ALONE IN A PANDEMIC: THE LIVED EXPERIENCE OF
OLDER ADULTS LIVING ALONE IN THE COVID-19 PANDEMIC

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Alone in a Pandemic: The Lived Experience of Older Adults Living Alone in the COVID-19 Pandemic

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Abstract

The ongoing COVID-19 pandemic has profoundly impacted people’s lives around the world. Evidence from the early months of the pandemic indicates increased psychological distress among the public. Older adults face heightened health risks in the pandemic and may be especially susceptible to its negative psychosocial impacts. The impact of isolation due to home-confinement measures is particularly concerning for older adults. As such, a sub-group within the older adult population warrants special attention in the context of this pandemic—those living alone. Given the unprecedented scale of the COVID-19 pandemic, extant literature on the psychological impact of smaller-scale epidemics likely provides only a glimpse into its potential impact. As such, this research was an exploratory phenomenological inquiry on the lived experience of older adults living alone in the COVID-19 pandemic. van Manen’s (2016) approach to hermeneutic phenomenological research guided the data collection and analysis. In-depth interviews were conducted with 12 retired older adults (aged 65 and over) living alone in British Columbia, Canada between mid-July to early August 2020. Through thematic analysis, the phenomenon of living in the initial 4 months of the pandemic for older adults living alone was found to be evolving and multi-faceted. The multiple facets of the phenomenon were captured by 5 core themes: 1) Confronting a mysterious threat; 2) Shrinking existence; 3) Navigating a new world; 4) Recognizing older adult identity in society; and 5) Adjusting to the new normal. These core themes spoke to an experience marked by emotional distress, loss and isolation, change, ageing, and resilience. This research adds to the expanding literature on the psychosocial impacts of the pandemic by providing a rich, descriptive portrayal of the lived experience in the pandemic. Importantly, this work focused on older adults living alone, likely an overlooked group in current literature.
Lay Summary

The ongoing COVID-19 pandemic has profoundly impacted people’s lives around the world. Research from the early months of the pandemic indicates increased psychological distress among the public. Older adults living alone may be especially susceptible to the negative psychological effects of the pandemic, particularly the impacts of home-confinement measures.

As such, this research explored the lived experience of older adults living alone in the pandemic in the first 4 months of the pandemic. Five core themes were found to characterize this experience: 1) Confronting a mysterious threat; 2) Shrinking existence; 3) Navigating a new world; 4) Recognizing older adult identity in society; and 5) Adjusting to the new normal. This research adds to the expanding research on the psychological impacts of the pandemic by providing a detailed portrayal of the experience and by focusing on a group likely overlooked in current research.
Preface

This thesis is the original and independent work by the author, M. M.-J. Chiang. This work received ethics approval from the University of British Columbia Behavioural Research Ethics Board (Certificate Number: H20-02016) under the project title “The lived experience of older adults living alone in the COVID-19 pandemic.”

The project was conceptualized by the author in consultation with Dr. Richard Young, Dr. Sheila Marshall, and Dr. Beth Haverkamp. The author was responsible for the study design, data collection and analysis, and manuscript writing. Dr. Richard Young provided guidance and feedback in the design, data analysis, and writing processes. Research assistants P. Holden and S. Rosario provided review and feedback in the data analysis process.
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Chapter 1: Introduction

The ongoing COVID-19 pandemic has profoundly impacted people’s lives around the world. In addition to the grave physical and economic toll of the pandemic, scholars have highlighted the potential dire psychological consequences associated with living through the pandemic (Holmes et al., 2020). The United Nations (2020) cautions that the pandemic “has the seeds of a major mental health crisis” (p. 2) if not appropriately addressed. Initial evidence from the most affected countries at the onset of the pandemic indicate heightened levels of psychological distress among the public (Zhang et al., 2020; Jahanshahi et al., 2020). In Canada, a recent survey (Mental Health Research Canada, 2020) showed an increase in the proportion of Canadians reporting high levels of anxiety and depression symptomatology since the pandemic.

Older adults face heightened health risks in the COVID-19 pandemic (Government of Canada, 2020) and may be especially susceptible to its negative mental health impacts (Holmes et al., 2020). The impact of isolation due to home-confinement measures is particularly concerning for older adults (Armitage & Nellums, 2020). As such, a sub-group within the older adult population warrants special attention in the context of this pandemic—those living alone.

In Canada, the number of persons living alone more than doubled from 1981 to 2016, and over 25% of older adults aged 65 or older live alone (Statistics Canada, 2019). While living alone does not necessarily equate to social isolation or loneliness (Perissinotto & Covinsky, 2014), evidence suggests that these constructs are related (de Jong Gierveld et al., 2015). Social isolation and loneliness have been shown to strongly associate with a host of negative physical and mental health outcomes (Hawkley & Capitanio, 2015) and much of this robust literature has focused on older adults (Ong et al., 2016). There is also evidence suggesting that living alone is a risk factor for early mortality independent of other social isolation measures (Holt-Lunstad et al.,
Finally, living alone has been found to relate to lower social support and fewer social contacts because of the lack of proximal support from partners or children (Sinha, 2014). In the current pandemic then, the imposition of societal-wide lockdown and social distancing measures may further compromise the amount of social support for the older adult population living alone. Indeed, in a pan-Canadian survey conducted from April to July 2020 (Canadian Red Cross, 2020), older adults living alone with fair or poor physical health fared worse in terms of self-reported feelings of anxiety, depression, and loneliness than other Canadians.

The small literature on the psychological impact of previous infectious disease epidemics have consistently shown increased psychological distress and morbidity and prolonged effects in some cases (Gardner & Moallef, 2015). Much of this research has focused on frontline healthcare workers and disease survivors and not enough is known about the psychological effects of epidemics on other vulnerable populations such as older adults. Moreover, the COVID-19 pandemic is unprecedented in its scale and impact as it is affecting nearly every corner of the world and all aspects of people’s daily lives. As such, previous literature on smaller-scale epidemics likely provides only a glimpse into the potential psychological impact of the current pandemic. Thus, all investigations on the impact of the COVID-19 pandemic can be considered exploratory in nature and qualitative research documenting the lived experience of individuals will be especially valuable. Based on these reasons, my research is a phenomenological inquiry exploring the lived experience of older adults living alone in the COVID-19 pandemic.
Chapter 2: Literature Review

In this chapter, I review three areas of research relevant to my research exploring the lived experience of older adults living alone in the COVID-19 pandemic. I first review extant literature on the psychosocial impact of infectious diseases, particularly focusing on literature on the 2003 SARS outbreak, an epidemic that shares many of the same features as the COVID-19 pandemic. Next, I turn to research focused on older adults living through crisis events, including infectious disease epidemics. Finally, as isolation is a key experience in this pandemic and will likely negatively impact the wellbeing of my population of interest, I review literature on the mental health impact of social isolation. I focus particularly on literature on older adults living alone. Recognizing that quarantine likely results in the experience of social isolation and to tie in the literature reviewed in the preceding sections, I end the section with a summary of literature on the psychological impact of quarantine. I end the chapter by outlining the rationale for my research methodology and the research question in consideration of the discussions of this literature review.

Psychological Impact of Infectious Diseases

Across history, infectious diseases have claimed more human lives than any other types of pathology (Morens et al., 2008). As such, Pappas et al. (2009) suggest that they have engraved a subconscious and automatic fear response in humans. Particularly, the nature of infectious diseases being invisible, transmissible and imminent causes great psychological distress. These authors outlined the wider psychosocial reactions to infectious diseases based on the time-course of an outbreak from acute, protracted to forthcoming. Understandably, acute outbreaks, such as the severe acute respiratory syndrome (SARS) outbreak in 2003, elicit the strongest reactions including fear, denial and frustration. Stigma against certain groups also often accompanies
public fear during acute outbreaks (Person et al., 2004). Pappas et al. (2009) cited AIDS as an example of an infectious disease with a protracted outbreak and pointed out that the AIDS pandemic was marked by stigmatization and discrimination against a targeted group. Finally, for forthcoming or anticipated epidemics such as the mad cow disease (bovine spongiform encephalopathy), the authors highlighted examples where the mass media contributed to sensationalization or misinformation and stoked fear and irrational behaviour among the public.

Given that the COVID-19 pandemic is an acute outbreak that shares many of the same features as the 2003 SARS outbreak (e.g., in terms of transmission and containment measure), below I summarize the small literature on the psychological impact of the SARS outbreak.

**SARS Outbreak and Healthcare Workers**

Most of the literature that examined the psychological impact of the 2003 SARS outbreak focused on healthcare workers and SARS survivors. Studies that surveyed frontline healthcare workers during the outbreak consistently reported high levels of psychological distress across all of the affected countries (Nickell et al., 2004; Sim, & Chua, 2004; Tam et al., 2004). Some of the factors associated with higher psychological distress included being a nurse, exposure to SARS patients, job-related stress, perception of personal vulnerability, and perceived stigmatization (Maunder, 2004; Tam et al., 2004). A few studies examined the longer-term psychological impact of the SARS outbreak on frontline healthcare workers and found that they experienced sustained distress. Maunder et al. (2006) found that healthcare workers at hospitals that treated SARS patients in the Toronto region reported significantly higher levels of burnout, psychological distress, and posttraumatic stress compared with a control group of healthcare workers 13-26 months after the outbreak. Wu et al. (2009) surveyed healthcare workers at a hospital in Beijing 3 years after the SARS outbreak and found that 10% had experienced high
levels of posttraumatic stress during the 3-year period following the outbreak. They found that SARS-related risk exposure and risk perception positively related to posttraumatic stress and altruistic acceptance of risks negatively related to posttraumatic stress.

**SARS Outbreak and Survivors**

Gardner and Moallef (2015) conducted a systematic review of literature on the psychological impact of SARS on survivors. They found that the documented psychological impact varied over time post-infection. Most of the cited psychological impacts were present from the Acute stage of recovery (up to 1 month post-infection), including fear for survival, fear of infecting others, emotional distress, reduced quality of life, and perceived stigmatization. Psychotic symptomatology was also documented but was a unique factor for the Acute stage. Fear for survival and fear of infecting others persisted until the Early recovery stage up to 6 months post-infection, and the remainder of the factors cited above persisted into the Later recovery stage for as long as 51 months post-infection. Finally, posttraumatic stress was the single factor with a later onset from the Early recovery stage and it lasted into the Later recovery stage. Studies examining longer-term psychological adjustment and resilience in SARS survivors have found social support to be an important factor associated with better adjustment (Bonanno et al., 2009; Mak et al., 2009). Appraisal of coping efficacy and post-traumatic growth (‘personal growth’ and ‘relationship growth’) have also been found to relate to better adjustment (Cheng et al., 2006).

It is clear from the above that the psychological impacts of infectious disease outbreaks for those with the most direct exposure to the disease, frontline healthcare workers and survivors, are serious and long-lasting. In the next section, I review relevant literature focused on older adults. Because only a handful of empirical studies have examined the psychological impact of
infectious disease epidemics specifically on older adults, I begin with the broader literature on the psychological impact of disasters on older adults then come back to the small literature focused on infectious diseases (SARS in particular) and older adults.

Older Adults Living Through Crisis Events

There is debate within psychological disaster research as to whether older adults are more vulnerable or resilient to the adverse mental health outcomes following a disaster compared with younger adults (Parker et al., 2016). In a review of empirical psychological disaster literature from 1981 to 2001, Norris et al. (2002) found that the majority of the relevant studies (14 out of 16) reported that age in adulthood was protective against the negative psychological impact post-disaster. By contrast, in Parker et al. (2016)'s more recent meta-analysis which included literature up to 2014, the authors reported a meta-analytic effect (based on 5 studies) that older adults were 2.11 times more likely to report PTSD symptoms than younger adults. However, they did not find the same effect for outcomes related to depression and anxiety in their review.

Various explanations have been proffered for these different findings. Prior experience and maturity are most often cited as explanations for the observation of post-disaster resilience in older age. For example, Norris and Murrell (1988) found that during a severe flood in Kentucky, older adults with no prior flood experience reported more severe anxiety symptoms than those who had prior experience, providing support for an ‘inoculation hypothesis’. In qualitative studies, older adults also often make reference to previous experiences with disasters or other challenging events as a source of resilience (Brooke & Miller, 2017; Ta odby & Stephens, 2012). To explain the observation of older adult vulnerability to psychological morbidity post-disaster, some suggest that this may be related to greater risk exposure in a disaster as many older adults...
have to contend with pre-existing health conditions that pose further dangers in evacuations or relocations (Gibson et al., 2018). Some have also reported an under-utilization of available mental health resources by older adults compared with their younger adult counterparts post-disaster (Jia et al., 2010; Ticehurst et al., 1996).

While there doesn’t seem to be a consensus as yet on whether older age is a protective or risk factor for adverse mental health outcomes post-disaster, some have pointed out that the different nature of natural and human-caused disasters (e.g., 9-11) may explain some of the observed differences (Norris et al., 2002). Further, researchers call for attention to confounding factors such as gender, prior trauma, bereavement, and disability in this literature (Parker et al., 2016) and more refined examinations based on different age groups (e.g., young-old, old-old, oldest old) within the older population (Gibson et al., 2018).

**Older Adults and Infectious Diseases**

As mentioned, literature on the psychological impact of infectious disease epidemics typically focus on healthcare workers or survivors. Here I summarize the handful of empirical studies that have examined the psychological consequences of the SARS outbreak on older adults.

