, and the research design was outlined and presented in detail. Furthermore, the reflexive position of the researcher was put forward, and ethical considerations were deliberated. Finally, the chapter discussed the trustworthiness and credibility of the study. In the upcoming chapter, the results obtained from the data collection process will be presented.

Results

Introduction

In this chapter, a brief phenomenological description of each participant is included. Additionally, the master list showcasing the GETs and subthemes that resulted from analysing the seven semi-structured interviews with an IPA approach will be presented in Table 2. The exhibited themes reflect the lived experience of the seven participants exhibiting symptoms of anxiety during the COVID-19 pandemic.

Table 1

Participant Demographic Data and Phenomenological Profile

Pseudonym	Age	Brief Phenomenological Profile
Susie	68	Susie lives with her husband and had several pastimes such as sewing, attending mass, and going for walks. However, these activities and more were impacted by the onset of the pandemic. This also resulted in high levels of anxiety, as well as a very strict hygiene routine that she still partly follows to the present day.
Henry	71	Henry lives with his wife and is a down-to-earth person who enjoys bird hunting and taking care of his field. Even though he kept to himself during the pandemic, he felt terrified of the overall situation and shunned people outside his household.
William	78	William lives with his wife and worked all his life in an educational setting. He is an anxious person by nature and struggles to find the positive in a situation. Due to this, his levels of anxiety increased with the onset of the pandemic, and even more so when he was not able to meet his family, including his grandchildren.
Catherine	81	Catherine is a family-oriented person and lives alone. While she experienced anxiety and tension due to the pandemic, she was especially concerned about other people and how they were coping with the struggles that the pandemic brought along.

Ruth	69	Ruth lives with her husband and is passionate about teaching and education. She also enjoys reading, gardening and watching documentaries. Ruth's main struggle with the pandemic was the worry about her husband, as he was considered to be vulnerable to the virus.
Elizabeth	67	Elizabeth is a mother, a wife, and a housewife. While Elizabeth experienced fear, anxiety and uncertainty during the pandemic, her religious faith was of great support and comfort.
Mary	68	Mary is an independent person, a widow, and was working part-time until the pandemic struck. She spends her day with her dog, taking care of the home, and attending a social group for older adults. She experienced fears about bringing the COVID-19 virus into her home, as well as had high levels of anxiety surrounding her children when they contracted the virus.

Table 2

Presentation of the Group Experiential Themes and Subthemes

Master List of Group Experiential Themes	
Group Experiential Themes	**Subthemes**
The Pandemic – "A Time of Fear and Terror"	• Coronaphobia • Fear of People • Fear of Hospital
The Different Flavours of Anxiety - "I was Consumed"	• "Un Chiodo Fisso, it's There" • What About my Loved Ones? • News: "The Red Switch"
Outcomes of Living Through the Pandemic	• Feeling Isolated in a Crowded World • Defending the Castle at all Costs • Long-term Living Outcomes of the Pandemic

	• Feelings of Vulnerability
How will we Survive This?	• Finding Serenity Through Prayer and Support • Protective Factors • Sharing Wisdom Through Experience

The Pandemic – "A time of fear and terror"

During the interviews, all the participants voiced how they experienced high levels of fear, uncertainty and worry as a result of the pandemic. As Susie put it, the pandemic was "a time of fear and terror". These feelings were not present in pre-pandemic times. This GET includes three subthemes that will be described below.

Coronaphobia

Coronaphobia is defined as an exaggerated and fear-driven reaction to the potential contraction of the COVID-19 virus (Arora et al., 2020). This high level of fear towards contracting the virus was a shared experience among the participants. As a result, this caused the participants to take drastic actions to protect themselves from the virus. Below, one can see how Susie felt during the onset of the pandemic, and the measures she took to feel safe.

> In the beginning, when I found out about COVID... I was really shocked. We were really scared... they used to say don't go near older adults. So we didn't even let our children or our grandchildren come near us. I used to tell them "Don't come over!". I was concerned about what would happen if they went out and then would come near us. I wouldn't even let them in.

Asked about his first memory of the pandemic, Henry recalled that it was when it was mentioned on a local news channel. He went on to say that he “used to get chills from the fear when they used to mention the pandemic” as he was afraid “that you will die quickly” should you catch the virus. As a result, he only felt safe when he was at home, or in his field where he would not see any people.

Similar to Henry, Elizabeth also conceptually equated the virus to a death sentence should she catch it. This was because she believed that older adults are especially vulnerable to the virus. This belief stemmed from COVID-19 news she saw online. Elizabeth recounted her biggest fear during the pandemic below.

> My biggest fear was that I would get COVID, but even worse than that is that it will kill me. Because if someone young gets COVID they'll be fine and recover, but if I get it... it would be worse. When you see all the number of cases, and all those older adults dying from COVID... I would say that I could easily be one of them.

Fear of People

The fear experienced by the participants that came about due to the pandemic was also extended to a feeling of being in distress when being near other people. This is as the participants could not know where other people have been, who they interacted with, and most of all, if they have the virus and thus could potentially pass it on to the participants.

In Susie’s case, she completely stopped going to supermarkets and grocers due to the fear of being near people, as well as touching items that were touched by people she does not know. This fear has continued to the present day.

> It's better if I don't go to the supermarket, or it will be worse. It would be a scary experience. I would be scared to touch things, I'd be scared that there would be many people, I'd be scared, I'd feel uncomfortable.

Henry's experience was similar to that of Susie, in that he felt uneasy and threatened whenever he saw people outside of his home. So much so that he spent most of his time at home with his wife to be away from people, or in his field. In his own words, Henry said the following:

> I was always afraid. When I saw people, I would move back. I used to be too scared to go out, and we didn't go anywhere. I spent a lot of time in my field because I would be alone. I wouldn't see anyone.

Asked about her feelings towards the pandemic, Catherine recounted an experience while she was at mass. The scenario below accurately showcases the fear she experienced during the pandemic, especially when it came to being close to people.

> There was fear and thoughts about it. One time in church I was sitting down on one edge, and another person on the other side. But then someone came in the middle of our church pew. My brother's wife then came as well and I told her it's better not to sit here because it's already quite full, with covid and all. I then called her and told her that it's not because I didn't want her, but because I was feeling scared. It was always at the back of my mind.

Fear of Hospital

One specific fear that was repeatedly mentioned by the majority of the participants was that of the hospital. The participants did all they could do to avoid going to the local hospital, even when not doing so was detrimental to their health. Participants felt that the local hospital was considered to be the epicentre of many COVID-19 positive patients, and thus felt that

entering the hospital for appointments was a sure way of contracting the virus. This fear has not abated in some of the participants after the pandemic ended.

Mary urgently needed specialised medical attention from the local hospital, however, the fear of contracting the virus prevented her from seeking this care and instead went to her family doctor. This fear seems to have stemmed from stories she heard about other people who needed to go to the hospital. This in turn impacted her decision-making process when she needed medical attention herself.

> One time I was going down the stairs of my home, and I skidded on a parcel. It was a big fall. But I didn't want to go anywhere near the hospital, and it was a mistake. Because everyone was saying to avoid going to the hospital. I needed to go for an X-ray but I just pushed through the pain, and went to my family doctor instead. There were people who caught COVID from hospital.

William's experience is very similar to that of Mary, as his fear of the hospital led to the worsening of a serious chronic health condition. Reflecting on one of his worst fears during the pandemic, William shared the following:

> I didn't want to go to the hospital, as they would put you in a ward with many people and you wouldn't know what they have or don't have. Even with my heart procedure, it took me a long time to do it and it worsened, as I did not want to do it during the pandemic. I felt that if I went to the hospital, I would contract COVID-19.

Susie's fear of hospitals has continued to the present day, indicating a long-lasting effect left by the pandemic. Similarly to the above-mentioned participants, Susie's husband needed

medical attention after a fall, but they did all they could to avoid going to the hospital, as seen below:

> One time my husband fell and he had a deep cut. I called our doctor so we can go to her private clinic. The doctor said that he needed stitches and that we needed to go to the hospital, but we asked if she can do it for him. We asked her several times if she can the stitches herself. We didn't want to go to hospital because we were scared of going there. I am still scared of the hospital. Even if I have an appointment, I still get scared.

The Different Flavours of Anxiety - "I was consumed"

All the participants shared their experiences of anxiety during the pandemic. The participants often struggled with anxious thoughts that resulted in a variety of negative biopsychosocial outcomes. The anxious thoughts were repetitive, catastrophic and obsessive. As William put it, he "was consumed" and overwhelmed by the anxiety, just as the other participants were. Anxiety was triggered in different ways, such as when participants ruminated about their vulnerability to the virus and when they reflected on their mortality. Additionally, participants felt anxious when they worried about loved ones, as well as when they watched COVID-19 news. While death feels more plausible in later life, participants were faced with a more realistic chance of this happening with the onset of the pandemic. Thus, their thoughts about death may have reached a more conscious level, resulting in death anxiety.

"Un Chiodo fisso, it's there"

Participants recounted how it felt for them to live with the struggles of anxiety during the pandemic, with a particular emphasis on the heaviness that came with ruminating thoughts that were very hard to shake off.

William shared that he has lived with anxiety for most of his life, with a myriad of anxiety-related symptoms stemming from his overthinking and worries. However, the onset of the pandemic provided a new dark avenue for William's thoughts to explore, resulting in a larger struggle as a result of his pre-existing mental health issue. In his own words and in reference to his experience of anxiety, "un chiodo fisso, it's there".

> I am by nature an anxious person. I have experienced all anxiety-related symptoms, like irritable bowel syndrome, and tension headaches. I have experienced all these things, as my mind is always thinking, thinking, and thinking, and unfortunately, I'm not one of those positive people, I'm more negative. If I'm going to fall, I say I'm going to hit my head not my hand. So obviously something like the pandemic brings me tension and it added to the tension that I already had.

For Catherine, her anxiety had a flavour of hypersensitivity and catastrophising in that her thoughts would immediately go to the worst-case scenarios should she experience any symptoms related to the COVID-19 virus. Death anxiety was also present after hearing about how residents of her home town succumbed to the virus. This may also stem from Catherine's fear of dying alone.

> I would think if I had symptoms of the flu it would mean that I have COVID. I would hear about people who I knew from my home town that went to the hospital. Two people simultaneously passed away from COVID in my town. Their family members could not go to the church for their funeral because of restrictions. These thoughts used to run around my mind, like a trauma that I could not forget.

In Susie's case, the anxiety about the pandemic became so severe that it began to consume and control her life, dictating what she needed to do to feel safe. These compulsive-like behaviours were a way for her to minimize her anxiety, as well as to avoid contracting the virus.

> I know I have anxiety. Even for example when my grandchildren were coming over and they were at the playground my adult children would tell me that they won't come in because they know I'll need to clean all over, since they'd have had contact with other people and not coming straight from home, washed and everything. But if they're coming from the playground, I'll clean. I'll wipe the chairs and everything. That's how it affects me, it's more work.

What About my Loved Ones?

Anxiety was not limited to internal worry about the self but often extended to the participants' loved ones, especially in cases where they were vulnerable due to their age or if a physical condition was present.

As the main carer for her husband following his stroke, Ruth's main experience of anxiety during the pandemic was caused by the worry that her husband will contract the virus.

> Since I knew my husband was vulnerable, I used to be really worried and scared about passing on something to him, and that something bad would happen to him. And I think at that time I was going crazy I swear, because I, usually I am calm but I think... the worry about him getting covid and getting sick would constantly, constantly, constantly be there. That was my main experience of anxiety, it was about him.

Mary's worst nightmare was that her vulnerable adult daughter would contract COVID-19. Mary was anxious about this as her daughter has lupus, thus making her more at risk of both contracting the virus, but also dying from it.

> Yes, I was worried. I was scared that she'll get COVID and that it will really affect her badly. Some people get it and it passes, but others get severely affected. And some remained with the consequences of having COVID. I used to tell her to be careful all the time. I was worried. I used to worry about what was going to happen next.

Savlu's struggle with anxiety was exacerbated when his son was diagnosed with a chronic disease during the pandemic, and was unable to support his son at the hospital. This left him feeling anxious and powerless.

> My son has multiple sclerosis and I was very worried about him. I was worried because he was vulnerable. And I couldn't even see him at hospital because of the restrictions, even though I really wanted to. The staff didn't let me see him. I tried to see him multiple times but they didn't let me.