Lee et al. (2006) sampled non-SARS affected (i.e., without family or friends who contracted or recovered from SARS) middle-aged adults and older adults 2 months after the SARS outbreak in Hong Kong. They found that older adults scored significantly higher on a scale measuring posttraumatic stress disorder (PTSD) symptomatology compared with their middle-aged counterparts. The older adult group also had a significantly higher prevalence of probable PTSD compared with the middle-aged group. Cheung et al. (2008) examined the impact of the SARS outbreak on suicides in older adults in Hong Kong. Using data from 1993-
2004, they found a spike in completed suicides among older adults in 2003, particularly in April 2003, the peak of the outbreak in Hong Kong. They further investigated possible risk factors for older adult suicide during the SARS period using the Coroner’s death reports and found that severity of existing illness, level of dependency, and worrying about having SARS to be greater in those who died by suicide during the period of the outbreak than those who died in the periods before and after the outbreak. In a follow-up study, Yip et al. (2010) examined suicide notes and reports of family members of older adults who died by suicide in 2003 in Hong Kong and identified 22 SARS-related suicide deaths. They conducted both a qualitative case study and a quantitative analysis of the identified SARS-related older adult suicide cases to explore possible risk factors for suicide. Results from both analyses showed that disconnection (i.e., isolation from usual social networks) and fear of contracting SARS were prominent factors in the SARS-related suicide cases.

In addition to the empirical literature summarized above, Chiu et al. (2003) noted a resurgence of ageism and stigmatizing attitudes towards the elderly in Hong Kong during the SARS outbreak and highlighted the possible negative effects this may have on older adults’ self-image, sense of belongingness, and help-seeking behaviour. Within the context of the COVID-19 pandemic, Ayalon (2020) also described the ageism and intergenerational tension inherent in the messaging of certain governments. The author cautions against the framing of older adults as automatically vulnerable and dependent and notes the possible negative impact ageist attitudes may have on older adults’ wellbeing.

Extant literature on the grave psychological impacts of the SARS outbreak on older adults provides a compelling rationale for paying attention to this population during the current COVID-19 pandemic. However, psychological disaster literature that has documented both the
vulnerability and resilience associated with older age during a crisis is a good reminder to be more nuanced in examining the psychological impacts of the current pandemic on this population and to refrain from the ageist assumption of universal vulnerability.

**Social Isolation and Health**

There is a substantial body of research documenting the detrimental physical and mental health outcomes associated with social isolation and loneliness including cardiovascular disease (Cacioppo et al., 2002), impaired immune function (Pressman et al., 2005), depressive symptoms (Cacioppo et al., 2006), alcoholism (Åkerlind & Hörnquist, 1992), and early mortality (Holt-Lunstad et al., 2015). Much of this research has focused on the older adult population (Hawkley & Capitanio, 2015), and this subset of the research will be reviewed below. Before turning attention to this research, it may be useful to examine how the concepts of social isolation, loneliness, and living alone are understood and used in literature.

**Social Isolation, Loneliness and Living Alone**

Broadly speaking, social isolation is the objective measure of one’s infrequent social contact with others while loneliness is the subjective measure of one’s perception that there are deficits in the quantity or quality of their social contact (Smith & Victor, 2019). Thus, loneliness is sometimes termed ‘perceived social isolation’ (Hawkley & Cacioppo, 2010). Some have further distinguished between emotional and social loneliness where emotional loneliness relates to a lack of intimate attachment and social loneliness relates to a lack of social circles providing a sense of belonging (Weiss, 1973). Living alone, a simple measure of household size, has been used as a proxy for social isolation and loneliness, but is increasingly recognized as related but distinct from these constructs (Perissinotto & Covinsky, 2014). Evidence suggests that the
relationship between these three constructs is complex as some individuals tend to experience them separately while others in combination (Smith & Victor, 2019).

Below I briefly review the literature on the effects of both objective social isolation and subjective social isolation (i.e., loneliness) on the health of older adults then take a more in-depth look at the literature focusing specifically on living alone in older age.

**Social Isolation and Older Adults**

Data suggest that at least 25% of American adults aged 70 and over report being lonely (Hughes et al., 2004; Wilson & Moulton, 2010) and similar prevalence estimates are observed in other parts of the world (Ong et al., 2016). Dykstra (2009) cautioned against making a blanket assumption that loneliness is an elderly issue, and demonstrated in her review that only the very old (i.e., age 80 and over) within the older adult population has a higher prevalence of loneliness compared with adults under the age of 64. De Jong Gierveld et al. (2015) examined determinants of loneliness among Canadian older adults and found marital status, subjective health, financial status, social engagement and satisfaction with social engagement to be predictive of loneliness.

Loneliness in older adults has been shown to associate with significant morbidity including depressive symptomatology, cognitive decline, impaired daily functioning, and adverse physical health (Cacioppo et al., 2014). These associations have been demonstrated in cross-sectional as well as prospective studies (Ong et al., 2016). Research on the mechanisms underlying the relationship between social isolation and loneliness and adverse health highlight the following: behavioural mechanisms such as impaired sleep and poor health behaviours; neurobiological mechanisms such as dysregulated hypothalamic-pituitary-adrenocortical (HPA) axis (i.e., the stress response system); and cognitive mechanisms such as over-sensitivity to
negative social stimuli (Hawkley, Cacioppo, 2010). The effects of these mechanisms may be more pronounced for older adults (Ong et al., 2016).

**Living Alone in Older Age**

The proportion of older adults living alone in North America and Europe increased dramatically since World War II (Tomassini et al., 2004) owing to increased life expectancy, decline in intergenerational co-residence, and increased rates of divorce and widowhood (Reher & Requena, 2018; Ruggles, 2007). This increase has stabilized in recent years (Tomassini et al., 2004) yet with the trend of population ageing, the number of older adults living alone continues to grow. In Canada, the number of persons living alone more than doubled from 1981 to 2016, and over 25% of older adults aged 65 or older live alone as of the 2016 census (Statistics Canada, 2019).

The living arrangements of older adults are influenced by a myriad of factors including personal preferences, available financial and social resources, and constraints such as health decline (United Nations, 2019). Societal factors also play a role including norms around family systems and the availability of public support systems for the ageing such as pension and healthcare (Reher & Requena, 2018). In Reher and Requena’s (2018) analysis of data from over 60 countries around the world, they found that the odds of older adults living alone increases with the level of development across countries as well as the level of education within countries. These results suggest that living alone in older adulthood may be indicative of the wealth and public support systems afforded in more developed countries. The results may also indicate that living alone could be a personal preference for some. Indeed, in one of the few qualitative examinations of social isolation in older adults, a portion of the participants reported seeking and enjoying the solitude and personal agency gained from living alone (Finlay & Kobayashi, 2018).
Further, the preference to live alone could be due to the attachment to one’s home and the surrounding community, a preference to ‘age in place’ (Wiles et al., 2012).

As noted above, living alone is not synonymous with either objective or subjective social isolation. Zebhauser et al. (2015) examined factors that protect against loneliness in older adults who live alone. They found that having a stable social network and the absence of depression are strong protective factors against loneliness for older adults living alone while factors such as income and physical health had no impact. Some further suggest that cultural norms may play a role in whether older adults living alone report loneliness (Jylhä & Jokela, 1990). For example, it is well-documented that loneliness is less prevalent among older adults in Northern Europe than in Southern Europe even though solitary living is much more common in Northern Europe and some attribute this to cultural norms and discourses that portray living alone as commonplace in Northern Europe (Sundstrom et al., 2009).

In terms of impact on health, Holt-Lunstad and colleague’s (2015) meta-analysis of 70 prospective studies found that social isolation, loneliness and living alone each independently predicted early mortality, providing evidence that living alone in itself confers health risks. Stone et al. (2013) conducted a more fine-grained investigation focused on the transition to living alone. They examined whether the transition to living alone in older adulthood impacts subsequent mental health and whether this impact is different from that for those who consistently live alone. Using 6 years of longitudinal data from the British Household Panel Survey, they found that for older adults who experienced a transition from partnered to living alone, their odds for meeting the cut-off for psychological distress on the General Health Questionnaire (GHQ-12) increased dramatically the year following the transition; the odds returned to baseline levels 2 years after the transition. For participants who consistently lived
alone, there was no increased risk for psychological distress. The authors concluded that the transition to living alone has a strong but transient psychological impact on older adults, but consistently living alone does not.

The discussions in this section thus far outline a clear link between social isolation (both objective and subjective) and adverse physical and mental health outcomes in older adults. What seems less conclusive is whether the status of living alone in older adulthood confers the same risks. It seems that the level of choice in the living arrangement, cultural norms, and existing health and social resources may all play a role in whether solitary living in older adulthood is a risk factor for adverse health.

While it is acknowledged that being in quarantine is a temporary experience different from the more chronic experiences of social isolation described above, I summarize literature on the mental health effects of quarantine to end this section as increased social isolation is likely during quarantine. This also allows for a level of integration of the literature reviewed in the previous sections as this literature speaks to the experience of being in an epidemic coupled with experiences of social isolation.

**Quarantine and Mental Health**

Brooks et al. (2020) conducted a rapid review of literature on the psychological impact of quarantine. The majority of the 24 studies included in the review were quantitative studies on the effects of quarantine during the 2003 SARS outbreak with both healthcare workers and community residents subject to quarantine. Post-traumatic stress symptoms were the most commonly reported negative impact and others included feelings of anger and depression. A few studies documented longer-term effects including depression and alcohol dependency symptoms. Many research participants were also found to continue to engage in avoidance behaviours
weeks after the quarantine (e.g., avoiding those who appear to be sick or crowded places). The authors summarized stressors during quarantine to be: quarantine duration; fears of infection (of self and others); frustration and sense of isolation; inadequate supplies; and inadequate information. They also noted finances and stigma as main stressors post quarantine.

Cava et al.’s (2005) qualitative examination of the 21 individuals subjected to home quarantine during the 2003 SARS outbreak in Toronto documented prominent experiences of uncertainty, isolation, and coping before, during and after quarantine. Uncertainty was felt throughout and primarily related to the fear and concern over personal and family members’ health. The experience of isolation was particularly prominent during quarantine and participants reported feeling a strong sense of segregation from others and in some cases feelings of rejection and being blamed. Coping was another salient experience during quarantine with participants reporting instrumental and emotional support from family and friends, self-reliance, and credible information from health authorities or media as supportive. Consistent with the quantitative findings described above, many participants reported continued vigilance after quarantine and delays of many months before returning to normalcy.

Summary

The literature summarized in this chapter provide clear evidence for the adverse mental psychological impact of infectious disease epidemics and social isolation for older adults. It is important to keep in mind that this literature is largely quantitative some of which large epidemiological studies that are unable to provide nuanced examinations of experiences outside of pre-determined measures or ones that appropriately account for the diversity that exists within the older adult population. Thus, qualitative examinations of both older adults’ experiences of infectious disease epidemics and social isolation can likely add much depth to extant literature.
As well, given the findings from psychological disasters literature on the resilience associated with older age and the call to refrain from the assumption of universal vulnerability associated with older age in the context of the current pandemic, focus on both the negative impact of the pandemic on older adults and their resilience in confronting the pandemic would be important.

**Rationale for Research Methodology and Research Question**

As stated in the first chapter, my research is a phenomenological inquiry exploring the lived experience of older adults living alone in the COVID-19 pandemic. Discussions in this chapter highlight possible experiences of vulnerability, (dis)connection, and resilience in my population of interest during this pandemic. However, staying true to the ‘phenomenological attitude’ committed to openness (Finlay, 2008), I bracketed this knowledge in the course of my inquiry (this is elaborated upon in the next chapter). Nevertheless, the wide range of possible experiences highlighted in literature provides sound rationale for pursuing qualitative inquiry on this topic. The unprecedented nature of the COVID-19 pandemic and the paucity of corresponding literature on lived experience in similar events further point to the need for a phenomenological inquiry.

Consistent with my chosen research methodology and the exploratory nature of this study, I frame my research question in a general and open manner: What is the lived experience of older adults living alone in the COVID-19 pandemic?
Chapter 3: Method

In this chapter, I first describe the development of my phenomenological inquiry including a discussion of the philosophical foundation in hermeneutic phenomenology. Second, I describe the research procedure, including data collection and analysis procedures. Lastly, I address the issues of researcher reflexivity, trustworthiness, and ethical considerations.

Developing a Phenomenological Inquiry

Vagle (2018) contends that phenomenology is not only a philosophy or research methodology but “a way of being, becoming, living, and moving through the world”, a commitment to “be profoundly present in our living… to slow down in order to open up.” (p. xii)

I was prompted to embark on this research from my phenomenological ‘moving through the world’ in the COVID-19 pandemic. In the face of this unprecedented event, I felt a deep sense of grief for the loss of everything I knew as normal. However, I also felt a great sense of relief from being able to distance myself somewhat from the slew of expectations that were part of my normal. I wondered how others’ phenomenological encounters with the pandemic are like, whether they are also marked by contrasts. This was how I came to the conception of this research.

van Manen (2016) suggests that one’s personal life experience could be a useful starting point for phenomenological research. In my case, my lived experience in the pandemic certainly piqued my curiosity for this inquiry. My attending to my own experiences in the pandemic has also been helpful in ‘orienting’ myself to the phenomenon of my research.

The Phenomenon

In phenomenology, “phenomena are the ways in which we find ourselves being in relation to the world through our day-to-day living” (Vagle, 2018, p. 20). That relationality
between ourselves and the world, or what Husserl refers to as intentionality, is the very fabric that makes up phenomenon, and it is in within the ‘intentional in-between’ where living and experience take place (Vagle, 2018).

As described above, it was my own intentional relating to the COVID-19 pandemic that spurred my curiosity about how others were doing the same. For this research, I decided to focus on the specific population of older adults living alone, but my initial phenomenon of interest—living in the pandemic—stayed the same.

**Hermeneutic Phenomenology**

Heidegger departed from Husserl’s focus on the intentional consciousness and instead focused on the “day-to-day contextualized living in and through the world” (Vagle, 2018, p. 9). Thus, focus is shifted from knowing to being (Freeman & Vagle, 2013). Further, Heidegger brought forth a hermeneutic perspective, suggesting that intentional relations are under constant interpretation. For Heidegger, “phenomena are lived out interpretively in the world, and hence the world should not be bracketed but fully engaged in the phenomenological inquiry” (Vagle, 2018, p. 9) and the historical and social context in which the philosopher (/ researcher) is embedded is emphasized (Finlay, 2008).

Heideggerian or hermeneutic phenomenology’s focus on contextualized being is especially relevant for this research as consideration of the context is crucial to fully understand the experience of my population of interest, older adults who live alone. First, the physical context in which these older adults live may be important in their subjective experience in the pandemic as they may have chosen to ‘age at home’ for the security it provides (Wiles et al., 2012). Thus, attending to these older adults’ embodied being in such a context is particularly important. Second, as highlighted in the previous chapter, ageist attitudes and discourses are
particularly prominent in times of infectious disease epidemics. Older adults’ lived experiences in the pandemic must be examined in consideration of these socio-cultural influences. As well, I simply don’t believe that full bracketing of my previous knowledge and training relevant to this inquiry is possible nor desirable to achieve empathic understanding, which is in fact a goal of bracketing or reduction (Ashworth, 1996).

I noted at the end of the previous chapter that I intend to bracket the perspectives gained from the literature review in my inquiry. This may seem at odds with the hermeneutic stance I described here. To reconcile this, I adopt what Finlay (2008) proposes as the ‘phenomenological psychological attitude’ where the researcher is in a constant dialectical dance “between bracketing pre-understandings and exploiting them as a source of insight” through critical reflexivity; always keeping in mind the aim of the phenomenological attitude “to see through fresh eyes, to understand through embracing new modes of being” (p. 13). For my research, this means maintaining reflexivity throughout the entire process of the inquiry and being cognizant of the role that I (and everything that constitute who I am) play in the co-construction of meaning with my participants, particularly during data collection and analysis.

To guide my research design, I drew on van Manen’s (2016) approach to hermeneutic phenomenological research. Below I outline the specific procedure I implemented.

**Procedure**

*Recruitment and Eligibility Criteria*

Approval was obtained from the University of British Columbia Behavioural Research Ethics Board before recruitment began. Purposive sampling was conducted through a local community seniors’ organization with a large membership base of older adults living alone as well as through personal contacts who have access to the study’s population of interest.
Prospective participants were provided with the study poster (Appendix A) and invited to email myself as the primary researcher, if interested in participation.

**Inclusion Criteria.** Participants must meet the following inclusion criteria to be included in the study:

1. An older adult aged 65 or over;
2. Living alone for 5 years or more;
3. Self-identify as being retired;
4. Willing and able to participate in the study either online or over the phone;
5. Fluent in English;
6. Access to email

**Exclusion Criteria.** Given previous literature highlighting disease exposure as a factor affecting mental health outcomes in an infectious disease outbreak, participants with direct exposure to COVID-19 would be excluded from the study. The specific exclusion criteria were as follows:

1. Have personally contracted or recovered from COVID-19;
2. Have family members who have contracted or recovered from COVID-19;
3. Have close friends who have contracted or recovered from COVID-19

**Telephone Screening and Informed Consent**

Thirteen prospective participants contacted me by email and were screened over the phone (see Appendix B for protocol) for eligibility to participate based on the above inclusion and exclusion criteria. One of the prospective participants screened was excluded for having lived alone for less than 5 years. Once eligibility has been determined and the participant expressed continued interest to proceed, I verbally reviewed the consent form (Appendix C) with
the participant on the phone and addressed any pertinent questions. An electronic consent form was sent by email to the participant following the telephone screening and the participant was asked to reply in writing through email indicating consent. The participant was also reminded of their right to withdraw consent after reviewing the sent consent form. At the end of the phone call, a tentative date for the initial interview was set up and I confirmed the participant’s preference to conduct the interview over the phone or online using Zoom. The 12 included participants all indicated consent to participate by email and made up the final sample (sample characteristics will be described in the next chapter).

**Data Collection**

**Initial Interview.** The primary researcher contacted the participant at the agreed time for the initial interview by phone or via Zoom based on the participant’s indicated preference. Before the interview began, consent was re-visited and I went through a short demographics form (Appendix D). The interview was audio-recorded for transcription and permission was obtained from the participant before audio-recording began. During the interview, I attended to the participant’s comfort level communicating using the particular remote medium and openly discussed with the participant if discomfort was observed.

The initial interviews took place between mid-July 2020 to early August 2020. The length of the initial interviews ranged from 46 to 81 minutes ($M = 61$ minutes). The interviews were largely unstructured. I opened the interviews with an explanation that the interview will be an open-ended conversation rather than a structured interview and that the focus will be the participant’s experience in the pandemic. To ensure that the conversation stay focused on the phenomenon in order to gather “lived experience descriptions” (van Manen, 2017), a set of guiding questions were prepared (see Appendix E) including: “Think about your life before the
pandemic. How have things changed?”; “Can you describe an experience yesterday that is
typical of your life during the pandemic?”; “How did you feel when you first heard about the
pandemic?”; “Can you describe the most vivid experience you had in the pandemic?” To elicit
less cognitive description of the experience, some participants were also asked to describe their
experience in the pandemic using an image. In all of the interviews, at least some of these
questions were asked. I followed up on participant responses with prompts such as: “Can you say
more about that?” or “Can you give me an example?”

I adopted the more open-ended format because I believe that it is precisely during the
interview that bracketing is most crucial to be able to embody the phenomenological attitude of
openness toward the participants’ subjective experience and “allow deeper, varied meanings to
emerge” (Finlay, 2008, p. 12). Participants were prompted to be concrete and to share “a specific
instance, situation, person, or event” (Van Manen, 2016, p. 67) through open-ended questions
and I was responsive to whatever emerged while keeping in mind the phenomenon under
investigation (Vagle, 2018). Murray and Holmes (2014) called to attend to what transpires in the
intersubjective context of the interview noting “the significance of gestures, lacunae, hesitations,
word choice, and figure of speech (tropes) such as metaphor, metonymy, and catachresis—the
misuse of terms” (p. 23). These were noted during the transcription and analysis. Murray and
Holmes’s urging to attend to participants’ assumed position within the intersubjective context
was particularly relevant for this research given my relative unfamiliarity with the older adult
population. I was attentive to the dynamic during the interview and critically reflected on this
after the interview in the research journal I kept throughout the research process.

**Second Interview.** A follow-up interview was conducted which was a ‘hermeneutic
interview’ where the participant reviewed and reflected on the findings from the initial analysis
of their first interview with the researcher and became a co-researcher (van Manen, 2016). Given that the pandemic situation in the province worsened considerably since the first interview, I decided, in consultation with my research supervisor, to add a question asking about any changes the participant may have experienced since the first interview. Participants received an initial analysis document containing themes and sub-themes gleaned from their first interview by email before the second interview and this formed the basis of the discussion. Participants were asked whether the themes were reflective of their experience, what was surprising, what they would like to add, and which themes they saw as core to their experience. All 12 participants were invited to participate in the second interview by email and 10 participated in the interview. The length of the second interviews ranged from 18 minutes to 43 minutes ($M = 33$ minutes). The second interviews were conducted from end of October 2020 to early February 2021. The interviews were audio recorded.

**Data Analysis**

The data analysis procedure was largely guided by the thematic analysis process outlined by van Manen (2016). He describes phenomenological themes as “the structures of experience” and notes that rather than a rule-bound process, thematic analysis is more “a process of insightful invention, discovery or disclosure” (p. 79). However, he does offer 3 approaches to the analysis: “(1) the wholistic or sententious approach; (2) the selective or highlighting approach; (3) the detailed or line-by-line approach” (p. 92-93). I adopted these approaches in the analysis procedure, which was implemented specifically as follows:

**Transcription and Initial Readings**

The bulk of the 12 first interviews (10 out of 12) were transcribed by a professional transcriptionist verbatim (I completed the remaining 2). For each interview, I listened to the
interview audio at least once while reading the transcript. As the transcriptionist did not note
linguistic features of the interviews, I noted these (particularly pauses and emphasis in speech)
on the transcript while listening to the audio. I then read the transcript at least once again and
applied van Manen’s (2) selective approach, highlighting the statements that seemed essential to
the phenomenon.

**Wholistic Reading and Summary**

Following the initial readings, I read the highlighted transcript again while applying van
Manen’s (1) wholistic approach, attending to the transcript as a whole and summarized “the
fundamental meaning... of the text as a whole” in a few sentences (p. 93).

**Line-by-Line Coding**

I then transferred the transcript in Word to an Excel file, breaking the transcript line-by-
line or into sentence clusters relevant to the phenomenon and entered these segments into one
column. Each segment was then coded using a short phrase in a process similar to the (3)
detailed approach described by van Manen.

**Identifying Initial Themes**

Once line-by-line coding was complete, I read over the codes and began to categorize
them and formulate initial themes. I referred back to the wholistic summary at this stage to guide
the formulation of the themes. In this way, the analysis was in line with the “whole-parts-whole
process” typical of phenomenological analysis (Vagle, 2018, p. 110). I used Microsoft Excel to
aid this process and presented an Excel sheet containing initial themes along with supporting
codes (see Appendix F for an example) to participants during the second interview. Immediately
following the second interview, I noted down any prominent discussion points. I reviewed the
audio of the second interview as well and the revised the initial themes based on participant feedback where necessary.

After the analysis was completed for the first participant, I sent the line-by-line coding as well as the initial themes sheet to my research supervisor and he provided feedback on the process and the analysis. During the process of the initial analysis, two research assistants also reviewed a set of transcript and analysis each. They largely indicated consensus with my analysis but also provided additional comments that were incorporated into the analysis.

**Identifying Core Themes**

Once the above analysis process has been completed for all participant conversations, a cross-participant analysis was done to identify core themes that point to the essential *structures of experience* that characterize the phenomenon.

To do so, I mapped out all of the initial themes identified using a mind mapping software (see Appendix G for a portion of the mind map). Once the initial mapping was completed, I used NVivo to conduct a textual analysis (i.e., word frequency and word tree) of all of the transcripts as well as each individual transcript to ensure that all pertinent themes were captured. Once the core themes were finalized, I prepared a summary sheet (see Appendix H) which was sent to all participants, 3 external reviewers working in community agencies serving older adults, and the research team for comments. All external reviewers expressed that the core themes resonate with their experience working with the study population. Additional feedback on specific sub-themes were considered and incorporated into the analysis. The writing process served as the final stage of the analysis as the extraction of participant quotes provided a chance to confirm whether specific themes reflected participant understandings. I revised a few sub-themes during this process.
Second Interview Data

As described, a decision was made to collect new data during the second interview regarding changes participants experienced from the first to the second interview. I took notes immediately following the second interview and went back to the recording subsequently and took more detailed notes. Following the completion of all second interviews and note-taking, I conducted a rough analysis categorizing the data from all of the interviews. This analysis is presented in the final section of the findings chapter.

Trustworthiness

The primary strategy I implemented to ensure the trustworthiness of this research was what Tracy (2010) terms member reflections (versus member check, which reflects more post-positivist assumptions) in the hermeneutic interview process described above. Certainly, the aim of this interview was to provide the participants “opportunities for questions, critique, feedback, affirmation, and even collaboration” (p. 844). As noted, 10 of the 12 participants participated in the second interview and their reflections and elaborations certainly enriched the analysis. Participants were also provided with the final analysis and invited to provide feedback.

Additionally, my research team which included my research supervisor and 2 research assistants provided review of the analysis both in the initial and final stages of the analysis. The 2 research assistants are fellow students in the counselling psychology program and both have clinical experience working with clients from a variety of backgrounds and have been seeing clients during the pandemic. One of the research assistants has a number of years of counselling experience with older adults and has been supporting isolated older adults through friendly phone calls during the pandemic. Consistent with the hermeneutic phenomenological perspective that guides this research, the role of the research assistants was not only to ensure “consistent (re)
interpretation” (Tracy, 2010, p. 843) but more importantly to deepen understanding through the addition of their perspectives given their unique positionalities.

As well, as described above, 3 external reviewers who work with the study population provided feedback on the final analysis. As with feedback from the participants and the research team, the comments from the external reviewers were elicited in order to achieve crystallization (Tracy, 2010) which aims for a richer rather than a single interpretation of the data.

Finally, to ensure transparency and reflexivity, I kept a research journal that documents significant activities and reflections throughout the research process. I elaborate on this practice in the section below.

**Researcher Reflexivity**

As noted earlier in this chapter, I strove to adopt Finlay’s (2008) ‘phenomenological psychological attitude’ which requires critical self-reflexivity throughout the research process. The main tool to facilitate this was a research journal in which I took note of my thoughts and feelings in relation to my phenomenon of interest both in and outside of the formal research process. I am very much living through the COVID-19 pandemic just like my participants and have been consuming much related information in the media. I welcomed reading such information, particularly the lived accounts of experiences in the pandemic as I believed that doing so allowed me to enrich my understanding of the phenomenon and maintain a “sustained engagement with the phenomenon,” so that I am able to be both “open and sensitive to the phenomenon” (Vagle, 2018, p. 72). As well, I kept abreast with the rapidly expanding literature on the psychosocial impacts of the pandemic. Of course, I documented what I gleaned from the consumption of any information pertinent to the research in the research journal to ensure
adequate bracketing. Another reflexive practice in which I engaged was consultation with my research supervisor on my reflections on the research process. Below I provide an example.