News: "The red switch"

COVID-19 news took a central role in all the participants' experiences of anxiety. As participants spent a lot of time indoors, they often followed the news to keep themselves up to date. On one hand, it informed the participants on how to protect themselves, but on the other, the macabre and recurring content led to activating a "red switch" in the participants as said by Susie, leading to increased anxiety and alarm. Furthermore, Ruth felt that "without you even realizing you end up being impacted". Below are quotes by participants showing how their anxiety was affected by COVID-19 news.

> My god, seeing those thousands of dead, thousands, every day, every single day. It's like you begin to think about these things without even wanting to. So I wouldn't even go out. And I saw that they would wrap up the dead bodies in plastic bags and throw them in holes. That's what I used to see mostly. They used to really leave an impact on me. All dead from COVID. (Catherine)

> I was seeing all of those people dying. Hearing on the news that hospitals abroad were unable to keep up with all the patients with COVID-19, it brought me more tension and anxiety. Positively as I used to then be more careful, but in a negative way it caused me to have more thoughts. (William)

> I remember I used to watch TV in the afternoon all the time since we were stuck inside. And you'd hear one doctor speaking about this, another person about that. And it would just make me feel worse. In their minds the doctors think that they are giving good information, but in reality they were switching on the red switch for people. (Susie)

Outcomes of Living Through the Pandemic

All the participants did not only have to endure through a pandemic but also needed to fight a continuous battle with anxiety. This led to several negative implications that were experienced by the participants, and make up the sub-themes of this section. These were the need to remain indoors, protecting their homes at all costs through hygiene routines, as well as reflecting on their state of vulnerability during the pandemic.

Feeling Isolated in a Crowded World

Due to the nature of restrictions in Malta as well as the experience of fear and anxiety, participants needed to reduce contact with the outside world. However, this also meant that they

were unable to attend their social clubs or meet their loved ones. Thus, not only was their routine impacted, but their support systems were disrupted.

During the pandemic, William was unable to venture out of his home as he was used to doing, but also could not see his grandchildren which was a big loss for him. As a result, he felt that he was missing out on the growth of his grandchildren. As his family was his support system, this had a doubly negative impact on him, as he describes below:

> Not going out, staying indoors, having to stay with the mask, not being able to see my children. If they come over, they quickly went running out to the balcony, as my children were going to work too. I wasn't seeing my grandchildren, one is 6 years old, and one is 2 years old. I wasn't able to hug them. These all had their toll on me ultimately.

Susie's social life turned upside down during the pandemic, as she stopped her hobbies as well as not meeting with her social groups which gave her a lot of meaning and purpose in her life. The fear of meeting people was stronger than the need to socialise. Nonetheless, she felt the loss of these support systems.

> I used to enjoy walking, but I stopped during the pandemic. This impacted me for example. I also stopped socialising, and I was in several groups. I stopped all of them. I used to go to prayer meetings and other things. But I stopped them all. I didn't meet with people. Isn't it terrifying being cut off from your family?

Catherine's home served as a focal point for family members to meet up and socialise, whilst also giving Catherine a sense of purpose. However, due to that pandemic, she needed to close her doors to all her loved ones to keep herself safe.

> Even my nieces and nephews, none of them used to come over which was very different to before the pandemic when they used to come over often. Or during the village feast they would all meet at my home. Then they stopped coming, and I stopped inviting people over. The door was closed. Not even I went outside of it. It's these sorts of things that were cut out. Life was completely different.

Defending the Castle at all Costs

The theme of creating a safety bubble in terms of hygiene between the inside and outside of the home was prevalent among the participants. In this way, participants attempted to create a barrier between the contaminated outside world and the safety of their own homes. The home became a symbol of the only place that was truly safe, and participants went to great lengths to keep it this way. The following quotes showcase the different ways of how participants ensured that their homes remained free of contamination. The ritual of cleaning the home was also needed to minimise their fear and anxiety, and became a fixation in some cases. Additionally, these cleaning rituals seem to reflect the need to establish control over an uncontrollable situation.

> One time during covid we got out of the car to go for a short walk but we left him [her husband] in the car. And someone saw him and went to speak to him. Mary mother of God, the second we got home we made him clean his face, removed his clothes, and everything. I told him “Next time I’m going to leave the window closed for you so no one comes to speak to you!". (Ruth)

> The more I thought about COVID and felt scared, the more I would end up cleaning the home all over. Even though I used to clean all the time with antiseptic, I would clean

> everything that we got from the grocer. And if someone came over to my home, I would remove all the carpets and wash everything all over again. Even in the street, I used to throw water mixed with bleach outside my door and leave it there. (Catherine)

> Even when I needed to buy groceries, I used to wash everything so I can say that they're clean because I was scared that people touched them and will pass on a virus. I didn't want anything in my fridge that came from the outside, it bothered me. To put anything in my kitchen drawers, I need to wipe everything clean. So in my mind I was protected at home. (Susie)

Long-term living outcomes of the pandemic

While half of the participants managed to adjust and return to their normal lives post-pandemic and experienced less anxiety, the other half saw long-term changes even after the pandemic passed and restrictions were eased. In a sense, going through the hardship and turmoil of the pandemic had persisting living outcomes on the participants, leaving an impact on their present-day lives.

Even though the participants were active and part of social groups before the pandemic, several of them struggled to return to how things were in pre-pandemic times, even though such activities gave them psychological wellbeing. This resistance to going out of the home may reflect how participants feel in control at home, whilst going outdoors means facing unknown dangers. This is especially the case after living through the pandemic. Below are three quotes showing this struggle.

> I used to go to the 5:30am mass and leave at 5am to arrive slowly. It was bliss for me. I used to feel that it helped me a lot. It used to charge me for the duration of my day. Today I find it difficult to even go out. And I go to mass later to meet fewer people. (Susie)

> Yes definitely, we used to go out more before COVID. Not a lot, but we would go out. From the pandemic onwards we didn't really go out, and it remained that way till today. It's like we got used to not going out anymore. (Henry)

> I'm not how I was before, because it's like I got used to living in here now. My family offer to take me for a car ride, but I tell them to not come so I can stay at home for some peace and quiet. (Catherine)

While the majority of participants struggled in some areas of their lives once the pandemic was over, other areas did improve or completely went back to normal. This was the case for four of the seven participants who felt that their anxiety levels were reduced, as can be seen below.

> My anxiety about COVID has reduced now. First of all, the pandemic isn't mentioned as much, but they still say it is among us and that we need to be careful. But it isn't as bad as it was before. Now it will take the form of a cold, right? So my anxiety was reduced. It was reduced for everyone. (Elizabeth)

> It's like I forgot about it all. I stopped giving it a lot of notice. I know that it's still with us, but I'm not paying attention much. Even if I go to the supermarket. (Mary)

> I don't have that big fear that I used to have, because it feels like COVID now is barely mentioned. We still are attentive and take precautions, but it isn't that anxiety that makes you panic. Before I used to panic if someone came to my home. (Susie)

For Ruth, the rituals that started during the pandemic remained post-pandemic. This is possibly a result of fearing that her anxiety may resurface, or because these rituals became ingrained in her and made her feel safer and more in control.

> No no, my anxiety is much better now. But regarding hygiene we remained the same. Until recently when I used to go grocery shopping I would wear the mask. I also recently stopped wearing the mask at mass. Hygiene is part and parcel of us now. (Ruth)

Feelings of Vulnerability

The majority of participants shared their thoughts on the concept of vulnerability, which they felt was a frequent topic of discussion during the pandemic. During the interviews, the topic of vulnerability often led to a discussion on the implications of age. In most cases, the participants felt that they were vulnerable during the pandemic.

Susie learnt that she was a vulnerable person from COVID-19 news, rather than it being a preconceived idea. She also felt that she was different from younger people due to her age. Perceiving herself to be vulnerable also increased her anxiety and tension.

> Absolutely, yes. I used to, and I still see myself as vulnerable. You young people and my grandkids don't feel scared about getting COVID you know? But I felt scared that I would get COVID. Because the news put it into our minds that we are vulnerable if we have high blood pressure or are over 65 years old. So that affected me because I have high blood pressure.

In William's case, not only did he feel that he was "naturally" vulnerable due to his age, but also that age plays a big difference in how one will be affected by the virus. Those that are vulnerable are at more risk of having complications and thus will feel more apprehension.

Additionally, it seems that William felt his health had deteriorated with increasing age. The below quote also seems to reflect the participant grieving his previous health self.

> Between you and me there is a difference. Because if I was young, I would have said I'll get COVID-19, I'll spend 2 weeks inside and I'll get better. But I knew it could give me a really hard time and send me to hospital. And that makes a difference.

The feeling of vulnerability shaped the way that Elizabeth viewed the pandemic and how threatening it was for her livelihood. This perceived vulnerability stemmed from the susceptibility one gets to sicknesses such as COVID-19 in later life, as well as the fact that she is diabetic.

> I'm 67 now and I was 64 when the pandemic hit. So I was considered to be vulnerable if I got COVID because I also have diabetes. I've had it for 5 years, so since I am diabetic I was a bit more scared. As you get old, you get conscious of the fact that you aren't as strong as when you were younger.

In contrast to the above participants, Mary and Henry felt that they were not vulnerable, regardless of whether they are above the age of 65 years. These feelings of invulnerability could be a defence against what was happening throughout the pandemic and a way of managing COVID-19 fears. This is also because all the participants experienced increased anxiety during this period. Rather than reflect on their own vulnerability, both Mary and Henry commented on how their loved ones are vulnerable due to physical health conditions.

> I didn't really care. I was 65... I'd be vulnerable not just because I was in my 60s, but if I was someone who cannot move a lot, or walk well, in that extreme you know. Not someone active and independent. Then some people have conditions that are not visible

> and need treatment. I used to worry a lot about my daughter because she suffers from lupus. (Mary)

> I still feel that I'm healthy. I was more worried about my son. But I also don't know if I am vulnerable since I am getting older. (Henry)

How Will we Survive This?

While all the participants struggled and suffered for various reasons throughout the pandemic, the different ways in which they remained resilient and what bolstered them were highlighted. Participants spoke about coping mechanisms, support systems and protective factors, as well as offered advice to other older adults who may be struggling with anxiety.

Finding Serenity Through Prayer and Support

During the challenging times brought about by the pandemic, participants often turned towards prayer and support systems as a way of finding relief and comfort. The strength they found after utilising these support systems allowed them to navigate the challenges of daily life with greater equanimity and grace.

William felt most supported during the pandemic by his family and especially felt their positive impact whilst he was recovering from COVID-19. Apart from the physical symptoms of the virus, William “nearly had a mental breakdown” due to the quarantine period. Furthermore, both his granddaughter and therapist gave him the space to process his fears and anxieties.

> My children, my wife, my family, my granddaughter. Even afterwards when I recovered, they used to take me out. My granddaughter used to listen to me and talk to me. Also my therapist that I told you about.

A recurring coping mechanism was prayer and the strength it gave the participants to keep on fighting when they were lonely and felt like giving up. Prayer helped participants to cope in numerous ways such as trusting in a higher power, a way of grounding themselves, as well as processing feelings of fear and anxiety. Below are three accounts of how prayer helped participants cope throughout the pandemic.

> Oh without a doubt. I used to listen to Mass every day with the rosary. It strengthens you because God is always with us. It gave me peace and relief. God forbid we don't have faith, because things would not go well. (Catherine)
>
> Prayer, praying helped me. I believe in prayer very much. I felt more calm and peaceful after praying. Even the fact that I prayed for other people helped me you know, especially after seeing all that Italian news, and all the coffins, and all those army trucks carrying the dead. (Ruth)
>
> Just my faith in God, that He will help me, and nothing else. My faith in God. I think that when you believe in God, you have "una marcia in più" (translation: ‘something extra’). It gives you strength, in that even if you feel down, you process what's going on. (Elizabeth)

Protective Factors

While all the participants experienced symptoms of anxiety and fear, they also had protective factors that dampened the negative biopsychosocial effects of the pandemic in various ways. These factors ranged from taking the COVID-19 vaccination to having a lifestyle that was focused on being in the home rather than out of it before the pandemic struck.

Below, Susie highlights how she desperately felt the need to take the COVID-19 vaccine to have a protective layer to subsequently feel comfortable enough to meet other people.

> I took the first vaccine alone without my husband because I was so scared that I needed something. Something to protect me. I felt like I had a shutter you know? A bit of protection. I felt like I had something on my side, and I started to let go and felt less anxious about meeting my children.

In the following statements, Mary and Ruth share their experiences of how their accustomed lifestyle of spending ample time at home became a form of protection during the pandemic. They explain that adapting to the isolation resulting from COVID-19 restrictions was relatively easy for them, as they were already accustomed to less frequent outings compared to others. Thus, this behaviour served as a positive influence throughout the pandemic.

> It didn't affect me as much as it could have because I'm not the type of person who likes to go out a lot. I like to do my errands and stay at home. Relaxing at home, watching TV, cleaning. I go out as needed, for me it's enough. Because other people who were used to going out a lot suffered with everything closed. (Mary)

> What was in my favour was that we have been inside our home for 7 years practically, as my husband is very dependent on me. I had my life before, I would go to mass, I would go shopping. I was prepared to stay inside so I didn't feel it too much. (Ruth)

Elizabeth had a different protective factor in her favour when compared to the above participants. Keeping a positive outlook on life is something that she has grown up with and allowed her to tackle painful and unpleasant experiences such as the pandemic in a more hopeful and productive manner.

> You need to hope for the best and say that it will be fine, or that if I get COVID that it will pass. You need to try and see the positive of a situation and not let the bad part take over. You need to be aware of the risk and that what will happen, will happen. I still used to get scared, but I was an optimist and things kept on moving forward thank God.

Sharing Wisdom Through Experience

Participants were keen to offer advice to other older adults who may have experienced anxiety during the pandemic. This advice was often based on their own experiences and struggles and thus was elicited through their learnt wisdom. When considered all together, the advice is offering a clear message – spend more time outside of the home, and find support wherever it may be.

Susie's message advocates for embracing the negative occurrences that transpired during the pandemic, whilst emphasising the importance of not becoming fixated on these events. She encourages others to tackle anxious thoughts by challenging their fears. In her case, this would have meant spending more time outside of her home, and interacting with people since these were the things that caused her anxiety.

> To continue their normal lives as they had before COVID and to not obsess a lot as I did. They can go out more and challenge themselves to as much as possible not let their thoughts take over. To slowly start going out and continue leading a normal life.

Ruth emphasised the importance of being in the company of loved ones and supporting each other as a way to keep isolation at bay. To do this, she encourages one to have daily contact with people to ensure that a person does not creep into complete isolation.

> What's important is that you are not alone. That you have a chain of support. Relatives, friends, even a telephone call at least. So that you don't feel like you are alone. I used to walk to the front door, and the other older adults would wave to each other. That's the advice I give. So that they don't feel lonely they should have at least one telephone call a day.

Elizabeth in turn echoed the importance of moving on and not focusing on negative past events, just as Susie mentioned. However, she also highlighted the need to share concerns as a way of minimising any catastrophising thoughts.

> That they need to go on with their life. They must talk about what is going on, maybe a close friend or family member. If they have the chance to go out, they should. And to not keep everything inside. Because when you keep something that is worrying you inside, it will only grow bigger in your mind. And when you share it with someone, it seems more manageable.

Mary took a unique approach regarding her advice and highlighted the importance of taking a proactive approach to minimise anxious thinking and ruminating on negative topics such as the pandemic. This can be done by focusing on more positive subjects or simply following one’s normal routine and being active.

> Everyone will think and worry. The difference is how much you can control your mind. It depends on how capable you are of finding other things to think about, or going for an errand and going out. You're thinking about something else. Thinking about the pandemic all the time doesn't help. But you try to stand up and stop thinking about it, to not let your mind control you.

Conclusion

To conclude, this chapter presented the themes that were generated following an analysis of the conducted interviews. The elicited themes illustrated both the unique and shared experiences of older adults that lived with anxiety during the pandemic. In the following chapter, the findings of this study will be discussed in light of current literature.

Discussion

Introduction

Throughout this chapter, the themes elicited from the interviews conducted regarding the lived experience of older adults with anxiety during the COVID-19 pandemic will be examined in light of relevant and recent literature. These salient findings will be framed within the conceptual framework of this study, this being the *Dynamic Biopsychosocial Model* (Lehman et al., 2017). Furthermore, the sociocultural context of Malta will be given additional consideration.

The Lived Experience of Older Adults With Anxiety During the Pandemic: A Dynamic Biopsychosocial Approach

Analysing the themes indicated that a culmination of biological, psychological, and social factors were implicated in participants' anxiety. These factors lessened the degree of anxiety in the participants or directly contributed to the experience and exacerbation of anxiety. In turn, the participants responded to their anxiety through various coping styles and strategies. Such strategies are used as a way of regulating the symptoms brought about by their anxiety (Muazzam et al., 2023). Thus, due to the complexity that is needed to comprehensively understand the lived experience of older adults with anxiety during the pandemic, a broad and multi-scalar approach such as the one employed by the *Dynamic Biopsychosocial Model* (Lehman et al., 2017) was needed (Kop, 2021; Laher et al., 2021). Additionally, emphasis should be placed on the word 'dynamic', indicating that the model recognises that the experience of anxiety is not static and unchanging, but rather one that has the potential to transform and ebb as time passes (Wainwright & Low, 2020). This dynamic experience of anxiety can be particularly seen in the theme titled 'Long-term living outcomes of the pandemic' where participants

reflected on the long-term effects and changes the pandemic had on their QOL, as well as their anxiety.

The Pandemic – "A time of fear and terror"

At its core, fear is a vital emotional response that protects us from dangerous environmental stimuli by driving us into taking adaptive and protective actions (Mobbs et al., 2019), such as against the COVID-19 virus. Emotional and physiological reactions to the pandemic can be further understood through several theories. The *Fight or Flight Response Theory* postulates that when faced with an event that is perceived to be dangerous, this results in the emotion of fear which in turn drives a flight or fright response as a way of surviving (Chen et al., 2021). Hence, the decision to self-isolate and reduce contact with people can be considered a flight response to adapt to the environment around the participants and to increase their chances of survival. Additionally, the *Cannon–Bard* theory of emotions would state that the emotion-inducing event, which in this case is the COVID-19 pandemic, impacts the brain in two ways (Šimić et al., 2021). This is by stimulating the automatic nervous system to elicit a physical response, whilst simultaneously sending signals to the cerebral cortex to perceive emotions (Šimić et al., 2021).

Fear during the pandemic was an all-too-common experience among the general public (Shafran et al., 2021), with this being similarly echoed by all the participants who shared their experience of intense fear stemming from contracting the virus, the fear of people who potentially had COVID-19, as well as fear of hospitals. In William's case, fear played a protective role as it pushed him into being cautious and aware of his surroundings whenever he ventured out of his home and thus was positive in that regard. However, other participants experienced overwhelming amounts of fear, which became detrimental to their QOL and

impacted their anxiety. This range of fear can be conceptualised through the *Yerkes-Dodson* law, which states that medium levels of arousal are beneficial for one's productivity. However, once a certain threshold of fear is reached, this productivity drops and negative outcomes begin to be seen (Nürnberger et al., 2022). Such outcomes can be seen in Henry, who shunned and avoided people to the point where he only felt safe at his home or field. Similarly, Susie needed to take measures such as cutting off all contact with her children and grandchildren to feel safe and contain her fear. These reactions can also be considered as a flight response to protect themselves from impending danger.

The specific fear of contracting COVID-19 has been coined as 'contamination fear'. This was especially prevalent within older adult cohorts, and is associated with reduced psychological wellbeing and less frequent healthcare visits (Alhalal et al., 2022). This in turn can negatively impact one's QOL (Medvedev & Landhuis, 2018). The presence of high contamination in the participants makes sense when considering Elizabeth's perception towards COVID-19, in that contracting the virus is equal to a death sentence due to her increased vulnerability and mortality risk because of her age (Alhalal et al., 2022).

While the pandemic greatly disrupted health promotion campaigns on a global scale, an opportunity was found to re-evaluate how such campaigns are delivered to improve their effectiveness, fairness and impact (Jafari et al., 2021). This can mean moving away from single-illness health promotion campaigns, to focusing on a 'Health-in-All' policy that gives importance to integrated approaches, improved communication and partnership between such campaigns (Jafari et al., 2021).

While the initial shock of fear ensured that participants remained safely indoors, they then began to experience the long-term outcomes of fear such as the symptoms of anxiety (Allan

et al., 2015) as participants began to feel the strain of living indoors and did not have access to their support systems. Thus, fear is a psychological factor that contributes to the experience of anxiety within the *Dynamic Biopsychosocial Model* (Lehman et al., 2017). This is because while fear in part led to the experience of anxiety in the participants, several other factors such as social and biological ones were also implicated in this experience. Furthermore, the extent of how much these factors contributed to the experience of anxiety also changed with time as the pandemic progressed. The fluctuation of how anxiety, fear, and perception towards the pandemic changed as the pandemic progressed can be seen in the study conducted by the Richmond Foundation (2022) who assessed the impact of the pandemic over 13 surveys. Results indicated that worry, fear, and other negative emotions and perceptions towards the pandemic were especially high at the beginning of the pandemic, fluctuated, and gradually reduced by the 13th survey. In terms of the *Transactional Model of Stress and Coping* by Lazarus and Folkman (1984), the resources participants usually had access to such as social groups, outdoor activities, and family support were diminished or completely absent. This resulted in them being unable to effectively cope with the perceived psychological stress placed upon them.

Having a sense of fear towards the local general hospital was echoed by the majority of participants. Mary, William and Susie needed to seek medical attention from the hospital for different conditions however opted to completely avoid going to the hospital or postponed their appointments. In William's case, this was to the detriment of his chronic heart condition which worsened as he postponed his heart surgery for after the pandemic for fear of contracting the virus. This specific fear of hospitals further highlighted the level of contamination fear that was felt by the participants and was similarly found to have occurred in other countries (Deledda et al., 2021; Moore et al., 2022). An area of interest regarding this topic is the use of telehealth,

which has promising results in cases of disrupted in-person health care (Moore et al., 2022). Additionally, telehealth has been found to result in several positive outcomes, such as reaching the wanted behaviour change, increased QOL, reduced psychological distress, and increased illness-related knowledge (Rohde et al., 2021; Salisbury et al., 2016). Thus, telehealth can be utilised as a way of overcoming barriers related to help-seeking. Nonetheless, barriers to telehealth in older adult populations have also been noted, such as a lack of technological knowledge, hearing issues, and a preference to see professionals face-to-face (Kalicki et al., 2021; Mao et al., 2022).

The Different Flavours of Anxiety - "I was consumed"

Whilst anxiety and fear share several clinical features, they differ in their neurobiological pathways and serve different evolutionary functions. As previously described, fear drives us to take action against threatening situations reflexively, whilst anxiety is an intentional pattern of behaviour aimed at anticipating and preventing potential harm in the future (Porcelli, 2020). 'What if' thoughts coupled with feelings of uncertainty were prevalent across the whole participant group. These were related to the uncertainty of their future in a pandemic world, their health and potential death, as well as about their loved ones. These types of thoughts often led to rumination and catastrophising until they ended up in the worst-case scenario in participants' minds. In Catherine's case, a simple flu-like symptom would spiral her into thinking that she has COVID-19 and that she will certainly be killed by the virus. This was also the case for William, in that his overthinking led him to have catastrophic thinking, and added to his already present tension. This 'what if' behaviour is a staple clinical feature of anxiety disorders, and has also been found to be typical behaviour in anxious people during the pandemic (Shafran et al., 2021). Shared cognitive features were also present in the participants which may have contributed to

their experience of anxiety. These included the exaggerated perception of danger, amplified responsibility, excessive focus on thoughts, and being unable to contain themselves when presented with the uncertainty of the future. These cognitive features have also been found in other studies exploring anxiety disorders throughout the pandemic (Shafran et al., 2021).

The feeling of amplified responsibility was seen when participants put it on themselves to ensure that their loved ones were out of harm's way and were protected against COVID-19 (Moss et al., 2019) and in how they tried their best not pass on the virus onto their family members. Ruth was extremely worried that she would infect her vulnerable husband with COVID-19 and went to great lengths to keep him within a bubble of safety. This reached the point where she realised that this overprotection was not her usual self, but rather was stemming from her anxiety. Similarly, Henry's anxiety about being unable to visit his son in the hospital due to COVID-19 restrictions may have been partly due to the amplified responsibility he felt as a father, coupled with his inability to provide care. Being unable to follow through with this sense of responsibility for their loved ones may have added to the feeling of uncertainty, which is linked to anxiety in older adults (Gosselin et al., 2022). This situation could have possibly challenged Henry's beliefs about how a good father should behave towards his son, instilling an element of guilt for not being able to visit. This sense of responsibility and the subsequent anxiety has been echoed in other qualitative studies that explored the lived experience of older adults during the pandemic (Bundy et al., 2021; Sit et al., 2022).