I have a strong clinical interest in promoting older adult well-being and I am a believer in strength-based approaches to well-being in general. As such, I came to this research with perhaps some romanticized notions about older adult resilience. This actually had an influence in the first few interviews I conducted. I was surprised by the extent of the vulnerability shared by my first participants and I actually steered away from the vulnerable content at times and asked direct questions on coping and resilience. Luckily, I was able to debrief these first few conversations with my supervisor and discussed this issue and ways to keep the conversation non-directive.

Ethical Considerations

The most critical ethical issue for my research was that of working with a study population that may be especially vulnerable to the psychosocial impacts of the pandemic. I addressed this issue in a number of ways. First, each participant was sent a resource sheet for low-cost counselling via email prior to the first interview. Second, during the interviews, I attended to signs of psychological distress presented by participants and checked in on those who appeared to be distressed. Third, I asked participants to share their experience of the interview at the end of the first interview to ensure that any distress they may have experienced during the interview was fully debriefed. Finally, consent was re-visited at each interview and participants were reminded that they have the option to withdraw from the study at any point without explanation should they find the involvement to be overly distressing.
Chapter 4: Findings

This study explored the central research question: What is the lived experience of older adults living alone in the COVID-19 pandemic? The aim was to capture the phenomenological lived meaning of this experience, one that is pre-reflective and atheoretic (van Manen, 2017). In this chapter, I present the findings from this exploration based on thematic analysis conducted in accordance with the process described in the previous chapter guided by van Manen’s (2016) approach to hermeneutic phenomenological research.

In the sections that follow, I first briefly describe the characteristics of the participants that comprised the sample. Next, I outline the research context to situate the findings. I then present a summary of the core themes that emerged from the analysis. These core themes together characterize the essential meanings of the phenomenon of this inquiry, living in the COVID-19 pandemic for older adults living alone. Finally, the bulk of this chapter will be a detailed elaboration of the core themes and their associated sub-themes using material from participant interviews, including quotations.

As well, where appropriate, I will make use of poetic transcription (Glesne, 1997), poetry that I created with data coded under a theme that most poignantly express its meaning. I created the poems solely using participants’ words and with minimal alterations to their original utterances. The occasional alternations I made were the adding or dropping of word endings such as “-ing” or “-s.” I used this form of representation to better convey “the pathic or non-cognitive dimension” (van Manen, 2019, p. 919) of the phenomenological understanding gleaned from this research.
Sample Characteristics

The sample consisted of 12 retired older adults living in British Columbia (BC), Canada. All participants were female, and all reported their ethnicity as White. All participants reported being financially stable in their retirement life. Participants were aged between 68 to 85 ($M = 74$). All participants reported having lived alone for 10 years or more, ranging from 10 to 41 years ($M = 21$). All participants reported having completed high school education or above, including 3 with a bachelor’s degree and 7 with a master’s degree. The majority of the participants (10 out of 12) live in BC’s largest urban centre. Participants reported varying amounts of social interactions with friends and family the week prior to the first interview with in-person interactions ranging from 0 to 14 times ($M = 4$) and virtual interactions ranging from 0 to 21 times ($M = 5$) during the week.

Some variation existed in the sample that was revealed during the first interviews. One participant reported living with a pre-existing physical disability and two noted living with pre-existing mental health conditions. Three participants described having gone through a recent transition (moving and ending of relationship).

Given phenomenology’s focus on the phenomenon rather than the individual, I will not characterize participants as individual cases. In the results section below, I will indicate participant numbers (P1 to P12) following quotations and poetic transcriptions to demonstrate the breadth of the represented data.

Research Context

Data collection began in mid-July 2020, approximately 4 months after the declaration of a public health emergency by the provincial government of BC. The province entered Phase 3 of its Restart Plan several weeks prior to this on June 24, 2020. This phase marked the beginning of
wider-scale easing of pandemic restrictions for individuals and businesses and some refer to this phase as the re-opening. Data collection for this round was completed in early August 2020.

It is important to highlight that given this research context, the findings presented below are reflective of participants’ experience in the initial 4 months of the pandemic and the phenomenon was captured at the point in time when restrictions were beginning to ease.

**Results: Five Core Themes**

*Summary of the Core Themes*

Five core themes emerged from the analysis to characterize the essential meanings of the lived experience of older adults living alone in the COVID-19 pandemic: 1) Confronting a mysterious threat; 2) Shrinking existence; 3) Navigating a new world; 4) Recognizing older adult identity in society; and 5) Adjusting to the new normal. These core themes address different dimensions of participants’ lived experience in the pandemic, specifically how participants related to different aspects of the pandemic, including: the virus and the pandemic; their lives and selfhood; the external world and the new normal; and the society, especially the younger generation. The numbering of the themes conveys a broad chronological order. However, I do not intend to imply that there was a linear progression of the themes. Indeed, all core themes were relevant and salient in the initial 4 months of the pandemic, and many interacted with one another. For example, the fear and vulnerability described in theme 1 were certainly present in theme 3 as they shaped how participants engaged with the world.

Table 4.1 below summarizes the 5 core themes with their associated sub-themes and provides an overall view of these different parts that worked in concert to shape the whole of the phenomenon. I delve further into each of the core themes in the sections that follow.
Table 4.1 Summary of the 5 Core Themes

<table>
<thead>
<tr>
<th>Core Themes</th>
<th>Sub-themes</th>
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<tbody>
<tr>
<td>1. Confronting a mysterious threat</td>
<td>Initial shock and disorientation</td>
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<td></td>
<td>Fear and anxiety</td>
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<tr>
<td></td>
<td>Powerlessness and vulnerability</td>
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<tr>
<td>2. Shrinking existence</td>
<td>Multiple losses</td>
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<td></td>
<td>Limited future</td>
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<tr>
<td></td>
<td>Home-bound life</td>
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<td></td>
<td>Isolated existence</td>
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<tr>
<td>3. Navigating a new world</td>
<td>Engaging with a new world</td>
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<td></td>
<td>Uncertain and somber future</td>
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<td></td>
<td>Reflecting on the bigger picture</td>
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<tr>
<td>4. Recognizing older adult identity in society</td>
<td>Deepening generational divide</td>
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<td></td>
<td>Existing ageism reinforced</td>
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<td></td>
<td>Appreciating gestures of goodwill</td>
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<td>5. Adjusting to the new normal</td>
<td>Adjustment as a process</td>
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<tr>
<td></td>
<td>Factors that help and hinder adjustment</td>
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<td>Adjustment over time</td>
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Core Theme 1: Confronting a Mysterious Threat

Living in the pandemic for older adults living alone meant first and foremost confronting the threat of an unknown virus. This core theme captures the intense emotional reactions of participants at the onset of the pandemic as well as the continued insecurity and vulnerability participants expressed in the face of threat of the virus.

Initial Shock and Disorientation. Participants described disbelief and confusion over what seemed like a sudden emergence of the virus and the pandemic: “I felt quite shocked, and puzzled, like “Really? Where did this come from?”… “How did this happen?”… and wondering how something this terrible could just, boom, suddenly come upon us” (P5). One participant likened the pandemic to a hurricane: “[It] rolls, rolls in, suddenly, destroys everything, and then gets the hell out, eventually” (P4). Participants also expressed shock at the imposition of the lockdown and how things unfolded at the onset of the pandemic: “It was quite shocking, and I
didn’t know in the beginning, I didn’t know when it first started, ah, how severe the lockdown would be … or how hard hit our area would be” (P9).

With the lockdown participants’ lives came to an abrupt halt: “when the shutdown happened, of course all that [outside activities] just suddenly ended. Especially with seniors, right, there was no, nothing…” (P7). This left participants feeling “unmoored” and “adrift.” One participant described how the sudden loss of activities affected her perception of time: “my sense of time was completely out of whack, because I had nothing to anchor my days” (P6). In response to these unexpected changes, some participants spent the early days of the pandemic frantically busying themselves at home: “I got very busy doing a lot of cleaning up in my place, you know, emptying drawers and throwing out things and so for the first two weeks I just worked, worked, worked on my own little apartment” (P2). This seemed like a way for participants to cope, “to do something”, in the face of the upheaval caused by the pandemic:

That’s why I did all that busy work. I think I became a little frantic or hyper… it was almost like I was really stressed out and thought I had to do something. I mean… I would never have thought that I would have to live through a pandemic like this. (P2)

**Fear and Anxiety.** In addition to the shock and distress at the onset of the pandemic, fear figured prominently in the experience of participants as they confronted a “mysterious” and “ethereal” virus: “I knew it was a bad thing right away… all of my internal alarms went off, and I knew it was going to be horrible… Fear, I was afraid because I just knew it was going to be bad” (P1). The unknowns associated the virus in the initial stages exacerbated the fear: “I, it was full of fear… we didn’t know anything, really. Remember, like, washing down your food… and, oh, you can’t touch the cardboard for 24hrs, and all this kind of stuff” (P6). The fear and anxiety over contracting the disease were especially prominent when participants had to go outside of
their homes: “it was terrifying to go to the grocery store” (P11). Participants also felt anxious in crowded situations and reported an “apprehension about going out in the midst of other people” (P2). This anxiety made it more difficult to navigate their daily lives. For example, a participant described how the insecurity she felt in crowds made it challenging to take public transit:

Well, it’s that feeling. Too many people are getting on the bus, so you feel insecure, you get off. You’re on the train, and you see… too many people without masks, you feel insecure. [If] you stay on the bus, it makes you feel insecure. (P4)

Age also seemed to play a role in amplifying participants’ fear and anxiety. First, the dire conditions in long-term care which was widely reported early in the pandemic prompted participants to reflect on a gloomy possible future for themselves:

We who are still living independently… in my own case… I’m hoping I’ll be one of the people that doesn’t need long term care, but you know that that’s one of the possibilities. So … what you’re seeing as this very scary future that might include the possibility of being in… a group living situation where you need care, and where infections are possibly rampant and deadly… it’s a very scary prospect. (P9)

As well, many participants spoke about examples of their older adult peers who were particularly afraid, highlighting an atmosphere of fear among their peers: “[He] sterilises things that haven’t left the house… and he [is] just, afraid of everything, and he’s afraid to leave the house. So, it depends on the person, but I think we’re all afraid” (P4).

In addition to fears over their own health, participants described concerns they had for the wellbeing of their family: “with the pandemic there is another huge anxiety because you’re afraid for your children, your grandchildren” (P2). They expressed concern for family living in the United States and working on the frontlines as well as grandchildren returning back to school. As
well, they described concerns they had for the stress that family members were experiencing in
the pandemic and the impact this may have longer-term:

He’s [grandson] so concerned with this… He’s 9, and he already knew that kind of chain
of necessary… information. I was blown away that he knew that much. So that concerns
me that little kids are… it’s like living through a war or something, it’s going to have…
life-long negative impacts on children’s perception of safety. (P12)

Over time, the acute fear participants experienced at the onset of the pandemic evolved
with increased familiarity with the pandemic and knowledge about the virus: “because it was
new… it was a lot more fearful than now” (P6). However, a constant underlying stress persisted:
“there’s always a little bit of stress, I can feel it, um, you know, just body tension” (P7).

**Powerlessness and Vulnerability.** There was also a sense of powerlessness that
participants felt in the face of the pandemic they saw as an “insurmountable mountain” (P7). The
participant who likened the pandemic to a hurricane explained the futility she saw: “You know, a
hurricane, there’s nothing you can do, it’s just, you know, it’s going to do the destructive thing,
no matter what you do” (P4). The sense of helplessness and vulnerability is even more
pronounced for those with pre-existing conditions. A participant with a physical disability
described feeling lost and helpless, having little sense of direction and control over her situation
in the pandemic:

Lost at Sea

I feel very lost at sea.  
Bobbing around,  
not knowing what to do next.  
I am not accustomed to that feeling.

Reaching out,  
waiting to be saved.  
Nobody else can save me,
but I don’t know what to do to save myself. 
(P1)

**Core Theme 2: Shrinking Existence**

Living in the pandemic for older adults living alone is characterized by a shrinking of the different dimensions of their existence. This core theme captures participants’ diminishing sense of selfhood, temporality, spatiality, and relationality in the pandemic.

**Multiple losses.** For older adults living alone, living in the pandemic is marked by losses. The loss of significant aspects of their lives contributes to a shrinking sense of self.

**Loss of Activity and Community.** Most participants described the loss of regular activities in which they participated outside the home, such as choirs, group exercise, going to the concert, or volunteering. For older adults living alone, these activities mean much more than hobbies. They provide a sense of community, belonging, and engagement with the world: “everything you did outside the house… they’re supports that hold you up.” (P4). Participants underscored the social aspects of these activities: “the pool was very social too, because we’re all the same people… going all the time, and the same instructors, so, you know, it was a very jovial thing” (P5). As the participant poignantly expressed in the poetic transcription below, engaging in activities also allowed her to “be seen”, to “be witnessed”:

Disappearing

It’s hard to describe 
but I had the feeling of…
disappearing

I’ve disappeared from activities 
where I was witnessed and seen
Going and being a presence there 
you can’t do that anymore

Tremendous loss
Things that constituted my identity
My ability to be in community
to be involved and engaged

It probably sounds kind of strange
but it’s a feeling of…
disappearing (P11)

**Loss of Structure.** The loss of outside activities also meant a loss of structure and routine. Many participants reported having had significant activities that they structured their days around before the pandemic:

I’m a huge fan of the library, and I would be in the library almost every day… check the emails, do, search whatever I had… I would go to events there, and I borrowed DVDs there, and so, so it was a huge part of my life” (P8)

Losing such activities in the pandemic meant losing the rhythm to their lives. Participants noted the difficulty in establishing new routines at home without external accountability and motivations such as peers’ company or a sense of engagement with the world:

I couldn’t, um, seem to get on any kind of schedule, like that just went out the window.