The development of anxiety and other mental health issues in the participants can be conceptualised as stemming from both genetic factors, as well as environmental ones. Taking the *Diathesis-Stress Model* (Arnau-Soler et al., 2019) the pandemic can be considered as the stressful life event and trigger which interacted with the participants' different innate dispositions to

mental health issues. Thus, the pandemic may have activated the vulnerability of the participants, which consequently led to anxiety. This same model has similarly been applied as a framework to understand mental health issues such as COVID-19 anxiety stemming from the pandemic (Langhammer et al., 2021; Siddaway, 2020).

COVID-19 news has been the subject of contention due to the questionable credibility of some sources, as well as its impact on the general public which has been seen to have both positive and negative outcomes (Freckelton, 2020). As COVID-19 became a popular topic, fake news and misinformation became abundant and further aggravated the situation which led to an increased perception of risk and increased levels of worry among the participants. Other studies have found similar results where participants feel overwhelmed and anxious due to COVID-19 news coverage (Dong & Zheng, 2020; Sit et al., 2022). This led to vaccine hesitancy in some participants such as Elizabeth, who questioned whether the COVID-19 vaccination is safe and if it causes more harm than good. This is because she blamed the vaccine for causing her heart problems. This has been found to be a common myth about the COVID-19 virus (Ullah et al., 2021).

As the older adult participants spent most of their time at home due to restrictions, they also spent more time watching television, including COVID-19 news. The constant stream of COVID-19 news became a trigger for the participants' anxiety as it was a recurring reminder that COVID-19 is very much present, that it is a killer in older adults and that healthcare systems are overwhelmed. Additionally, conflicting information from professionals and news outlets increased the level of uncertainty in participants, and subsequently their anxiety. This cycle of viewing COVID-19 news leading to anxiety was also a theme in other qualitative studies focusing on the experience of older adults (Aboh et al., 2022; Sit et al., 2022).

Several reasons may expound on the relationship between COVID-19 news and its role as a trigger for anxiety among the participants. This link may be partly explained through catastrophic cognitions, whereby participants who watched COVID-19 news may have experienced a higher perceived risk of the illness. It can also be construed that COVID-19 news had an impact on the illness perception of participants as understood from the perspective of the *Self-Regulatory Model* (Leventhal et al., 1997). Hence, if they internalised the idea that they will pass away if they contract the virus (as was the case with Henry and Elizabeth) as was being pushed on the media, then this would have impacted how they understood their illness as well as their coping strategies. Additionally, the catastrophic cognitions led participants to make predictions about their health and their susceptibility towards the virus, leading to an increased threat response and increased levels of anxiety (Jagtap et al., 2021). It may also be the case that the participants were actively seeking health information from news and social media as a way of reducing their anxiety for reassurance purposes (Asmundson & Taylor, 2020). However in the long run this cycle causes more anxiety and tension than reassurance through the negative reinforcement of watching COVID-19 news (Jagtap et al., 2021).

Emotional reasoning or ‘ex-consequentia reasoning’ can further shed light on the relationship between COVID-19 news and the anxiety felt by the interviewed participants. Emotional reasoning as discussed and developed by Beck (1979) and Arntz et al. (1995) is distorted thinking experienced by individuals with anxiety disorders and refers to how a person comes to a conclusion regarding a situation based on one’s emotions rather than objective reasoning (Arntz et al., 1995; Gangemi et al., 2021). Thus, with participants experiencing fear and anxiety as a response to COVID-19 news, they may conclude that they are genuinely in danger. Consequently, they would feel that they should further seclude themselves from society

and remain indoors at all costs as based on their emotional state rather than objective thinking. Additionally, their feelings of fear and anxiety may have further confirmed their beliefs surrounding their vulnerability towards the COVID-19 virus.

Outcomes of Living Through the Pandemic

All the participants experienced fluctuating levels of isolation and loneliness throughout the pandemic as a result of government restrictions and their fear and anxiety. Isolation played a dual role in the lives of the participants, as well as their experience of anxiety. On one hand, self-isolation was carried out by the participants to reduce the chance of contracting the virus. Conversely, it cut them off from their social groups, family support systems and outdoor activities, leaving them to fend for themselves behind closed doors. The dual role of isolation in the lives of older adults throughout the pandemic was echoed in other studies (MacLeod et al., 2021). Considering that social connectedness and perceived social support play a critical role in the lives of older adults and are associated with improved physical and mental health (Asante & Castillo, 2018), it is a crucial area to explore. Isolation challenged the 'grandparenting' role of many of the participants as they could not take care of their family members and grandchildren. This was the case for William and Mary who regularly took care of their grandchildren. The grandparenting role is highly relevant considering Malta's culture where grandparents often play a major role in the lives of their family members, such as by taking care of their grandchildren for several hours a day (Abela & Grech Lanfranco, 2016). Similarly, Catherine's home was the focal point for family members to meet up for get-togethers and gave her a sense of purpose. This however came to a halt during the pandemic as she needed to protect herself. This left the participants feeling like they are missing out on the growth of their grandchildren. This was a difficult loss as their grandchildren gave them a sense of satisfaction and resulted in positive

psychological wellbeing. The positive results of grandparenting have also been found in other studies (Mahne & Huxhold, 2015).

In addition to the discussed factors throughout this chapter, social isolation may have compounded the experience of anxiety within the participants. Similar studies have also found that anxiety is one of the outcomes of prolonged isolation during the pandemic in older adults (Sepúlveda-Loyola et al., 2020). It is proposed that isolation and a lack of social connectedness had negative outcomes in participants for several reasons. People possess an inherent need for seeking social connections as it is associated with forming relationships and survival. Conversely, feelings of isolation result in a worsening mood and increased sensitivity to threats (Santini et al., 2020), such as the pandemic. Thus, social isolation may have contributed to the experience of anxiety within the participants as their coping abilities were reduced, and their perceived threat levels were heightened (Santini et al., 2020).

Participants such as Ruth, Catherine and Susie experienced quasi obsessive-compulsive disorder (OCD) related symptoms towards hygiene and contamination as a way of ensuring that anything brought into their homes passed through a rigorous hygiene process, over and above what was recommended at the time. The participants also put forward that this level of hygienic practice was new to them, and that some of these practices have continued to the present day as they struggled to eliminate them. These hygiene behaviours may be a result of the lack of control the participants felt throughout the pandemic. In this way, participants attempted to reassert control in their lives, as well as to minimise the anxiety that was resulting from this lack of control. Hence, these hygiene rituals acted as safety behaviours. Excessive cleaning routines throughout the pandemic were also found to be present in those with anxiety as a way of controlling their anxiety response (Knowles & Olatunji, 2021). This was especially the case with

Susie, who would need to wash herself each time she went out of the home and would cause her high levels of distress if she did not do this. If Catherine had visitors, she would need to wash her home with antiseptic and went as far as throwing bleach outside of her home. Similar results were found when comparing the experience of participants with other studies that explored obsessive-compulsive symptoms during the pandemic in non-OCD settings and within the general public. Results indicated that higher prevalence rates of obsessive-compulsive disorder symptoms in non-OCD participants were present throughout the pandemic due to the COVID-19 pandemic as a stressor in combination with the negative impact of fear and anxiety (Ji et al., 2020; Loosen et al., 2021; Munk et al., 2020). However, other studies have found contrasting results and none of the cited studies were specifically related to older adults. Another explanation can be that due to the elevated fear and anxiety towards contracting the virus, participants overcompensated by carrying out more stringent hygiene practices as has been seen in other populations (Thomas & Feng, 2021).

Several participants continued to experience negative long-term psychological and social changes in their lives, even after the pandemic abated. Post-pandemic, Henry, Catherine and Susie all struggled to be as sociable and physically active as they were in pre-pandemic times. This is because they felt that they got used to spending time at home and felt little to no reason to meet people outside of their homes. While a gradual reduction of activities of daily living is a typical process as one ages (Gao et al., 2022), this does not fully explain the stark difference in socialising in pre- and post-pandemic times. One possible reason for this difference is the long-term deficits that have been found in older adult COVID-19 survivors due to the cognitive and physical changes brought about by the virus (Bae et al., 2022). Thus, participants such as William and Elizabeth who were COVID-19 positive may struggle more to reach their pre-

pandemic QOL and functioning due to the changes caused by the virus. This has also been the case for many other older adult COVID-19 survivors (Tamai et al., 2022). Additionally, the social withdrawal experienced by participants after the pandemic ended can also be attributed to the prolonged social isolation they experienced throughout the pandemic and is similar to the phenomenon known as hikikomori syndrome (Kathirvel, 2020). Hikikomori is a Japanese term that refers to the long-term withdrawal from society (Neoh et al., 2023).

The *Health Belief Model* (Rosenstock et al., 1988) as well as the *Theory of Planned Behaviour* (Ajzen, 1991) can also be used as a way of understanding the behaviour of participants who remained isolated at home and limited their socialising after the pandemic ended. Both of these models have been applied to the behaviour of isolation as well as to the pandemic (Carico et al., 2021; Issrani & Alam, 2021; Wollast et al., 2021). In the case of the *Health Belief Model* (Rosenstock et al., 1988), the majority of participants felt highly vulnerable for a variety of reasons towards the pandemic and thus had a high perceived susceptibility to the virus. Coupled with this sense of vulnerability, they also felt that COVID-19 poses a serious health risk and has a high chance of killing them which indicates their perceived severity. Additionally, several substantial benefits of remaining indoors were felt by the participants, such as experiencing less anxiety and fear even after the pandemic ended, as well as a minimal number of barriers such as the need to go shopping and other necessary activities. The cue to action may be the negative emotional state they experience via fear and anxiety when thinking about going out, thus further persuading them to remain indoors.

Vulnerability can be said to be stemming from the perceived individual belief that a person is susceptible to being hurt, experiencing negative situations, and not having the correct resources to manage such harm (Oris et al., 2016). This is in line with the vulnerability that the

majority of the older adult participants felt throughout the pandemic and often was related to biological factors such as their age or physical conditions. Susie, William and Elizabeth all felt that they were vulnerable to COVID-19 and that the impact of contracting the virus will be more severe than if a younger person contracted the same virus. This perceived vulnerability in turn increased the perceived threat of the pandemic and thus resulted in increased levels of fear and anxiety (Rosenstock et al., 1988). This is in line with other studies that found that vulnerability plays a mediating role in older adults in terms of COVID-19 health anxiety (Bergman et al., 2020). Thus, perceived vulnerability throughout the pandemic may also have contributed to the experience of anxiety among the participants.

Nonetheless, this experience of vulnerability towards the COVID-19 virus was not felt by Mary and Henry. This highlights the fact that older adults are not a homogenous group, but rather heterogeneous (Jaul & Barron, 2021). This lack of perceived vulnerability may have acted as a buffer against worse health outcomes and anxiety (González-Castro et al., 2021). Rather, Mary and Henry focused on the vulnerability of their children with chronic conditions, which resulted in increased worry and anxiety in them. Due to Malta's socio-geographical conditions, family ties, family involvement and the overall importance given to family structures are culturally significant (Satariano & Curtis, 2018). The family support network within the Mediterranean has been found to play a crucial role in terms of resiliency in the face of hardship (Satariano & Curtis, 2018). Thus, the anxiety and worry felt by these participants about their vulnerable family members is congruent with the above-mentioned cultural aspects. The study by Richmond Foundation (2022) similarly found that older adults were the age group that was most worried about the impact of COVID-19 on Malta and may further support the idea that family systems and society in general are important for this cohort. Furthermore, the worry and anxiety felt by

participants for their loved ones are also echoed in other international studies (Sit et al., 2022; Wang et al., 2020).

How Will we Survive This?

Religion, spirituality and prayer took a central role in the lives of most of the participants and helped them to cope with the negative impact of the pandemic in numerous ways. These included trusting in a higher power, a way of grounding themselves, as well as managing negative emotions such as fear and anxiety. Ruth felt a sense of peace after praying, whilst prayer and faith in God allowed Elizabeth to let go of her fears and trust in Him. Hence, a feeling of acceptance and tranquility was experienced the participants through their religious faith. Religious life and prayer have long been associated with coping and reduced levels of anxiety (Upenieks, 2022). Additionally, the core of Maltese identity is intertwined with Christianity and even forms part of its constitution (Giordmaina & Zammit, 2019). Considering the cultural and historical importance of Christianity in Malta and its positive historical role in society, feeling buttressed and supported through prayer is expected.

Psychologically, prayer gave the participants comfort and hope for the future (Finlay et al., 2021). Prayer is also a way for one to cope with life stressors such as the COVID-19 pandemic by seeing it as an act of God, or simply having more certainty in their lives through their certainty in their faith (Bentzen, 2021). Overall, prayer had a dampening effect on the overall emotional turmoil that was caused by the pandemic and eased the extent of anxiety in the participants.

While all the participants were impacted by COVID-19 and experienced anxiety and fear as a result, specific protective factors were also found to be present that lessened the overall

impact, as well as their level of anxiety. Several participants such as Susie and Elizabeth spoke about their experience of the COVID-19 vaccination and felt that it added a layer of protection and that it was a way of reducing the chance of passing on the virus to one of their loved ones. This helped them feel less anxious and experienced less contamination fear, just as other older adults felt less anxious after taking the vaccination (Chen et al., 2022; Holwerda et al., 2023). Additionally, perceived social support was a powerful protective factor as participants felt that they had people that they could share their worries with, that cared for them and encouraged them. This had a positive effect on their QOL and reduced the burden brought about by the pandemic (Holwerda et al., 2023; Manijeh et al., 2021). Considering the *Transactional Model of Stress and Coping* by Lazarus and Folkman (1984), having the COVID-19 vaccination as well as perceived social support added further coping resources that participants could utilise in adapting to the harsh environment brought about by the pandemic. Thus, as they had more coping resources at their disposal, the perceived severity of the overall pandemic may have been reduced, resulting in reduced stress and increased QOL.

Personality also played a part in how participants experienced the overall pandemic, and subsequently their level of anxiety. Elizabeth in particular felt that adopting a positive approach during the pandemic and having a high level of acceptance of things to come allowed her to live a more tranquil life, even though anxiety was still present. This corresponds to research which found that specific personality traits such as optimism, high tolerance of uncertainty and overall positive thinking are predictive of lower levels of anxiety in older adults during the pandemic (Köverová et al., 2021). These traits are also in line with findings framed within a positive psychology approach. Positive psychology recognises that resilience leads to enhanced coping mechanisms when faced with challenges, improved QOL, and psychological well-being (Lasota

& Mróz, 2021). Even though Elizabeth experienced anxiety throughout the pandemic, she was able to keep a sense of meaning in her life despite such challenges.

Participants put forward several recommendations of how others in their position can tackle anxiety in their lives. Upon analyses of these recommendations, several traits emerged such as adaptability, psychological flexibility and acceptance in the face of hardship. Unbeknownst to the participants, these are central traits in the ideology of *Acceptance and Commitment Therapy* (ACT). ACT is a behaviour change model that aims to improve psychological flexibility in part through the acceptance of distressing events, as well as incorporating more adaptive responses to life experiences (Zhang et al., 2018). ACT posits that negative experiences such as fear and anxiety as experienced by the participants throughout the pandemic are an inescapable aspect of life (Dindo et al., 2017). Rather than eradicating these experiences, ACT supports individuals with anxiety to pursue the values that are meaningful to them, as well as to appropriately look at and acknowledge anxious thoughts (Hasheminasab et al., 2015).

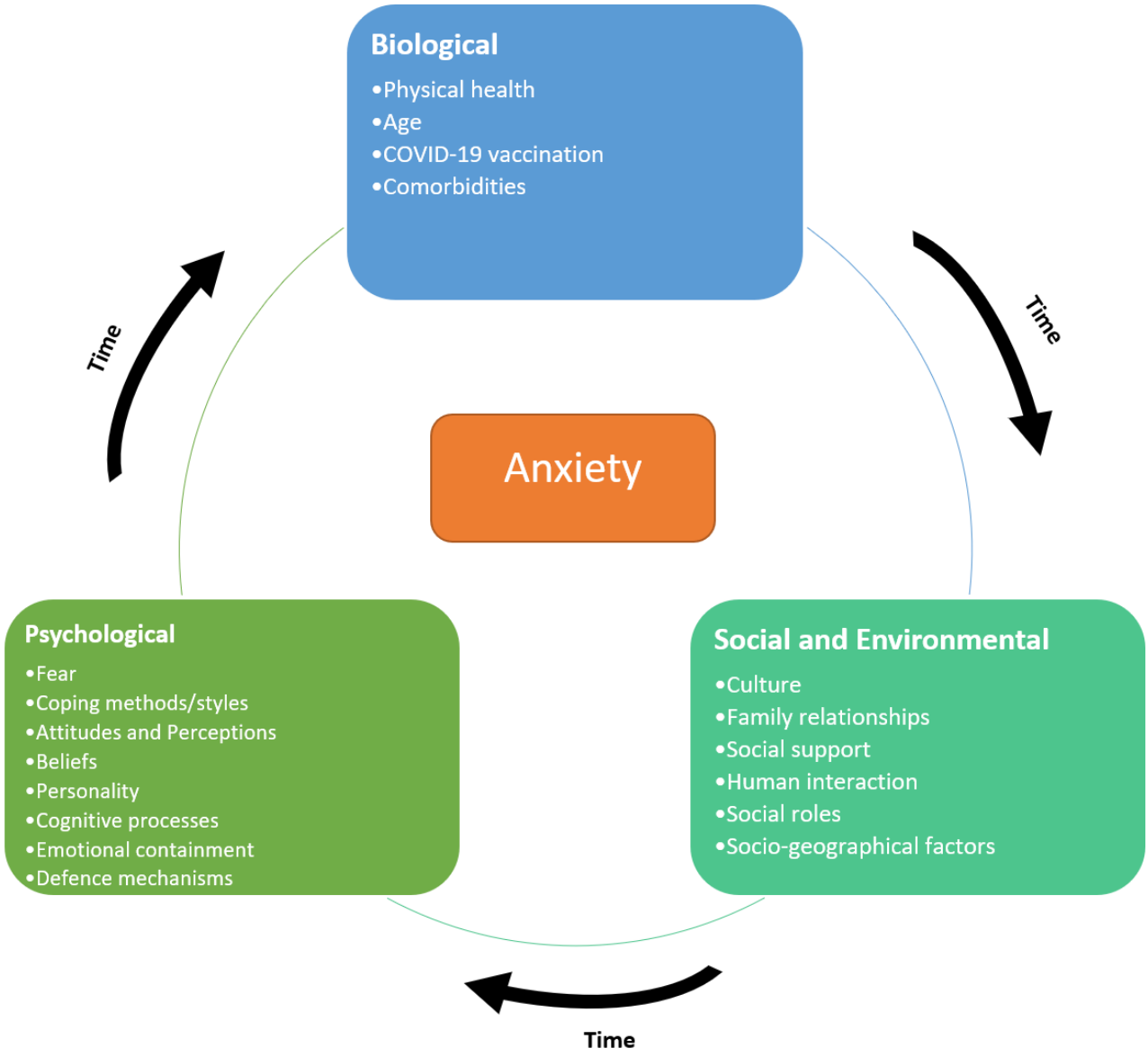
Pessimism on the other hand, as experienced by William who explained that it worsened his mental health, is linked to higher levels of fear and anxiety throughout the pandemic (Jovančević & Milićević, 2020). Mary and Ruth felt that their introverted behaviour of being used to spending most of their time at home, rather than finding enjoyment outside of the home, mitigated the effects of the pandemic. Research has given mixed results regarding introverted behaviour and its mediating role in mental health throughout the pandemic. Participants in a qualitative study put forward that the pandemic was “a haven for [older adult] introverts” (Chen et al., 2021; Goins et al., 2021, p. 6). However, other studies have specifically found that introversion predicted worse outcomes and higher levels of anxiety, depression and loneliness

throughout the pandemic (Wei, 2020). This may be as those with higher levels of introversion tend to focus their attention in an internal direction, which increases the chance of sadness (Dong et al., 2022). This personality trait is also linked to higher levels of fear and arousal (Dong et al., 2022) and thus introverted participants may more easily perceive that a situation requires a fight or flight response.

The factors that were found to be implicated in the dynamic experience of anxiety in older adult participants throughout the COVID-19 pandemic can be found below, in Figure 1.

Figure 1

The Dynamic Biopsychosocial Model Showcasing the Factors That Impacted the Experience of Anxiety in Older Adult Participants Throughout the COVID-19 Pandemic.



Conclusion

Throughout this penultimate chapter, the main findings based on the elicited themes of the study were discussed in relation to relevant and modern research whilst being framed within a *Dynamic Biopsychosocial Model* (Lehman et al., 2017). As a result of this process, the lived experience of older adults with anxiety during COVID-19 was broadened and the understanding of this topic was deepened. Considering that this research study was conducted with Maltese older adults in Malta, the sociocultural context was also tackled. The following chapter will present the overall results of this study, its strengths and limitations, as well as recommendations.

Conclusion

Introduction

The conclusion chapter serves to summarise the main findings of the study while the strengths and limitations of the conducted research are deliberated. Additionally, recommendations for future research and implications for policymakers and clinical practice are presented.

The Summary of Findings

The overall aim of this research to explore the lived experience of Maltese older adults with symptoms of anxiety during the COVID-19 pandemic was achieved, together with the two objectives of exploring their coping skills and the perceived risk and protective factors. This was carried out through an IPA approach framed within a *Dynamic Biopsychosocial Model* (Lehman et al., 2017). Thus, it was elucidated that biological, psychological and social factors were implicated in the lived experience of the participants. The results of this study corresponded with similar international qualitative studies; however unique cultural factors that also impacted the experience of anxiety among the participants were highlighted.

The process of analysing and interpreting 7 semi-structured interviews with local older adults that experienced anxiety during the COVID-19 pandemic yielded 4 GETs. *The Pandemic – "A time of fear and terror"* highlighted the high levels of fear experienced by the participants, and how this feeling was intertwined with the experience of anxiety. These feelings of fear were related to contracting the virus, being close to other people, as well as a specific fear of the local general hospital. *The different flavours of anxiety - "I was consumed"* showcased different cognitive processes that led to and maintained the experience of anxiety within participants.

Anxiety was often related to the health of loved ones, the heaviness participants felt whilst feeling anxious, and how they were triggered by COVID-19 news. *Outcomes of living through the pandemic* illustrated the biopsychosocial outcomes of this turbulent time, such as the need to isolate, building a protective barrier between their homes and the outside world, the long-term changes in a post-pandemic world, as well as their reflections on their vulnerability. Lastly, *How will we survive this?* elicited the resilience of the participants through their coping mechanisms, protective factors, and the wisdom they shared with other older adults.

Strengths and Limitations of the Study

The primary strength of this research paper is that it is the first local qualitative study to solely focus on the lived experience of Maltese older adults that had symptoms of anxiety throughout the pandemic with an IPA approach. This allowed for the uncovering of previously unknown in-depth information about the lived experience of this cohort throughout the pandemic. Simultaneously, this study added to the compilation of local qualitative data on older adults, which is sparse when compared to other age groups (Formosa, 2015). The study also allowed the voicing of experiences by the participants who form part of a population that often suffer in silence (Royal College of Psychiatrists, 2018).

As per the primary research objective, the study required that participants had experienced symptoms of anxiety during the COVID-19 pandemic to have uniformity within the participant group (Smith et al., 2022). This was ensured through the selection process carried out by the gatekeeper of the study, as well as by verbally carrying out the Coronavirus Anxiety Scale (Lee, 2020). However, while anxiety was assessed through the aforementioned scale, it is possible that participants experienced anxiety before the onset of the pandemic. This is a

limitation as it could have affected the symptoms experienced during the pandemic, as well as their overall experience of anxiety.

Another possible limitation is that variables that were not part of the selection criteria could also have resulted in some participants experiencing higher levels of anxiety than others. Such variables included varying ages, different educational and socioeconomic backgrounds, as well as how some participants lived alone compared to others who lived with their spouses.

Future Research

As mentioned by several participants, their experience of anxiety throughout the pandemic did not only affect them but also the family unit. Thus, data triangulation in the form of interviewing loved ones such as spouses and children of older adults with anxiety may shed further light on this phenomenon through additional perspectives (Noble & Heale, 2019). In the same vein, professionals such as psychologists and psychiatrists may be used as additional sources of data to gain their perspective regarding their older adult clients throughout the pandemic.