Because… if you’re going to meet someone to go for lunch at, you know, 12, you got to get up, and get dressed, and get out of the house, but… there’s no external kind of motivation [being at home]. (P12)

**Loss of Freedom to Travel.** Many participants also spoke about the significance of the loss of freedom to travel in the pandemic. Travel was an important means for older adults living alone to be connected with family, as many participants noted having close family living in other provinces or countries. Travel also appeared to be an important aspect of older adults’ lifestyle; many participants lamented over trips that had to be cancelled due to the pandemic for which they had been planning for months. Further, the ability to freely travel represented access to a
broader world, which became severely limited in the pandemic: “my world has shrunk a lot… and I experience a lot of limits. I can’t travel, I can’t visit my family, which I’ve been doing a lot and I’ve been very connected to” (P11). Travel also afforded a sense of freedom that was taken away in the pandemic. One participant described that she felt like her “legs have been cut off” with her discomfort for air travel since the pandemic (P2). Another participant described how the loss of freedom to travel impacted her lifestyle: “the mobility… the ability to go places… the kind of… free-spirit kind of way of living that I used to choose… doesn’t work anymore” (P7).

**Loss of Identity.** As described above, the pandemic stripped away many significant aspects of the lives of older adults living alone. These losses combined lead to a sense of “disappearing,” a loss of a sense of self, as the participant described in the poetic transcription at the beginning of this sub-section. As she noted, the losses that contributed to this diminishing sense of self pertain to important activities that constituted her identity and the sense of engagement and community she derived from those activities. She also emphasized the role isolation plays in feeling a sense of disappearing, “you’re not witnessed and seen, in most of your day-to-day life,” and added that there is another layer to this experience: “the loss of physical touch… It contributes to the feeling of disappearing physically” (P11).

Another participant shared how the sense of helplessness that the pandemic engenders made it challenging to maintain her pre-pandemic sense of self: “I’ve always been a very capable person, independent, um, solved my own problems pretty well, so this is new, not knowing what to do next. And… that is a large part because of the pandemic” (P1).

**Grief and Mourning.** Amid these profound losses, participants reported feelings of grief and sadness. These emotions seemed to be in the background of participants’ experience in the
pandemic but manifested in occasional outbursts. Participants described that every so often, they would have a “weep” or “cry”:

So, it’s big, um, that sadness… every once in a while I do [feel it], like, yesterday I think it was, I did have a good cry. I don’t know why, I just felt like it… all of a sudden everything just felt really overwhelming. (P7)

I’ve mostly been okay, but there are days where it just hits you in a different way. You know, instead of carrying on and thinking “Oh, whatever, life is life”, um, it kind of hits me like, ah, “oh dear” (P5).

Another type of emotion relative to the losses was a feeling of “lack”:

This feeling of lack, there’s something missing here, there’s something not, not right here, and I feel bad. I don’t feel good, I feel, I feel bad… it wasn’t chronic, it’s not serious, um, I just noticed it. Um, yeah, I noticed that it was going on, and that it could happen very quickly… (P8).

There was also a general sense of mourning and longing for the “old normal”: “I’ll watch some things on TV and movies… You see people hugging and coming together… and you think, “Wow, we used to do that” (P11); “We can’t just pick up and go visit somebody now” (P7). The absence and deprivation of what was normal amplified the presence of the slices of the old normal that participants experienced in the re-opening. A participant described the exhilaration she felt when she visited the local garden centre for the first time after 4 months of lockdown:

I thought I was on holiday. I honestly thought I was, I thought: “Oh my God!” It was so wonderful, and the colours, and the trees, and the plants, and, and it was just so uplifting, it was an uplifting experience… it’s safe to say that as much as I enjoy going to [the store], I’ve never had that experience before. (P8)
Limited Future. Older adults living alone also experience a shrinking temporality in the pandemic, a limited sense of their personal future.

Inability to Plan. The pandemic took away both activities people can plan for and the ability to plan for the future given its unpredictability: “I look at my calendar, and there’s nothing scheduled. There is a blank page for the month, and then, you know, month after month, there’s a blank page, there’s nothing scheduled.” (P9) Without plans, there is “nothing to look forward to” and there is a loss of anticipation and expectation: “the future looks very small” (P2). Within the context of restriction in the pandemic, the kinds of possible future also seem limited: “And what future would there be even later on. Like how would we be doing any family gatherings or gatherings of friends to celebrate any occasions? It seems very bleak” (P2).

Life on Hold. Given the limited ability to plan and anticipate, participants spoke about a sense that their life is “on hold”, that time has “suspended” for them in the pandemic:

I get this image where I’m sitting in this car, and I’m in the passenger seat, looking out a window, and we’re on the highway so the car is going fast and everything is passing in a blur, right, as I look out the window, but I’m sitting still. And that’s the image I get really, so time is going fast like this but I’m sitting still because to a greater extent, my life is on hold at a time when I sure don’t want to be. (P6)

Sense of Ageing Amplified. As the participant noted above, the temporal awareness of time being on hold is related to her sense of ageing, which seemed to be amplified for participants in the pandemic: “a lot of my plans are now on hold as well, and I’m not getting any younger, and it seems like, oh, well, maybe this is never going to happen” (P7). Both the uncertainty in the pandemic and the heightened sense of ageing seemed to prompt a further sense of pessimism and finitude:
But in term of someone my age... I mean, I think I’ll be fortunate if I can go back to some of my old experiences. I despair I may not see my family again. I really do… people there say oh, you will and it will change. I don’t know, I can’t sort of see beyond that… and it feels like in my age and stage of life there are things that are kind of finite. (P11)

**Home-Bound Life.** Many older adults living alone lead a largely home-bound life for at least several months following the onset of the pandemic and experienced a shrinking spatiality.

**Safe Yet Constricted.** Participants have an acute awareness of the health risks outside of their homes and many described a sense of safety they feel at home: “this [my apartment] is a very safe place for me” (P10). At the same time, some participants described a sense of constriction and being trapped in their home-bound life:

A Bird in a Nest

I can’t fly out of the nest  
I can see what’s going on around me  
I feel relatively safe  
But I’m very isolated,  
and up a tree  

It’s not safe to fly around  
So here I am,  
in a nest,  
up a tree  
(P12)

**Forced Transition.** Participants contrasted their new home-based life with the busy life they had and lost outside their home. As noted previously, older adults living alone tended to organize their lives around activities outside of the home and the transition to a home-based life has not been easy:

I’m feeling perplexed about finding a new routine, about finding a new set of habits, because what I’m doing now isn’t really working. I know it isn’t good to turn on the
computer and spend that much time on it, you know. It’s been fun in a way… but it hasn’t, it isn’t something long term… It’s not really a healthy routine, it’s more struggling to fill the time. (P1)

Participants characterized their new home life as “quiet”, “calm”, but also “boring” and “solitary.” A participant described the monotony she felt in her home life: “every day was starting to feel like exactly the same day… That was hard… one day just bled into the next” (P12). This is also reflected in participants’ changed sense of time: “time is really odd. It is out of sync. I wake up in the morning and my first thought is, what day is it?… It was bad enough when I retired and weekend didn’t have the same importance but now…” (P6) Certainly, for participants who recently retired, they were adjusting again following the transition after retirement.

For those living with pre-existing conditions, the transition to a home-based life proved even more challenging. A participant living with chronic pain described how without the things she used to do outside of her home to distract herself from her condition, “pain is now my life” (P1).

**Lack of Motivation.** Some participants also reported a lack of motivation that made the transition to a home-based life challenging:

I found that I was doing nothing. Um, you know, it’s like all of a sudden, I didn’t even have the motivation. I still don’t, actually um, to, like, I don’t even get out in the, the yard, I don’t do any yard work, it doesn’t interest me. You know, nothing seems to motivate me to do much other than basic maintenance stuff. (P7)

Similarly, another participant described a listlessness she had been feeling at home, depicting her experience in the pandemic as a bear in hibernation:
You lie down, and you have a sleep for 6 months, or 4 months… you may not be asleep all the time, but when you’re awake, you’re kind of dozy and, you know, listless, and you don’t want to go out… I feel as if I’ve been in hibernation for a while. (P8)

The lack of motivation and energy is also reflected in the sedentary lifestyle that many participants reported in their new home-based life. Further, one participant noted the difficulty in maintaining a more active lifestyle in the pandemic being largely isolated:

I wasn’t… going out to exercise as much as I needed to, because I realise that that kind of thing is more social for me… I found it really hard to sort of get dressed and push myself out the door just to go for a solitary walk around the block. (P12)

Participants who reported more challenges in their transition to a home-based life all expressed a desire for change. Some acknowledged the changes they wanted to make, and others have taken steps to get “jump started” and “going again” from the passivity they experience in their new lifestyle at home.

**Savouring Home Life.** Finally, one participant stood out in reporting how she was savouring her calmer lifestyle at home in the pandemic and was feeling better physically as a result: “I’ve slowed down, I’m more relaxed and stuff, my body is reacting very well to that” (P10). She noted that she is “living much more in the present” in her new life and viewed her home as a refuge: “I’m happy, and I’m safe, I’m content at home” (P10). It is worth noting that like other participants, she also described a contrast between her pre-pandemic and current life. What is different is that while most other participants reported enjoying their pre-pandemic lifestyle, this participant reported having had an overly busy life marked by stress: “you’re running from one thing to the next, and I mean, I might as well, I might as well be out there
working or something. I mean… I’m retired, so I should be enjoying it” (P10). The pandemic provided her a chance to slow down and re-examine the optimal pace for her life.

**Isolated Existence.** As participants live alone, the home-bound life they led in the pandemic is also an isolated one where they experience a shrinking relationality.

**Physical Isolation and Lack of Touch.** The lockdown and physical distancing measures resulted in physical isolation and a “forced detachment” from others (P11). The heightened fear and vulnerability at the onset of the pandemic described in the previous section reinforced the physical isolation as some participants were prompted to limit contact with others to a minimum:

I didn’t go out for at least a couple of months at all, I think it was. I have all my food delivered, the only time I did go out was once every few weeks to pick up pet food, and that was it. (P1)

It was a very odd time, three months pretty much on my own, except for phone. (P12)

The physical isolation was felt poignantly in the lack of physical touch:

One of the things I miss a lot with all this isolation is, like, touch, is human touch. You know, there, um, so whether it’s just a hug, right, or somebody to snuggle against, there’s none of that, so, um, that’s been hard. (P7)

Not being able to hug my grandchildren or my daughter for a long time was, and we’re a very huggy family, and that was hard on all of us. (P5)

The absence of physical touch underscored its presence in the re-opening. Much like the participant who marveled at her visit to the local garden centre, one participant vividly described the first hug she had with her son after 7 weeks of isolation:

So the thing about people living alone is I had not been closer than 2 meters to another human being in 7 weeks, and I don’t, oh, I hadn’t been hugged or kissed by another
human being. Even the proximity of sitting together… And my son cycled over with some groceries for me… and he gave me the biggest hug, and it was an explosion of wonderful. It was like, unimaginable… and I, you know, no words… (P6)

As one participant explained, what was missed was not only the physical act of a hug but also the caring and affection shared between themselves and their loved ones conveyed in the “touches of love” (P5). To re-visit the words of the participant who spoke about feeling like she was disappearing, “the loss of physical touch… It contributes to the feeling of disappearing physically” (P11). Thus, physical touch takes on a further meaning, that of an inter-corporeal recognition without which there may be a sense that one ceases to exist.

With physical distancing measures continuing to be in place, older adults living alone remain largely in physical isolation with limited physical contact with others: “I can count the times I hugged since the pandemic started” (P11). It is worse for those without close family or friends living nearby: “I mean the only person that has touched me since March 15 is my hairdresser” (P3); this participant shared that for her, even a handshake in an informal interaction before the pandemic was a “comfort”. This has been taken away from her in the pandemic. In this context of physical isolation, participants who owned pets reported really taking solace in their company and “warm, beating heart” (P6): To be living alone-alone, you know, if I didn’t have a pet, I think [it] would be so much harder (P5).

Longing for In-Person Connection. Participants largely reported that they maintained socially connected with friends and family using the phone or video-calling technology such as Facetime or Zoom. However, many longed for in-person connections:
I’d see them [grandchildren] on the, on the video, on the, on the computer, and we’d laugh and play games and stuff on, and make each other laugh, and then I’d close it down and just burst out crying, because I couldn’t touch them. So that was really hard. (P12)

A participant also highlighted the importance of in-person informal interactions that were lost in the pandemic: “in the case of the other things [going to the hairdresser], each month, they, they add, they add something to life, not just to get your hair cut, but the interaction also, with that person” (P9).

**Heightened Sense of Loneliness.** The physical isolation and deprivation of close human contact older adults living alone experience in the pandemic contribute to a heightened sense of loneliness that many participants reported:

I’m just super lonely. I just, I, I wish I had someone.. to share this with. You know, they talk about increasing your bubble, but I have a few friends, all of whom have family here, so I can’t be, I can’t join their bubble, so I’m a bubble of one (P3).

The stress of navigating the challenges in the pandemic alone seemed to further reinforce the loneliness participants felt. Like the participant above, others also lamented not having someone to go through the pandemic with: “the isolation, um, feeling that I didn’t have a partner to go through this with…” (P6). As one participant put simply: “stress and isolation together make it hard” (P12). Participants’ heightened loneliness is also reflected in some participants’ re-examination of their living arrangement. A number of participants noted that they have discussed with family members the possibility of moving closer to them: “When the pandemic is over, I do not want to go back to this kind of isolation” (P6).

It is worth highlighting that the participants in this study have all lived alone for over 10 years and most reported enjoying and faring well in their independent lives prior to the
pandemic. However, living alone in the pandemic seems to be a characteristically different experience, particularly in its pervasive isolation. Some expressed their surprise at how hard the isolation has been for them: “I thought I would be able to weather it, because I’m pretty… independent, and pretty used to being on my own, ah, but I found that I was doing nothing… all of a sudden, I didn’t even have the motivation” (P7). One participant described having to contend with the unfamiliar feeling of “lack” that contrasts the feeling of well-being in solitude she is accustomed to:

The most startling things was how I could go from this feeling of well-being, being alone, this solitude that I’ve experienced all of my life, to this, within hours, to this feeling of lack, there’s something missing here, there’s something not, not right here. (P8)

She added that her niece who also lives alone reported a similar kind of emotional experience:

She felt the same thing happening to her, that all of a sudden, you know, she’d be reading or something, and, and she’d feel, oh, you know, I want to cry or something… That kind of sad feeling that comes over… we were describing the difference between solitude and loneliness and, and that’s exactly what, what it was kind of going from. (P8)

**Core Theme 3: Navigating a New World**

Living in the pandemic for older adults living alone also meant the need to navigate a new world. This core theme characterizes participants’ engagement with an unfamiliar new world, the uncertainty that marks this new reality, and how this reality has invited reflection on a broader level.

**Engaging with a New World.** The pandemic significantly altered how the world operated. Participants had to learn to engage with this new world, one where “doors are closed”: 
Doors Closed

You’re alone
You’re looking around
Doors are closed everywhere

No smile
No sharing of food
No warm embrace

Behind closed doors
People are not visible
They are closed in

You’re alone
You’re looking blindly
At these closed doors
(P9)

One participant described how the atmosphere of her neighbourhood changed at the onset of the pandemic:

Our neighbourhood is… friendly, social, “Hi, how are you?” … but all that shut down, for a period of time, there was no contact, you don’t say “hi”, you don’t wave, people turn their back and walk away from you, so they don’t even make eye contact” (P9).

Physical distancing and mask-wearing measures further engender a wariness: “now, we’re leery of each other. Even people we’ve been close to it’s like, am I too close? You know, we’re wearing masks… a lot of people are hiding a lot of our affect” (P11).

**Cautious in the Day-to-Day.** Within this environment of vigilance, participants reported being “extremely careful” and “very cautious” in their day-to-day lives:

Every time I leave the house, as soon as I’m off my property, not while I’m in my car, but as soon as I’m going, like if I’m going to the grocery store, before I get out of the car, the mask goes on, and it stays on until I get back to the car. (P3)
I had Lysol, carrying Lysol wipes in my car, carry a mask with me all the time, wash my hands well when I got home… everything like that, all those precautions… I don’t go to any… up to now I haven’t done a group event. When I have met a friend, it’s been one person. (P9)

Participants’ cautiousness likely relates to a higher risk awareness due to their age:

I’m in this age range… so I’m one of the people that needs to watch out, you know. I mean, I think we all need to watch out, but I certainly don’t want to get COVID-19. I mean, I don’t, I want to do anything I can to not get it… (P10)

Some participants noted that they are being careful both for the sake of their own health and a sense of responsibility they feel towards others: “I want to be responsible. Because if I get sick, I feel I would be responsible, so I don’t want to get sick” (P2).

**Heightened Awareness of Others’ Behaviours.** As safety is contingent on others’ behaviours in the pandemic, participants took note of others’ conduct, particularly when they contrast participants’ own careful conduct in the pandemic. Participants expressed dismay over hearing about others ignoring or defying public health directives:

There are things that you hear others doing that are upsetting, you know, like partying on the beach. (P5)

I find that appalling, the sense of “I want to do this. I can’t sacrifice anything, not even a little bit.” … yesterday there was an anti-mask protest in Vancouver… And I’m not mad about it, I’m just curious as to why people are so, apparently, super selfish. (P3)

Others’ behaviours also impact participants’ lives more directly. A participant spoke about how she has to assert her boundary when others’ lax behaviours make her feel unsafe:
I’m very clear with people about where I, I wear masks, and if people aren’t wearing a mask… I say, I ask them to “please back up. I, I, you’re standing too close to me. Um, have you got a mask? Do you want to put it on?” (P10)

**Information Intake.** In tandem with their careful pandemic lives, participants reported keeping updated with information on the pandemic, particularly that from the government. This is a daily ritual for many: “I… get up… and get myself organised, and be sitting there at 8 in the morning to watch the prime minister make his comments. And then, later on, catch the update for BC” (P9). Participants described that the credible information from the government provides “comfort” and “calm” (P3). Information intake appears to be a tangible way for participants to gain some sense of control amid the uncertainty in the pandemic: “I sort of put my attention on studying the darn thing. You know, what is this? What’s going on? ah, if I’m leaving my home, how can I do it safely?” (P9)

Some participants also noted that they deliberately limit the amount of pandemic information they consume: “I would listen to [provincial health officer] every day… and it gave me the information that I needed to know… And, apart from that, I, I really haven’t spent a lot of time online reading about other stuff” (P8). Another participant described reducing the amount of information intake as the pandemic has gone on: “In the beginning, I was listening more because I wanted as much information as possible. Information is so important. Now, I listen less, because I think I’ve got enough information” (P1).

**Online Transition of Activities.** In the new world, many participants reported increased engagement in online activities. They participate in previous activities that have adopted an online format or new activities they have discovered online. Most participants described comfort with and usage of online technology prior to the pandemic. Many participants expressed that
they are grateful for online activities and tools in the pandemic: “I certainly watched a lot of Zoom lectures, even movies, and plays which had been really good to do. So I guess, thank god for electronics” (P2). At the same time, a number of participants noted dissatisfaction in their experience engaging in activities online, particularly with the lack of opportunity to meaningfully engage with other participants:

I feel no, no exchange of energy between the people, and sometimes I say something, and people look at me as if I have three heads or something… I feel, when I’m… on those Zoom meetings with several other people, um, that I’m, like, surrounded by sphinxes...

There’s just no, no interaction whatsoever. (P8)

But all those activities, I go to all the time, they’re gone. Now they’re starting them online, but it’s not the same kind of human contact. (P4)

The process of adopting new technologies can also present challenges. One participant described the “bumpy start” she had with Zoom:

Oh, it was awful. My computer, I, I think Zoom killed my computer... It was a virus I think, a pretty bad virus, and the only thing that I’d done, new, was Zoom, and I so I was pretty annoyed… But Zoom is the way to go, so, I got a new computer, and tried again, and now I like it. (P1)

**Contingent Broadening of the World.** Many participants spoke about how their experience in the pandemic improved since the re-opening (i.e., Phase 3). The re-opening meant the possibility for more in-person activities and participants reported the resumption of activities that are important to them making a difference:

“My [music group], um, has now met twice outside, so Phase 3 is, is really doable” (P6).

However, given the unpredictability in the pandemic, participants felt a sense of contingency
over whether conditions can prevail: “If it stays this good I’ll be glad, I’ll be happy. I hope it
doesn’t get worse” (P9).

Due to safety concerns, the return back to activities in their former setting was met with
both anticipation and anxiety. A participant described what it was like returning to the centre she
volunteered at for the first time in the re-opening:

[It was] scary. It was like, I, I, I kept telling people it was like the first day of school…
there was excitement, but there was a little bit of anxiety too… I was afraid that there was
going to be, um, too many people around… because it is an indoor context… so I was
afraid of that, but it worked out to be just fine. (P1)

In contrast to most other participants, one participant expressed finding the re-opening to be
more difficult because of the continued anxiety she felt outside of her home:

At least when you’re locked down, everybody knows you’re, that just stay home, and
don’t go out unless you have to… But now, with things half opening up… Like, someone
invited me to a… small birthday party, and they were going to do it outside, and, um,
they were… were quite young people who I know have huge social circles, and I really
wanted to go, and I said no. (P12)

Uncertain and Somber Future. Even with the improvement many felt in the re-opening,
most participants continued to hold a realistic outlook for the pandemic. They expressed the
perception that pandemic conditions will persist for some time: “I don’t think we’ll quickly get
back to where we were” (P8); “I think it’s going to be at least, well, the better part of a year from
now before there’s any meaningful change, because you can’t hurry science” (P3). Furthermore,
some shared the view that they “don’t expect the old normal” (P9) and that people must adapt to
a new normal where the virus is part of people’s lives: “this [the virus] is some other thing that’s
now in our environment, and it’s now in our lives, and, um, we, me included, have to, you know, accept that as a reality” (P7).

Overall, it seems that a “grinding, ongoing uncertainty” (P11) looms which drives the pessimistic outlook expressed by participants:

We are uncertain. Will there be a vaccine? We don’t know. I suspect there will be something, and maybe we’ll have to get a different one every year, like we do for the flu, you know, because the strain keeps changing… will I have to wear a mask for the rest of my life when I’m in an enclosed public space? I don’t know. We really don’t know. (P6)

**Reflecting on the Bigger Picture.** Living in a global pandemic seemed to prompt participants to take a broader perspective. Some discussed the pandemic as a common challenge faced by humanity: “It’s not our usual human path to be in a time of mystery” (P5). Others reflected on global issues that have been highlighted in the pandemic and how they are re-examining their own lifestyles as a result:

I think that’s one of the good things that’s happened with COVID, is maybe people have started to… realise that… when I’m bored, right, I can’t just go to the mall and buy something and feel better for a little while, I actually… have to manage that boredom in some way. It’s what I’m trying to do… Yeah, changing those long-standing habits, into something more sustainable, and more responsible. (P7)

More and more I think maybe a vegan diet might be the way to go… I really do think that that’s part of what’s… at issue here, is that the planet’s really, really crowded, and a lot of… our land is taken up growing meat that we don’t really need. (P12)

Some participants also noted how the pandemic highlights existential conditions and values:

It [the pandemic] has made people more, ah, aware, that life is rather precious. (P10)
I hope that, for humanity’s sake, that people realise it’s not all about money, money, money, money, money, money, there’s a quality of life. (P3)

One participant described how heartened she was when she heard an announcement at her grocery store reminding people to be kind. She believed that it reflected how the pandemic has prompted a focus on kindness, a value important to her:

Reminding each other to be kind is a bit ethereal, but it’s also really good advice, because a lot comes out of kindness. You know, sexism, racism, all those things, they don’t come out of kindness… So when your grocery store tells you to do that, that’s a pretty good thing. (P5)

**Core Theme 4: Recognizing Older Adult Identity in Society**

Living in the pandemic for older adult living alone is also coming to a greater recognition of their identity as older adults in the society. This core theme characterizes the generational divide and ageism that seem to be highlighted and reinforced in the pandemic and older adults’ responses to these issues.

**Deepening Generational Divide.** The framing of older adults as especially vulnerable in the pandemic likely contributed to a deepening of the generational divide in the pandemic. This is felt by participants in a number of ways. First, participants expressed their perceptions of the differences between the attitudes and behaviours of the younger generation and that of their generation in the pandemic. A number of participants noted the difference between the risk perception of the younger generation and that of themselves:

In general, I see that there’s still a lot of young people who don’t really get it, who don’t, I think, um, have any sense of urgency or crisis, um, about the pandemic… So, there is a
divide between, um, younger people and older people. The younger people don’t feel they’re at risk, um, if they get it, so they’ll get a mild case. (P6)

There’s a huge amount of anxiety and all my friends feel it, all of my older friends. But the young people don’t seem to feel it, the way we do. (P2)

As well, participants highlighted how the irresponsible behaviours of some in the younger generation impinges on the health of older adults:

It is concerning, because today’s death of COVID was someone in a long-term care center, so, you know, it may be the 20 year olds who are partying their faces off, but… it doesn’t affect just them, it affects everybody. (P5)

It should be noted that participants expressed considerable understanding of the younger generation in how they described these views. They acknowledged the challenges the younger generation may be facing in behaving in these ways: “I know it’s really hard, it’s got to be really hard for people in their early 20s, or late teens to have to curtail their social life, and a lot of them just aren’t doing that” (P6). One participant further empathized with the younger generation and noted the different impact the pandemic may be having on them: “I’ve already lived this long. Um, but it’s not affecting me in the same way it’s going to, or it’s already affecting younger people, um, because they’re going to be with this for a long, long time.” (P7)

The second way the deepening generational divide is felt by older adults involves participants encountering rhetoric that reflected inter-generational tension in the pandemic: “I’m a boomer, right? Boomer remover, that’s what they’re calling it. Or Boomer doomer… Well, it’s pretty shocking, you know” (P6). A participant shared the strong sense of exclusion she felt hearing this type of rhetoric:
It’s like “well, we’re going to start opening things up, but we think that people 65 and over should continue to stay home.” I felt like those things, when you get to a certain age, they put you on a raft and push you out to sea, stop living and being. (P11)

Finally, one participant had a personal encounter with a younger person who verbalized resentment towards older adults. She recounted the experience and how it shook her:

There was one store clerk that kind of lashed out, ah, I think she was just under stress… she was cleaning the countertop… she just said, you know, well I’m, I’m visibly older, and I was in at the time for older people, but anyway, she said something about how “we have to do this because of you.” And… it startled me, and I, I just said: “Thank you”… It felt like a blow to the chest… (P9)