Whilst several factors were found to have contributed to the experience of anxiety within participants, resilience against the negative outcomes of the pandemic was elicited. While resilience is protective (Chen, 2020), future researchers can explore the specific factors that make up resilience and that are protective in older adults with anxiety whilst considering the socio-cultural context of Malta.

The pandemic further paved the way for telehealth and is a useful asset in overall healthcare (Monaghesh & Hajizadeh, 2020). As the fear of going to the hospital was prominent among the participants and in turn impacted their care-seeking behaviour, it is recommended that

researchers look into the implications of adding further telehealth services for this cohort. Telehealth can encompass psychological and other clinical services. Exploring this avenue will also entail the development of telehealth principles and guidelines (Wardlow et al., 2022).

As anxiety stemming from the pandemic did not abate after the pandemic in several participants, it is proposed that a national study is conducted to ascertain the prevalence rates of anxiety in older adults following the pandemic. Such a study can additionally explore post-pandemic traumatic stress, as well as look into older adults who were hospitalised during the pandemic and how it impacted their mental health, along with any long-term repercussions.

Lastly, the highlighted factors that formed part of the *Dynamic Biopsychosocial Model* (Lehman et al., 2017) relating to anxiety in older adults may be explored in the local context with more detail. This would include how factors such as personality traits, isolation, family support, religious faith and cognitive processes may impact the experience of anxiety in local older adults.

Implications for Policymakers

While the COVID-19 pandemic has abated, its impact is still felt to the present day. Hence, it is being proposed that policymakers prioritise measures that support the older adult population to lessen and soften the negative mental health outcomes caused by the pandemic. Such policies should be framed with the knowledge that discriminatory practices against older adults attempting to access health care and other vital services are commonplace (Formosa, 2021). Policies need to recognise and combat the “perfect storm” that older adults faced throughout the pandemic (Whitehead & Torossian, 2021, p. 36) and which subsequently contributed to the experience of anxiety. Specifically, loneliness and isolation were prevalent

issues both during and after the pandemic. Policies targeting social support measures for older adults are direly needed as a way to ensure that older adults are monitored, have emotional support, and are given information regarding healthcare services. This can also take the form of a 'befriending programme' whereby isolated older adults are given a 'befriendee' that checks in with them regularly to have a chat and can act as a liaison between services and the older adult. This will ensure that these older adults are not forgotten and that adequate care services are given if and when needed. Lastly, measures need to be taken to ensure that health-related information and news are accurate and consistent as this was found to have a considerable impact on the older adult participants. Hence, ensuring that health-related information is provided by reliable and credible sources is essential, together with providing details on how one can assess related services. Hence, policymakers need to prioritise understandable and accessible information and news for older adults.

Implications for Clinical Practice

This study has shown a need for increased screening and diagnostic practices in older adults with potential anxiety. This is especially the case when risk factors such as isolation, fear and physical comorbidities are present. This will aid in identifying symptoms of anxiety as soon as possible and enable psychologists and other health care professionals to provide timely interventions. Such a screening routine procedure can be developed and carried out through the numerous services which cater for the needs of older adults (Government of Malta, n.d.). This can involve a training programme whereby healthcare staff will be made aware of the risk factors of anxiety in older adults. These professionals can then make a referral to a psychologist for a screening assessment to be carried out. This can be further aided by having a sufficient number of psychologists employed within older-adult care settings such as rehabilitation hospitals, long-

term facilities, community-based services and care homes. Having psychologists who are specialised in supporting older adults should be considered a benefit. Similarly, a multidisciplinary team specialised in geriatric care that covers medical, psychological and functional needs in this age cohort is needed within these healthcare settings to offer tailored and specialised care (Choi et al., 2022).

Additionally, psychological interventions can consider the factors that transpired as a result of this study and which were included within the created *Dynamic Biopsychosocial Model* (Lehman et al., 2017) in the context of anxiety. These factors include the implications of different personality traits, coping methods, cognitive processes, contamination fear and support systems and were found to impact the experience of anxiety. Addressing social isolation is another potential implication within a clinical setting, where referrals to community-based programmes or support groups can be made.

Conclusion

The overall aim of this study was to explore the lived experience of older adults who experienced symptoms of anxiety during the COVID-19 pandemic. This was only possible by allowing the older adult participants the time, care, and attention needed for them to voice their life stories in a way that most befitted them. This study highlighted that anxiety is not simply a singular construct, but rather is made up of several multi-dimensional factors and influences that make up the experience of anxiety. It is hoped that this study has helped raise awareness on the needs and experiences of this group of individuals, who are often the main consumers of health care but also are often underrepresented.

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Appendix A

Interview Guide (English)

Interview Guide

1. Can you tell me a bit about yourself?
2. Can you tell me about your experience of anxiety during the pandemic?
3. Where there any things in particular that made you anxious during the pandemic? (contracting covid, finances, social isolation, covid-19 news)
4. Where there any things in particular that helped you manage or control your anxiety?
5. What were your biggest fears during covid, if any?
6. How did these fears (if any) affect your day-to-day life?
7. Can you tell me about your experience of exercise (if any) during the pandemic? (Walking, jogging, swimming etc).
8. Can you share your experience related to your level of your anxiety during the pandemic, as compared to before the pandemic?
9. Can you describe any differences (if any) in regards to your anxiety since the easing of the restrictions and pandemic in general?
10. Do you have any advice for any older adults that have experienced symptoms of anxiety due to the effects of the pandemic?
11. Debrief question: Is there anything else that you would like to add or share?

Interview Guide (Maltese)

Interview schedule (Maltese version)

1. Tgħidli xi ħaġa fuqek?
2. Tista' tgħidli dwar l-esperjenza tiegħek ta' ansjetà waqt il-pandemija?
3. Kien hemm xi affarijiet b'mod partikolari li ġagħluk tħossok ansjuż/a waqt il-pandemija? (Li jaqbdek il-covid, finanzi, iżolament soċjali, aħbarijiet fuq covid-19 etc).
4. Kien hemm xi affarijiet li għenuk timmaniġġja jew tikkontrolla l-ansjetà tiegħek?
5. Kellek xi biżgħat kbar matul il-covid?
6. Jekk kien hemm biżgħat, kif affettwaw il-ħajja tiegħek ta' kuljum?
7. Għamilt xi tip ta' eżerċizzju matul il pandemija? (Mixi, għawm etc)
8. Tista' tgħidli dwar l-esperjenza tiegħek tal-ansjetà waqt il-pandemija, ikkumparat ma qabel il-pandemija?
9. Tħoss li kien hemm differenzi fl-ansjetà tiegħek minn meta bdew ittaffu r-restrizzjonijiet tal-pandemija?
10. Għandek xi parir għal anzjani li esperjenzaw sintomi ta' ansjetà minħabba l-effetti tal-pandemija?
11. Hemm xi ħaġa oħra li tixtieq iżżid jew taqsam?

Appendix B

Excerpt of Analysed Transcript

An excerpt from Catherine's interview

Exploratory Comments	Transcript	Experiential statements
The large impact of watching COVID-19 related news, leaving an impression on her. It is as if she internalised the message of chaos and uncertainty being shared on the media.	Catherine: So the pandemic started in March, but in January, on the 10th, my brother passed away. I used to take care of him and he passed away. And we all said that it's a good thing that he didn't pass away during covid because we wouldn't have been able to enter the church for his funeral, and that was one of the worst things. Then all the restrictions started you know. But I mostly used to hear about covid on the Italian channels. My god, seeing those thousands dead, thousands, every day, every single day. It's like you begin to think about these things without even wanting to. So I wouldn't even go out. And I saw that they would wrap up the dead bodies in plastic bags and throw them in holes. That's what I used to see mostly. They used to really leave an impact on me. All dead from COVID.	Being exposed to the harshness of the pandemic through news.
She needed to protect herself from the fear, danger and uncertainty of the pandemic by isolating herself from the outside world. Themes of safety, protection, and hypervigilance. Change of normal routine and well as reduced socialisation.	Malta was then closed as well. I stopped going outside of my door so I don't meet anyone. I'd have masks everywhere. I'd always feel tension. Even going shopping at the grocery shop, i'd feel tension. I didn't go on any buses for example. Before the pandemic, I used to use them. But afterwards, I never used them. I also stopped going to activities that were organised by the local council of my town so that I don't mix with other people. I: Okay so you stopped these activities during the pandemic.	Taking the decision to isolate herself in order to survive.
Her self-isolation was not only decided by restrictions, but also her own need for safety and security. It was difficult for her to get thoughts of COVID-19 out of her mind, and they would	Catherine: They stopped them, but when they restarted them I still did not go. And when I used the bus because I had to with my grandkids, I would stay at the very back. Just to show you how covid impacted my mind.	Control versus a lack of control.

dictate the actions she needed to take in order to feel safe. Adapting to the new world in order to find moments of relief and enjoyment. Again, she needed to remain hypervigilant and needed to re-evaluate her normal routine so that she is as safe as possible. The less people that got close to her, the better. Vivid and macabre images of death and dying people from COVID-19. A theme of mortality and how everyone can be touched, and killed, by this virus. Her anxiety and fear led her to take several protective steps. This may be a reflection of her attempting to regain control of an uncontrollable situation. Creating a divide between the contaminated outside world and her safe, clean home was of utmost importance.	I: So you needed to cut a lot of your socialising. Catherine: Absolutely. I stopped going anywhere. Then in the summer afterwards I went swimming a couple of times with my brother. We'd go with the bus and stay at the very back and have our masks on, and then we'd take it off. We'd go to Gnejna for some open air. For around 3 hours and we'd be back home by 11 am. I used to enjoy it. We went a couple of times in summer at least, in 2021. Even 2020. And in 2022 I didn't go anymore. And in 2022 they were reducing the restrictions slowly slowly. I used to be really careful when grocery shopping. I used to go once a week only. And not at 11 am, but at times when there are not other people, and always with a mask on. Even at mass, even after the pandemic, I would wear the mask. That was mostly it. And the injections... We went to the local council to take them. I took the first few, but I didn't take the last one. I took the flu injection though. And I wouldn't listen to the Maltese news - I know they spoke about the injections and what not but the news on the Italian TV really left an impression on me. Those thousands of dead people... all the trucks passing by, the hospitals and all the doctors that died poor things. I: And you mentioned that when you used to hear the Italian news... Catherine: The more I thought about covid and felt scared scared, the more I would end up cleaning the home all over. Even though I used to clean all the time with antiseptic, I would clean everything that we got from the grocer. And if someone came over to my home, I would remove all the carpets and wash everything all over again. Even in the street, I used to throw water mixed with bleach outside my door and leave it there.	Adapting to survive. The impact of COVID-19 news. Regaining control through safety measures.

Appendix C

Letter of Approval – Nanniet Malta

Gatekeep request - Fondazzjoni Nanniet Malta
3 messages

Andre Soler <andre.soler.13@um.edu.mt> 24 June 2022 at 14:00
To: Philip Michael Chircop <phchircop@gmail.com>

Dear Mr Chirchop,

I hope this email finds.

My name is Andre Soler and I am a student at the University of Malta, presently reading for a masters in Psychology. I am currently conducting a research study for my dissertation titled 'Anxiety during COVID-19: The Lived Experience of Older Adults'.

This study aims to explore the lived experience of older adults who experienced symptoms of anxiety during the COVID-19 pandemic. This project is being conducted under the supervision of Dr Pamela Portelli (Health Psychologist).

I am kindly requesting your permission on behalf of Fondazzjoni Nanniet Malta to act as gatekeeper for my study. The role of this would be to forward my information sheet to your members, so that any interested members that fulfill the participant criteria may then contact me to participate. My data collection method will involve face to face interviews with older adults who experienced anxiety during the pandemic, and should last around 60 minutes each.

Participation will be entirely voluntary and participants will be free to withdraw at any point, without any repercussions. Data collected will be pseudonymised. Only my supervisor, examiners and I will have access to this data.

Should you require further information, please do not hesitate to contact me or my supervisor; both our contact details are provided below.

Thank you for your kind consideration of this request.

Sincerely,
Andre Soler - andre.soler.13@um.edu.mt

Supervisor: Dr Pamela Portelli - pport03@um.edu.mt

Philip Michael Chircop <phchircop@gmail.com> 24 June 2022 at 16:34
To: Andre Soler <andre.soler.13@um.edu.mt>, pport03@um.edu.mt
Cc: Philip M Chircop <phchircop@gmail.com>, Philip Chircop <nannietmalta2013@gmail.com>

Dear Mr Soler

Thank you for your communication
It would be our pleasure to act sa Gatekeeper for your project which we find very interesting for our elderly sector.

You can count on us to diffuse your project material accordingly at your convenient opportunity

sincere regards
philip

Philip M Chircop MQR
Founder President for Life
Fondazzjoni 'Nanniet Malta' (**VO/869**)
(Grandparents Malta Foundation)

6, Triq il-Parata, St. Venera SVR1311, Malta
(00356) 99207043; 79446568; Fax: 21498127
res & off. **21447304**; 21446568;
nannietmalta2013@gmail.com; phchircop@gmail.com

GRANDPARENTS DAY 2022 -
(2nd) **SUNDAY 09 OCTOBER**
JUM IN-NANNIET 2022 -
(It-Tieni) **ĦADD 09 TA' OTTUBRU**

Recipient of the National Medal for
The Service of The Republic (13.12.21)
***National Active Ageing* Award 2018/2020**
***National Volunteer* Award 2012**
***National Ambassador* EY2012**
[European Year (EY2012) dedicated to
Active Ageing in Volunteering
& Solidarity between Generations]
https://www.facebook.com/NannietMalta/
https://www.facebook.com/phchircop
www.nannietmalta.org

To become a member or to renew your membership,
please send a donation of £5.00 (cash)
in a self-addressed envelope (with 30c stamp) or
a money transfer to one of these accounts:

Bankers: Bank of Valletta (BOV St. Venera Branch)
Account Name: Nanniet Malta
IBAN: MT93VALL22013000000040021978731
Swift Code: VALLMTMT
OR REVOLUT / BOV Mobile app:
Philip Chircop (Mob. 0035699207043)

[Quoted text hidden]

Andre Soler <andre.soler.13@um.edu.mt> 24 June 2022 at 18:49
To: Philip Michael Chircop <phchircop@gmail.com>
Cc: Pamela Portelli <pport03@um.edu.mt>, Philip Chircop <nannietmalta2013@gmail.com>

Dear Mr Chirchop,

Thank you for your reply, as well as for accepting to have your organisation to take on the role of gatekeeper for this study. It is much appreciated and it is our hope that we will continue to support our older adults.

Once ethical clearance is granted, I will follow up via email and pass on the required information that can then be disseminated with your members.

Kind regards,
Andre.

Appendix D

Health Ethics Committee Clearance

/KUMITAT
DWAR L-ETIKA FIS-SAĦĦA

Direttorat ta' l-Informazzjoni fuq is-Saħħa u Riċerka
95, Telgħet Guardmangia,
Pieta' PTA 1313
Malta

Our Ref: **HEC16/22**
Your Ref:

HEALTH
ETHICS COMMITTEE

Directorate for Health Information & Research
95, Guardamangia Hill,
Pieta' PTA 1313
Malta

Tel: (+356) 25599000
Email: hec@gov.mt

Dear Mr Andre Solar,

The Health Ethics Committee has taken note of the approval by Faculty Research Ethics Committee and reviewed your proposal in line with the requirements of the Mental Health Act. The HEC considers your proposal to be in line with such requirements.

HEC Number	HEC16/22
Project Title	Anxiety during COVID-19: The lived experience of Older Adults.
Acceptance Date	09/02/2023
HEC Decision	Accepted

Kind regards,

Profs. Neville Calleja
Secretary- Health Ethics Committee

Cc: Commissioner for Mental Health

Faculty Research Ethics Committee Clearance

L-Università ta' Malta

Andre Soler <andre.soler.13@um.edu.mt>

Research Ethics Application - Approved by FREC, no UREC decision needed

1 message

SWB FREC <research-ethics.fsw@um.edu.mt> 24 February 2023 at 16:18
To: Andre David Soler <andre.soler.13@um.edu.mt>
Cc: Pamela Portelli <pport03@um.edu.mt>, Gottfried Catania <gottfried.catania@um.edu.mt>

REDP Application ID: SWB-2022-00406

Dear Andre Soler,

Your ethics application regarding your research titled *Anxiety during COVID-19: The lived experience of Older Adults* has been **approved**.

Faculty Research Ethics Committees are authorised to review and approve research ethics applications on behalf of the University of Malta, except in the case of sensitive personal data. In this regard, your ethics proposal **does not need to be sent to UREC-DP**. Hence, **you may now start your research**.

Disclaimer: *The research team should note that only the English versions of the documents submitted have been reviewed by FREC. It is the duty of the research team to ensure that all documents in Maltese (or any other language) are faithful translations of the English version.*

Regards,

L-Università ta' Malta

Faculty Research Ethics Committee

Faculty for Social Wellbeing
Room 113, Humanities A Building
+356 2340 2237/3220
um.edu.mt/socialwellbeing/students/researchethics

Appendix E

Consent Form (English)

Participant's Consent Form

Anxiety during COVID-19: The lived experience of Older Adults

I, the undersigned, give my consent to take part in the study conducted by Mr Andre Soler. This consent form specifies the terms of my participation in this research study.

1. I have been given written and/or verbal information about the purpose of the study; I have had the opportunity to ask questions and any questions that I had were answered fully and to my satisfaction.
2. I also understand that I am free to accept to participate, or to refuse or stop participation at any time without giving any reason and without any penalty. Should I choose to participate, I may choose to decline to answer any questions asked. In the event that I choose to withdraw from the study, any data collected from me will be erased as long as this is technically possible (for example, before it is anonymised or published), unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form.
3. I understand that I have been invited to participate in an interview in which the researcher will ask me questions related to my experience of anxiety during the COVID-19 pandemic to explore the lived experience of older adults with symptoms of anxiety during the COVID-19 pandemic. I am aware that the interview will take approximately 45 – 70 minutes. I understand that the interview is to be conducted in a place and at a time that is convenient for me.
4. I understand that my participation *entails the following risks:* the possibility of minimal psychological risk as difficult experiences encountered during the pandemic may be discussed during the interview. However, measures such as passing on contact information of organisations that offer support, such as Kellimni.com, the Psychological Services department within the Health Ministry of Malta, and the therapeutic services offered by 'Ta Kana'. These mentioned services are free of charge.
5. I understand that *there are no direct benefits to me from participating in this study*. I also understand that this research may benefit others by addressing the gaps in local literature in regards to older adults in general, and more so on older adults that experienced symptoms of anxiety during the COVID-19 pandemic. Secondly, following the results that will emerge from this study, information regarding the lived experience of older adults that experienced symptoms of anxiety will be available. Thus, policies aimed at aiding older adults to cope better, increase their quality of life, and recover from the negative impacts of COVID-19 can take these results into consideration. Lastly, this research study will also give older adults the opportunity to voice their experiences and any concerns that otherwise might have gone unheard.
6. I understand that, under the General Data Protection Regulation (GDPR) and national legislation, I have the right to access, rectify, and where applicable, ask for the data concerning me to be erased.
7. I understand that my personal data collected will be treated with confidentiality, my real name will not appear on any scripts and a pseudonym will be used instead. My participation in this project will automatically imply that my identity as the participant will be known to the researcher, the supervisor and in exceptional circumstances, the examiners. Any quotes used in the writing of the dissertation, to enable better clarity in the results, will be used with a pseudonym so as not to reveal my real identity. I know that I have the right to revisit the transcribed interview material until 2

weeks from the set date which will be indicated by the researcher in due course. Should I, the participant, or the researcher at any point or on revisiting the data become aware that other people might identify me in spite of the fact that a pseudonym is being used, this data will be brought up prior to submitting the study, be further analysed, discussed and modified or eliminated until I am comfortable with the final outcome.

8. I understand that all data collected will be stored in an anonymised form until May 2025 for publication purposes, and will then be completely deleted/destroyed.
9. I have been provided with a copy of the information letter and understand that I will also be given a copy of this consent form.

I have read and understood the above statements and agree to participate in this study.

Name of participant: _____

Signature: _____

Date: _____

_____ _____

Mr Andre Soler
andre.soler.13@um.edu.mt
+356 99294509

Dr Pamela Portelli
pport03@um.edu.mt
23402312

10. I am aware that, by marking the first-tick box below, I am giving my consent for this interview to be audio recorded and converted to text as it has been recorded (transcribed).

- ☐ I agree to this interview being audio recorded.
- ☐ I do not agree to this interview being audio recorded.

11. I am aware that extracts from my interview may be reproduced in these outputs, either in anonymous form, or using a pseudonym (a made-up name or code – e.g. respondent A.)

- ☐ I would like to review extracts of my interview transcript that the researcher would like to reproduce in research outputs before these are published.
- ☐ I would not like to review my interview transcript extracts that the researcher would like to reproduce in research outputs before these are published.

12. I am aware that if the interview will be held online; the researcher will use Zoom and will activate the *Require Encryption for 3rd party endpoints SIP/H-323* function. The researcher will *audio record* the session.

13. I am aware that my identity and personal information will not be revealed in any publications, reports or presentations arising from this research.

14. If I feel that the interview has distressed me in any way, a therapist will be available to assist me at no financial cost on my part.

Consent Form (Maltese)

Formola tal-Kunsens tal-Parteċipant/a

Anxiety during COVID-19: The lived experience of Older Adults

Jiena, hawn taħt iffirmat/a, nagħti l-kunsens tiegħi li nieħu sehem fl-istudju ta' Andre Soler. Din il-formola tal-kunsens tispjega t-termini tas-sehem tiegħi f'din ir-riċerka.

1. Ingħatajt l-informazzjoni bil-miktub u/jew bil-fomm dwar l-iskop tar-riċerka; kelli l-opportunità nagħmel il-mistoqsijiet, u kull mistoqsija ngħatajt tweġiba għaliha b'mod sħiħ u sodisfaċenti.
2. Nifhem ukoll li jiena liberu/a li naċċetta li nieħu sehem, jew li nirrifjuta, jew li nwaqqaf il-parteċipazzjoni tiegħi meta nixtieq mingħajr ma nagħti spjegazzjoni jew mingħajr ma niġi penalizzat/a. Jekk nagħżel li nipparteċipa, jaf niddeċiedi li ma nweġibx kull mistoqsija li ssirli. F'każ li nagħżel li ma nkomplix nieħu sehem fl-istudju, l-informazzjoni li tkun laħqet inġabret mingħandi titħassar dment li jkun teknikament possibbli (ngħidu aħna, qabel ma tiġi anonimizzata jew ippubblikata), u sakemm l-għanijiet tar-riċerka jkunu jistgħu jintlaħqu u ma jintlaqtux serjament. F'dak il-każ, l-informazzjoni tiegħi tintuża u tinżamm anonima.
3. Nifhem li ġejt mistieden/mistiedna nipparteċipa f'intervista u l-persuna li qed tagħmel ir-riċerka se tistaqsini mistoqsijiet relatati mal-esperjenza tiegħi ta' ansjetà matul il-pandemija biex tesplora l-esperjenza ta' anzjani b'sintomi ta' ansjetà matul il-pandemija. Jiena konxju/a li l-intervista se ddum bejn wieħed u ieħor 45 – 70 minuti. Nifhem li l-intervista se jsir f'post u f'ħin li huma komdi għalija.

4. Nifhem li l-parteċipazzjoni tiegħi *tinkludi dawn ir-riskji:* l-possibbiltà ta' riskju psikoloġiku b'mod minimu peress li esperjenzi diffiċli matul il-pandemija jistgħu jiġu diskussi waqt l-intervista. Minħabba dan, servizzi li joffru sapport bħal 'Kellimni.com', id-dipartiment tas-Servizzi Psikoloġiċi fi ħdan il-Ministeru tas-Saħħa ta' Malta, u s-servizzi terapewtiċi offruti minn 'Ta Kana' se jiġu offruti. Dawn is-servizzi huma bla ħlas.

5. Nifhem li *bil-parteċipazzjoni tiegħi f'dan l-istudju, m'hemm l-ebda benefiċċju dirett għalija.* Nifhem ukoll li din ir-riċerka jaf tkun ta' benefiċċju għall-oħrajn għax: tindirizza n-nuqas ta letteratura lokali fuq l-anzjani, kif ukoll fuq l-anzjani li esperjenzaw sintomi ta' ansjetà matul il-pandemija. Għalhekk, jkun hemm iktar gwida fuq kif l-anzjani jistaw jkollhom iktar sapport, kif ukoll kwalità tal-ħajja aħjar. Dan l-istudju jagħti wkoll opportunità lill-anzjani biex jaqsmu l-esperjenzi tagħhom.