**Existing Ageism Reinforced.** Participants noted that the ageist rhetoric and behaviours are in fact a reflection of ageism that existed before the pandemic. The pandemic simply provided the conditions for it to surface and fester. A participant related the ageism she felt prior to the pandemic to the ageist attitudes in the pandemic:

What really surprises me… is how invisible I am on the street. I mean, I had, I’ve had people walk right into me, and I said to one man: “Did you not see me?” and he said: “Apparently not.” … It’s really this “What are you doing in my way?” “Why are you here?” and so I, I feel like I’ve been invisible, so when I see this attitude of “yeah, so somebody old’s going to die, who cares?” it’s already out there. (P3)

One participant highlighted how the over-emphasis of older adult vulnerability in the pandemic further deepens the divide between the young and the old:

Also there was a thing about identifying my age group as a problem, as, you know, all of a sudden we were all described as vulnerable seniors and we became a scary population,
like, and the younger generations, they didn’t necessarily know what they were supposed to be scared of, and so… just the reaction to you… changed. (P9)

This narrative of vulnerability serves to further exclude older adults from participation in society in the pandemic:

I have a friend in [my home town] who was excited that her massage therapy place had reopened and she made an appointment and they called and said that “well, you can’t come in because you’re over 65 and you’re in a higher risk group”… I mean, she’s the one at risk, she’s not the one who’s gonna give them the virus. They think they might give her the virus. Well, give her that choice. I mean she’s now being blocked from something that helps to keep her healthy. (P11)

The narrative of vulnerability likely also fuels the fear felt by older adults themselves in the pandemic and engenders a further sense of exclusion due to an internalized vulnerability:

I went to [tourist attraction] on Saturday and I saw so many crowds of people none of them wearing masks, I would never get out of my car in that situation. So, it just feels like the world isn’t for older people anymore. (P2)

Advocacy and Helping Among Older Adults. Amid the generational divide and ageism described above, older adults are not remaining passive. Participants described different ways they have confronted these issues prior to and since the pandemic. One participant described how she chooses to continue to participate in her community even after having encountered agist experiences: “I would encounter people … kind of looking at me sometimes [like,] “what are you doing here?” But I wasn’t going to leave the landscape entirely, because I felt… I could still be in my community safely” (P9). Another participant described being part of an advocacy project that “busts stereotypes” about older adults:
It’s for seniors, and it’s by seniors, and we, you know, and so it’s, it’s a remarkable idea because we’re stereotype busters, right? We want to bust stereotypes… a little old lady sitting around doing my knitting. Nothing wrong with that... But, I think there’s this general sort of feeling out there that that’s what old people are about, and it’s simply not true. (P8)

The same participant expressed a genuine appreciation for older age, which likely motivates her advocacy work for older adults:

I’ve come to terms with myself, over my life, and, um, I’m, I think I’m, because I’m old, being old’s not that bad, you know. The body falls apart, but I actually like it, I think it’s probably the, the time I am more at ease with myself. (P8)

Finally, one participant described reading books and engaging in discussions on older adult issues. She expressed her views on the importance of choice and inclusion for older adults and valuing the wisdom and voice of older adults:

It’s more important to me to risk having a fall but being involved in life and being out of the house than it is just to stay safe. And I think, I think there are other culture where elders and elder wisdom and elder involvement in the community are more valued than they are in our culture. (P11)

This participant noted that she believed that this research “indicates that seniors matter” and that her reason for participating in the research was to contribute to the conversation on “how we can move forward with these new realities in ways that show valuing of seniors” (P11). Similarly, another participant expressed that she found her participation in the research meaningful as it was an “exchange between youth and elder” (P5).
Other than actions that directly countered ageism, a number of participants reported engaging in actions that helped other older adults in the pandemic and in turn fostered a sense of solidarity among their peers. This can perhaps be considered an indirect means to work against ageism. Two participants spoke about volunteering work they were doing to provide phone outreach to isolated older adults in the pandemic (P10; P11). As well, participants reported supporting their peers in less formal ways. One participant described having organized a dinner ritual with her older adult neighbours on their respective balconies to ensure that everyone is socially connected in the pandemic:

I suggested it to my neighbour, I said, “Why don’t we have dinner?” You can have it in your place, and I’ll have it in my place … And she said, “Yeah, I’ve got a TV tray”… and so we started, just the 2 of us. And then we invited another lady just down the hall from us… then we decided to do it every week… so we had an hour’s conversation, really looking at each other. (P2)

Another participant described stepping up for other older adults in her building when she realized that they couldn’t speak up when they felt unsafe sharing an elevator with someone:

What I realised is that some of my older neighbours, who are like 90 and 94… And this person who is 94 does not have the confidence to say: “Ah, you know, actually Bob, I’d rather you take the next elevator.” And so what I did is I got hold of… our office coordinator, and I said: “I noticed before we had signage that said “One person at a time on the elevator”… Could you arrange for that? (P10)

**Appreciating Gestures of Goodwill.** While participants reported experiences with ageism, many of them also spoke about the gestures of kindness from the younger generation
that they have received and appreciated in the pandemic. First, many participants described the young people in their lives being considerate and careful towards them:

They’re very careful around me, they wear masks when, ah, we’re in any kind of enclosed space… there’s a real solicitousness towards me. So, with my particular young people, I don’t have an issue. (P6)

I just got a text from my granddaughter this morning… she’s going to come here next week for a visit… But then… her doing all this precautionary stuff… [she said,] “I’ve been self-isolating and I haven’t been going out.” And she’s doing all this for me. (P7)

Also, some participants cited kind gestures extended by young people not directly in their lives:

What truly surprised me was how many people took up the challenge. We had young folks in this building, and there, there are a few, quite a number of old people in my building… the younger folks, um, organised themselves quickly… if we needed support, we could get in touch with them, and they would do things like, um, go shopping, pick up medication, actually take us to medical appointments. (P8)

Core Theme 5: Adjusting to the New Normal

Living in the pandemic for older adults living alone is also finding ways to adjust to the new normal. This core theme characterizes participants’ adjustment process, including what they reported during the second interview. Participants’ coping strategies as well as the factors that help and hinder the adjustment process are also summarized.

Adjustment as a Process. Participants were at varying degrees of adjustment at the 4-month mark at which this research is conducted. Only a few participants explicitly described feeling “adjusted” (P4; P6) or “adapted” (P9). All of these participants talked about adjustment being a process. One participant used a sailing metaphor to describe her different experiences in
each phase of the government’s pandemic response; in Phase 1 she was “unmoored,” Phase 2 “sailing towards a harbour,” and phase 3 “being in a harbour” (P6). Another participant described the process as going through stages:

- I feel like I have, um, adjusted, like, you have to go through the little stages. At first, it’s “is this my life?” and… “oh my God, this is a big deal” and… the disorientation…, and then you kind of settle down and… then they let you out … I feel as though… I have been able to manage to develop a new life. (P4)

As these participants noted, the re-opening played a significant role in the adjustment process:

- “Now, because of the loosening up, and because of adaptations together, together, not one or the other, the loosening up and the journey that each of us takes in terms of adapting, it’s fine” (P9).

There also seems to be an adaption with time or getting “used to” the conditions in the pandemic:

- I’ve adjusted to what people are calling the new normal, um, so certain things are just second nature to me in the number of times I’ve washed my hands every day, um, the distance that I do keep from most people, um, you know, that kind of thing. So that’s, that’s partly it, is that I’m just used to the situation. (P6)

Finally, one of the participants described how crucial it was to let go of “bargaining” in her process of adjustment:

**Bargaining**

- I kept bargaining hoping all the time expecting it’s going to be alright next minute “oh, maybe, maybe now, maybe I can have…”

- I kept hoping and getting disappointed Because it’s really hard to think it’s going to be a year and a half
It’s a long time before I could settle down and realise “look, this is here to stay” (P4)

This participant, because of her professional background in mental health, drew on the grief cycle and the bargaining stage in particular to make sense of her experience in the pandemic. She described the pandemic as “just built for bargaining” given its unpredictability and protractedness. Only when she realized that she “kept planning” and saw the futility in doing so could she finally move out of the bargaining stage and “the mini depression, the mini circle” (P4) she was repeating.

**Coping Strategies.** While other participants didn’t explicitly speak about having reached a state of adjustment, many of them alluded to a level of emotional adjustment. As one participant described, the “acute fear” at the beginning of the pandemic seemed to have evolved into an “ongoing uncertainty” (P11). Many participants also noted coping strategies that had been helpful in the pandemic.

**Gratitude and Perspective.** Participants consistently expressed gratitude for their personal circumstances: “I’m not out of a job, I’ve, I have a roof over my head, my health is good, so, I mean, I can’t really complain about anything” (P10). Some participants noted using gratitude as an intentional coping strategy: “I try to tell myself every day: “Oh my goodness, I am so fortunate.” … Even though things are kind of grim for me right now, they could really be so much worse” (P1). However, for some older adults, the expression of gratitude also seems to be related to the guilt they feel discussing their challenges, a sense that they are not entitled to feel badly because of their fortunate circumstances:
I mean, it would sound ridiculous for me to complain when I think of all those who really have had nothing and had to rely on food banks. I should be ashamed of myself to have been feeling sorry for myself. (P2)

In addition to acknowledging their fortunate circumstances, older adults also spoke about perspectives they’ve developed through the years that offer hope:

What I found is when people get themselves in hot water, even though they might run around in circles [initially]… when they reach the point that they have to do something, I have always been surprised, my whole working life, at how well people did when they got over the initial panic. (P3)

Some participants also shared how their experience in previous epidemics helps them to maintain a positive perspective in the current pandemic:

I was a child, um, when Polio, um, struck… it was very real, lining up in school and, you know, getting, ah, sugar cube with some kind of… liquid on it, one time, and another time it would be a vaccine, and… I had a couple of friends who had polio, and… in the iron lung and stuff like that, so, you know that as, as [a] humanity, we get beyond these things. [Even though] they seem totally mysterious, and, ah, deadly… at the time. (P5)

**Ensuring Connection.** Given the heightened isolation for older adults living alone in the pandemic, many participants highlighted the importance of the support of close family and friends and setting up rituals to ensure they are connected on a regular basis. One participant described a Sunday dinner ritual with her son she initiated in the pandemic:

And I said [to my son]: …“How about, on Sunday, I’ll make dinner… and then, we get to sit at a distance, and we get to visit”… So, we’ve been doing that pretty well just about every Sunday. [And] the really nice thing that’s been happening is… [my son] has an
aunt that lives up in the interior, and she lives by herself… so what we do is… we’d call
his aunt… so we’ve been able to talk to her every Sunday while we’re having dinner.

(P10)

One participant who doesn’t have family living nearby spoke about how she increased
informal interactions intentionally to feel connected: “I’ll go and get my mail more often than I
need to, just to go downtown and see people and just have brief conversations in the post office”
(P7). As noted previously, many participants leading a largely home-bound and physically
isolated life also found connection through their pets. Participants noted that their pets not only
provided them with companionship but also a sense of purpose and touch. A participant who
adopted 2 cats in the pandemic described what she appreciated about her cats:

Having some company around, and having, you know, even cats just to, just to talk to, so
I’m just not listening to my own voice… they give me something to do, I guess, whether
it’s even just playing with them… one of the things I miss a lot with all this isolation is,
like, touch… But the cats help, because, you know, they, they’re a warm body. (P7)

**Maintaining Some Sense of Control.** In a new normal marked by uncertainty,
participants attempted to maintain some measure of control. The most prevalent means seemed
to be through the intake of information which was previously discussed. Some participants noted
other strategies such as recognizing and accepting what is beyond their control: “I don’t think
we’ll quickly get back to where we were, but I don’t worry about it. It is beyond my control,
there is nothing I can do about it” (P8). Also, some participants spoke about focusing on their life
sphere where they do have control, their “own little bubble” (P10): “us three, the bird and the
dog and me. That’s our little universe here. I’ve focused on keeping “us” okay. Eat well, feed
them well” (P9). Finally, a number of participants described informal helping activities in which
they engaged including making masks for friends and family (P10, P12) and providing health-related information to friends (P2). Many participants reported engaging in helping activities such as volunteering before the pandemic. As opportunities to engage in formal helping activities decreased in the pandemic, participants may nevertheless find a sense of competence in providing support to friends and family.

**New Activities and Routines.** Amid the loss of significant activities in the pandemic, some participants reported being able to start new activities and routines. These included online music classes, gardening, and taking online courses with friends. One participant described seeing the unexpected benefits of the pandemic from starting some of these new activities: “these are all really good things that might not have happened… discipline of playing [an instrument], I, my playing has improved so much, and I’m writing most days” (P6).

Part of starting new activities is also being realistic and acknowledging what is possible given the limitations in the pandemic: “going to get pet food starts to be… an appointment” (P9). Similarly, a participant spoke about how due to the lack of motivation that pervades her pandemic experience, she needed to bring any new activity she introduces “down to something small”: “basically get up off the couch and go for a walk” (P7).

**Factors That Help and Hinder Adjustment.** In this final section, I summarize factors that help and hinder participants’ adjustment in the pandemic, based both on participant report and what I have gleaned from the analysis.

**Individual Circumstances That Help.** As previously discussed, participants consistently noted financial stability and their retired status, that they don’t “have a job to lose,” (P5) as a blessing in the pandemic. For many participants, they reported a few key individuals (family members or friends) living nearby as their primary support in the pandemic helping them in a
variety of ways, from getting groceries to having safe in-person contact with them regularly. Participants also reported having tools to access the world as helpful in the constricted environment in the pandemic. These include the radio, internet connection, and the vehicle. As one participant described, her vehicle allows her to “get out of my four walls” (P9) and perhaps provides a sense of freedom so precious in the pandemic. Other helpful factors related to participants’ individual circumstances include living in a detached house, being healthy, and professional training in mental health.