6. Nifhem li, skont ir-Regolament Ġenerali dwar il-Protezzjoni tad-Data (GDPR) u l-leġiżlazzjoni nazzjonali, għandi dritt naċċessa, nikkoreġi u, fejn hu applikabbli, nitlob li l-informazzjoni li tikkonċernani titħassar.
7. Id-dejta personali tiegħi se tiġi ttrattata b'kunfidenzjalità, l-isem reali tiegħi mhux se jidher u minflok se jintuża psewdonimu. Il-parteċipazzjoni tiegħi f'dan il-proġett awtomatikament timplika li l-identità tiegħi bħala l-parteċipant tkun magħrufa lir-riċerkatur, is-superviżur u f'ċirkostanzi eċċezzjonali, l-eżaminaturi. Kwotazzjonijiet użati fil-kitba tad-dissertazzjoni għal aktar ċarezza fir-riżultati se jintużaw b'psewdonimu biex ma tiżvelax l-identità tiegħi. Nifhem li għandi id-dritt li nerġa' nara t-transkritt tal-intervista sa ġimagħtejn mid-data stabbilita li tiġi indikata mir-riċerkatur. Jekk inti, ir-riċerkatur jew jiena bħala parteċipant/a, f'xi punt nsiru nafu li nies oħra jistgħu jidentifikawni minkejja l-fatt li qed jintuża psewdonimu, din id-dejta tiġi diskussa qabel l-istudju jiġi sottomess, u tiġi analizzata, diskussa u mmodifikata jew eliminata aktar sakemm nkun komdu/a bir-riżultat finali.

8. Nifhem li l-informazzjoni kollha miġbura se *tinżamm b'mod anonimu* sa Mejju, 2025 għal raġunijiet ta' pubblikazzjoni, u mbagħad tiġi imħassra.

9. Ingħatajt kopja tal-ittra ta' tagħrif biex inżommha u nifhem li se ningħata wkoll kopja ta' din il-formola tal-kunsens.

Qrajt u fhimt l-istqarrijiet t'hawn fuq, u naqbel li nipparteċipa f'dan l-istudju.

Isem il-parteċipant/a: _____
Firma: _____
Data: _____

Mr Andre Soler	Dr Pamela Portelli
andre.soler.13@um.edu.mt	pport03@um.edu.mt
+356 99294509	23402312

10. Konxju/a li, jekk nimmarka l-ewwel kaxxa t'hawn taħt, inkun qed nagħti l-kunsens tiegħi biex l-intervista tiġi rrekordjata bl-awdjo u maqluba f'kitba fl-istess waqt (traskrizzjoni).

    ☐ Naqbel li l-intervista tiġi rrekordjata bl-awdjo.
    ☐ Ma naqbilx li l-intervista tiġi rrekordjata bl-awdjo.

11. Konxju/a li siltiet mill-intervista tiegħi jistgħu jiġu riprodotti b'mod anonimu jew bl-użu ta' psewdonimu [isem ivvintat jew kodiċi - eż. parteċipant A].

    ☐ Nixtieq nara siltiet mit-traskrizzjoni tal-intervista miegħi li r-riċerkatur/riċerkatriċi se j/tirriproduċi fir-riżultati tar-riċerka qabel ma jiġu ppubblikati.
    ☐ Ma nixtieqx nara siltiet mit-traskrizzjoni tal-intervista miegħi li r-riċerkatur/riċerkatriċi se j/tirriproduċi fir-riżultati tar-riċerka qabel ma jiġu ppubblikati.

12. Jiena naf li l-intervista tista ssir online; u r-riċerkatur se juża ż-Zoom u se jattiva l-għażla tar-*Require Encryption for 3rd party endpoints SIP/H-323.* Ir-riċerkatur se jirrekordja *d-diskors biss ta' waqt is-sessjoni, mingħajr filmat*.

13. Konxju/a li l-identità tiegħi u d-dettalji personali tiegħi mhux se jiġu żvelati f'xi pubblikazzjoni, rapport jew preżentazzjoni li tista' toħroġ minn din ir-riċerka.

14. Jekk inħoss li l-intervista b'xi mod kiddni jew iddisturbani, terapista tkun disponibbli li tassistini bla ħlas.

Appendix F

Information Sheet (English)

__/__/__

Information letter

Dear Sir/Madam,

My name is Andre Soler and I am a student at the University of Malta, presently reading for a Masters in Psychology in Health Psychology. I am presently conducting a research study for my dissertation titled 'Anxiety during COVID-19: The Lived Experience of Older Adults'; this is being supervised by Dr Pamela Portelli. This letter is an invitation to participate in this study. Below you will find information about the study and about what your involvement would entail, should you decide to take part.

The aim of my study is to explore the lived experience of older adults who experienced symptoms of anxiety during the COVID-19 pandemic. Furthermore, the way that older adults coped with symptoms of anxiety, as well as the perceived risks and protective factors in regards to anxiety in older adults during the pandemic will be explored. Your participation in this study would help contribute to a better understanding of older adults that have experienced symptoms of anxiety during the COVID-19 pandemic. Any data collected from this research will be used solely for purposes of this study.

Should you choose to participate, you will be asked to attend a one-to-one audio-recorded interview at a time and place convenient for you, the participant, where you will be asked about your experience of experiencing symptoms of anxiety during the COVID-19 pandemic. The interview will last between 45 – 70 minutes.

Personal data collected will be treated with confidentiality, your real name will not appear on any scripts and a pseudonym will be used instead. Your participation in this project will automatically imply that your identity as the participant will be known to me as the researcher, the supervisor and in exceptional circumstances, the examiners. Any quotes used in the writing of the dissertation, to enable better clarity in the results, will be used with a pseudonym so as not to reveal your real identity. You have the right to revisit the transcribed interview material until 2 weeks from the set date which will be indicated by the researcher in due course. Should you, the participant or myself, the researcher at any point or on revisiting the data become aware that other people might identify you in spite of the fact that a pseudonym is being used, this data will be brought up prior to submitting the study, be further analysed, discussed and modified or eliminated until you are comfortable with the final outcome.

Participation in this study is entirely voluntary; in other words, you are free to accept or refuse to participate, without needing to give a reason. You are also free to withdraw from the study at any time, without needing to provide any explanation and without any negative repercussions for you. Should you choose to withdraw, any data collected from your interview will be erased as long as this is technically possible (for example, before it is anonymised or published), unless erasure of data would render impossible or seriously impair achievement of the research objectives, in which case it shall be retained in an anonymised form.

Information Sheet (Maltese)

__/__/__

Ittra ta' Tagħrif

Għażiż/a Sinjur/a,

Jiena Andre Soler, student fl-Università ta' Malta, u bħalissa qed insegwi Masters in Health Psychology. Ir-riċerka għad-dissertazzjoni tiegħi jisimha: 'Anxiety during COVID-19: The Lived Experience of Older Adults', u t-tutur tiegħi hi Dr Pamela Portelli. B'din l-ittra nixtieq nistiednek tipparteċipa fir-riċerka. Hawn taħt issib aktar informazzjoni fuq l-istudju li qed nagħmel u fuq xi jkun l-involviment tiegħek jekk tiddeċiedi li tieħu sehem.

L-għan tal-istudju hu biex nesplora l-esperjenza ta' anzjani li esperjenzaw sintomi ta' ansjetà waqt il-pandemija tal-COVID-19. Barra minn hekk, se jiġi esplorat il-mod kif l-anzjani ffaċċjaw is-sintomi ta' ansjetà, kif ukoll ir-riskji perċepiti u l-fatturi protettivi fir-rigward tal-ansjetà matul il-pandemija.Sehmek jgħin biex ikun hawn iżjed għarfien dwar anzjani li esperjenzaw sintomi ta' ansjetà waqt il-pandemija. L-informazzjoni kollha li tinġabar fir-riċerka tintuża biss għall-fini ta' dan l-istudju.

Jekk taqbel li tipparteċipa, tintalab biex tattendi intervista dwar l-esperjenza tiegħek rigward l-effett ta sintomi ta' ansjetà waqt il-pandemija tal-COVID-19. L-intervista se ddum bejn 45 – 70 minuta. Dan se jseħħ fi żmien u post konvenjenti għalik.

Id-dejta personali tiegħek se tiġi ttrattata b'kunfidenzjalità, l-isem reali tiegħek mhux se jidher u minflok se jintuża psewdonimu. Il-parteċipazzjoni tiegħek f'dan il-proġett awtomatikament timplika li l-identità tiegħek bħala l-parteċipant tkun magħrufa lili bħala r-riċerkatur, is-superviżur u f'ċirkostanzi eċċezzjonali, l-eżaminaturi. Kwotazzjonijiet użati fil-kitba tad-dissertazzjoni għal aktar ċarezza fir-riżultati se jintużaw b'psewdonimu biex ma tiżvelax l-identità tiegħek. Għandek id-dritt li terġa' tara t-transkritt tal-intervista sa ġimagħtejn mid-data stabbilita li tiġi indikata mir-riċerkatur. Jekk inti, il-parteċipant jew jiena bħala ir-riċerkatur, f'xi punt nsiru nafu li nies oħra jistgħu jidentifikawk minkejja l-fatt li qed jintuża psewdonimu, din id-dejta tiġi diskussa qabel l-istudju jiġi sottomess, u tiġi analizzata, diskussa u mmodifikata jew eliminata aktar sakemm tkun komdu bir-riżultat finali.

Il-parteċipazzjoni tiegħek f'dan l-istudju tkun għalkollox volontarja; fi kliem ieħor, inti liberu/a li taċċetta jew tirrifjuta li tieħu sehem, mingħajr ma tagħti raġuni. Inti wkoll liberu/a li twaqqaf il-parteċipazzjoni tiegħek fl-istudju meta tixtieq, mingħajr ma jkollok tagħti spjegazzjoni u mingħajr ebda riperkussjoni. Jekk tagħżel li tirtira mir-riċerka, l-informazzjoni li tkun laħqet ittieħdet fl-intervista miegħek titħassar dment li dan ikun teknikament possibbli (ngħidu aħna, qabel ma tiġi anonimizzata jew ippubblikata), u sakemm l-għanijiet tar-riċerka jkunu jistgħu jintlaħqu u ma jintlaqtux serjament. F'dak il-każ, l-informazzjoni tiegħek tintuża u tinżamm anonima.

Jekk tagħżel li tipparteċipa, jekk jogħġbok innota li m'hemm l-ebda benefiċċju dirett għalik. Il-parteċipazzjoni tiegħek tinkludi l-possibbiltà ta' riskju psikoloġiku b'mod minimu peress li esperjenzi diffiċli matul il-pandemija jistgħu jiġu diskussi waqt l-intervista. Minħabba dan, servizzi li joffru sapport bħal 'Kellimni.com', id-dipartiment tas-Servizzi Psikoloġiċi fi ħdan il-Ministeru tas-Saħħa ta' Malta, u s-servizzi terapewtiċi offruti minn 'Ta Kana' se jiġu offruti. Dawn is-servizzi huma bla ħlas.

Bħala parteċipant/a, għandek id-dritt, skont ir-Regolament Ġenerali dwar il-Protezzjoni tad-Data (GDPR) u l-leġiżlazzjoni nazzjonali, li taċċessa, tikkoreġi u fejn hu applikabbli, titlob li l-informazzjoni li tikkonċernak titħassar. L-informazzjoni kollha li tingħabar fl-istudju se tinżamm b'mod anonimu sa Mejju, 2025 għal raġunijiet ta' pubblikazzjoni, u mbagħad tiġi imħassra.

Qed ngħaddilek kopja ta' din l-ittra biex iżżommha bħala referenza.

Grazzi tal-ħin u l-kunsiderazzjoni tiegħek. Jekk ikollok xi mistoqsija, tiddejjaqx tikkuntattjani fuq andre.soler.13@um.edu.mt; tista' tikkuntattja wkoll lit-tutur tiegħi elettronikament fuq: pport03@um.edu.mt.

Tislijiet,

Mr Andre Soler

andre.soler.13@um.edu.mt

+356 99294509

Dr Pamela Portelli

pport03@um.edu.mt

23402312