**Personal Factors That Help.** In terms of personal traits or attitudes that appear to be helpful, resilience developed through past hardships stands out. Participants noted how these hardships have helped them to learn to focus on the positive and develop strategies to manage emotional distress. A participant described a strategy she developed in bereavement years ago that had been helpful in the pandemic: “the days I felt bad, I allowed myself to feel bad for that day, and then I got back on track, and it largely worked” (P3). As noted previously, participants in this study have lived alone for an average of 21 years and one participant described how she views her independence, honed in her many years living alone, as an advantage in the pandemic:

I think I have a huge advantage in, I’m, I’m fiercely independent, and I have been since I was 18 years old, and I have lived a large part of my life on my own, and so I’m accustomed to that. I know what it is to fend for myself, to look after myself. (P8)

However, both this participant and others have noted their surprise at how isolating living alone in the pandemic is compared with their experience prior to the pandemic. Other helpful personal factors include introversion and planfulness.

**External Circumstances That Help.** By far the most widely cited helpful external factor was the government’s pandemic response, which participants perceived as largely effective. In
particular, participants expressed appreciation for the regular information updates from the government and the steady information delivery: “I think they’ve [provincial government] shown terrific leadership, and gave us good, consistent information without hyperbole, without any drama” (P1). The high level of trust in the government appeared to provide a stabilizing effect. As discussed previously, many participants credited the re-opening as what helped them adjust and re-gain a sense of normalcy. Participants also highlighted the importance of weather. Some noted that it was fortunate that the pandemic started in the spring given the “returning warmth” and “light” (P5). Others pointed out that they “don’t look forward to the winter” given that wintry conditions would limit outdoor activities (P3). Finally, the support and sense of community participants feel in their buildings and neighbourhoods also seem to be helpful.

**Factors That Compound Challenge.** As noted previously, needing to contend with a pre-existing disability or health condition in the pandemic adds tremendous stress. The participant with a physical disability noted that her condition compounded her sense of vulnerability, and the constricted, home-bound lifestyle exacerbated her condition, which made it particularly challenging to establish a new life at home. As well, the more limited access to medical care in the pandemic made it more difficult for her to reach out to medical professionals. Those who had experienced a recent transition such as moving or the ending of a relationship also appeared to have more challenges in their adjustment in the pandemic. These participants reported more intense grief and loneliness. For those who recently moved, they reported added challenges in the transition to a home-bound life as it is so drastically different from the lifestyle they had envisioned. It should be noted that a few participants seemed to have difficulty reaching out for support. They spoke about not wanting to burden family members and professionals even though they had been struggling in the pandemic. In some cases, it appeared that because these
participants fared so well on their own before the pandemic, being in a vulnerable, help-seeking position was too foreign to them. Finally, a few participants discussed challenges in accessing resources such as grocery delivery and navigating the changes in access to medical care in the pandemic. These participants suggested having a helpline for groceries and a central platform with information on the available resources for older adults in the pandemic.

**Adjustment Over Time.** At the second interview 3-6 months after the first interview, participants were invited to discuss any changes they may have experienced since the first interview. Pandemic conditions in the province worsened during the period from the first to the second interview with a steady rise in COVID-19 cases and the tightening of restrictions on in-person gatherings. Even amid these conditions, participants reported increased adjustment.

**Emotional Adjustment.** While most participants reported that their daily lives have not changed drastically, there was a clear increase in participants’ emotional adjustment. One participant described that she had “moved out of the huge grieving of loss” (P11) and another noted that the “intense fear turned into general anxiety” and she was “as steady and balanced” as she was before the pandemic (P2). Participants credited the increased knowledge about the virus for their decreased fear and anxiety. One participant described that even though the external condition was worsening, her anxiety has not crept up (P5). Participants noted that their moods have settled, and they were now “bored more than sad” (P8). More participants spoke about acceptance than during the first interview: “Change the things you can and accept the things you can’t” (P3); “Go with the flow until it changes” (P8).

**New Activities.** Within the several months that passed, many participants reported being able to initiate new activities or return back to their previous activities whether online or in-person. They described continued vigilance and cautiousness in their activities outside of the
home. Participants noted that these are conscious efforts to “re-develop” routine and structure and “strengthen community.” A participant reported feeling “more back to myself,” less isolated and “connected to things” (P11). Another participant described that by starting an activity related to the government’s pandemic response, she felt like she “could contribute” and felt “less helpless” (P9).

**Increased Connection.** Many participants reported an intentional increase in virtual connections with friends and family, resulting in stronger bonds with significant others. One participant reported that with the increase in virtual contact with her brother, she is probably “close to him than ever before” (P8). A participant noted that she had also increased “fleeting contact” as she realized that they helped her “feel that things are better” (P3).

**Creatively Adapting.** Within the context of continued restrictions, many participants noted that they had to be creative in how they increased activity and connection. They bought tarpaulin and heaters to hold outside activities and when restrictions tightened, they transitioned gatherings online (e.g., Zoom Christmas). Participants also needed to continue to adapt to their home-bound life. One participant spoke about actively developing strategies to fight the “brain fog” she now feels in her home life (P8). Another participant described introducing “a little bit of joy” into her home life by ordering something small online every month (P6). As well, some participants spoke about how they had been adapting the way they use online technology to make the online experience more engaging. For example, one participant described that for any online meeting she hosts, she would now open the meeting room early so that participants could have a chat beforehand if they so wished (P2).

**More Optimistic Future.** In contrast to the somber future outlook participants reported during the first interview, most participants expressed hope in “the promise of the vaccines” (P3)
in the second interview. Participants noted that the development of the vaccines is “a ray of sunshine in a rather dark situation” (P9) and that with the vaccine rollout, the end is finally in sight. Participants describe that it is now “a waiting game” (P12) and reminded themselves to “hang in there” and “keep the show on the road” (P9) until the end.
Chapter 5: Discussion

This phenomenological inquiry explored the lived experience of older adults living alone during the initial 4 months of the COVID-19 pandemic. The phenomenon was found to be multi-faceted, characterizing how older adults living alone related to different aspects of the pandemic, including the virus, their lives, the new normal, and the society. The 5 core themes spoke to an experience marked by emotional distress, loss and isolation, change, ageing, and resilience. In this chapter, I relate these findings to the expanding literature on the psychological impacts of the COVID-19 pandemic on older adults and those living alone as well as extant literature relevant to the core findings. I also discuss implications for future research as well as the limitations and strengths of this research.

Situating Findings in Literature

Emotional Distress

This research found emotional distress to be part of the lived experience of older adults living alone in the initial months of the pandemic. The salient emotions included fear, loneliness, and grief. Importantly, the qualitative data from this research captured a more nuanced portrayal of older adults’ emotional experience, one of vacillation and evolution over time.

Fear and Vulnerability. Following the shock and disorientation at the onset of the pandemic, participants reported fear and insecurity in the face of the unknown and invisible virus. The fear was particularly acute when older adults had to leave their homes for groceries and other errands. Participants also reported concern over the impact of the pandemic on the wellbeing of family members. Portacolone et al.’s (2021) qualitative study on the effects of the pandemic on diverse older adults living alone with cognitive impairment found “feeling scared” to be a main theme. These authors highlight that without others living with them, older adults
living alone were largely left to contend with the acute fears brought by the pandemic by themselves. Hamm et al.’s (2020) mixed methods study on the experiences of older adults with pre-existing depression also found the risk of contracting COVID-19 to be older adults’ primary concern. Finally, Whitehead and Torossian’s (2021) mixed-methods study on older adults’ experience of the pandemic found that “concern for others” was among the top 4 sources of stress for older adults. Importantly, worrying about the pandemic was found to associate with negative changes in mental health in a large-scale survey of Dutch older adults (van Tilburg et al., 2020).

It is important to highlight that there was an evolution in participants’ emotional experience around fear over the course of the four initial months. Most participants described that the acute fear they experienced in the early weeks of the pandemic was attenuated with increased knowledge about the virus over time and evolved into an underlying tension. It is possible that participants’ cautious and vigilant behaviours, a form of “proactive coping,” also helped to reduce their pandemic-related fears (Pearman et al., 2020).

This research also highlighted the added vulnerability and challenge felt by older adults living alone with a physical disability. Lebrasseur et al.’s (2021) rapid review of research on the impact of the pandemic on people with disability corroborates this finding. This review summarized the major impacts to be decreased healthcare access, negative mood changes, decreased physical activity, and changes to daily routine, all of which were documented in the present research.

**Heightened Loneliness.** Amid severe physical isolation due to stay-at-home orders, participants in this research also reported heightened loneliness. This is consistent with a host of quantitative evidence that has found increased loneliness in community-dwelling older adult
samples in the initial months of the pandemic (for a summary, see Dahlberg, 2021). Of note, a number of studies have found living alone to be a significant predictor of loneliness in older adults (Parlapani et al., 2020; van Tilburg et al., 2020; Wong et al., 2020).

Vacillating Emotions. Participants in this study reported the experience of vacillating emotions, particularly in regard to their grief or a sense of lack. Gonçalves et al. (2021) reported a similar phenomenon in their qualitative work on older adults’ experience in the pandemic in 4 countries, one they characterized as a “lack of emotional balance” in participants’ daily lives (p. 5). The phenomenological account of grief speaks to a similar experience; Fuchs (2018) describes that in contrast to the constant, frozen mood typical in depression, grief appears in “veritable pangs” that “take the form of episodes of acute, nearly physical pain” each time one is reminded of the loss (p. 46). This account provides some insight into participants’ reports of sudden shifts in their mood in the pandemic.

Emerging Evidence on Older Adult Resilience. The findings on emotional distress from this study must be considered in light of accumulating evidence that points to older adult resilience in the initial months of the pandemic compared to younger populations (for a summary, see Vahia et al., 2020). For example, in an American Centers for Disease Control and Prevention survey conducted at the end of June 2020, a significantly lower proportion of older adults (aged 65 or over) reported psychological morbidities compared with younger aged cohorts (Czeisler et al., 2020). One possible reason for the apparent discrepancy between the findings is coping. That is, while older adults may have experienced heightened levels of distress and loneliness in the pandemic, these did not translate into clinical levels of morbidity because older adults are more adept at coping than younger generations (Minahan et al., 2021; Pearman et al., 2020). Indeed, participants in this study adopted a variety of coping strategies and many did
report a level of emotional adjustment in the initial months. However, I hope to also highlight that the findings from this study suggest that older adults living alone may belong in a different group from older adults living with partners or family given the pervasive isolation living alone in the pandemic entails. To my knowledge there has been no direct examination of the psychological impact of the pandemic on this subgroup of older adults. Portacolone et al.’s (2021) qualitative study described above focused on older adults living alone with the added vulnerabilities of cognitive impairment and ethnic diversity. As noted above however, a number of quantitative studies examining older adult mental health in the pandemic with living arrangement as a covariate in their analysis have found living alone to associate with increased loneliness (Parlapani et al., 2020; van Tilburg et al., 2020; Wong et al., 2020). These findings reflect in part the intense isolation felt by older adults living alone in the pandemic. I expand on this in the following section.

**Pervasive Isolation**

A main finding from this research is the pervasive isolation felt by older adults living alone in the pandemic due to the lockdown and physical distancing measures that have contributed to their shrinking existence in the pandemic. The multiple losses older adults experience in the pandemic have made their lives living alone in the pandemic characteristically different from the independent lives they led and enjoyed before the pandemic.

**Multiple Losses.** This research documented the significant losses of activity, community, structure, and freedom to travel in the pandemic that together contributed to a profound sense of loss of identity felt by older adults living alone. Similarly, Williams et al.’s qualitative study with adults in the UK on the impacts of the stay-at-home order (2020) found a key theme of loss where the social and practical losses of in-person interactions, income, and structure and routine
led to the psychological losses of motivation, meaning, and self-worth. While the retired older adult participants in this research didn’t have to contend with the loss of income or a job, the loss of activities outside of their home was likely as significant psychologically as the loss of a job for younger adults. Importantly, older adults’ involvement in activities such as volunteering not only provides personal fulfillment but also social connection and attachment (de Jong Gierveld et al., 2018). Living alone, these activities may be the important source for regular social interactions for these older adults. When the pandemic stripped these away, it also took away the “interpersonal recognition” that is a “precondition for selfhood” (Laitinen, 2002, p. 474) that these activities afforded on a regular basis and left older adults living alone utterly unseen.

**Physical Isolation.** Within their home-bound lives, older adults living alone reported overwhelming physical isolation, particular at the onset of the pandemic. Portacolone et al.’s (2021) study on diverse older adults living alone with cognitive impairment corroborates this finding. One of the 5 themes from their study is extreme isolation, which documents participants’ heightened sense of isolation over and above the intense isolation that many of them were already experiencing in their pre-pandemic lives.

In the present study, what stands out in the findings on physical isolation is the significance of physical touch and casual in-person contact for older adults living alone. These are aspects of daily lives that were taken for granted before the pandemic. Their absence in the pandemic was especially prominent as older adults living alone do not have ready access to these kinds of basic interpersonal contact that those living with others do. Strutt et al.’s (2021) survey of older adults in Australia found that 80% of those with grandchildren reported challenges related to grandparenting in the pandemic, and 84% of these participants cited lack of in-person and physical contact with their grandchildren as the primary challenge.
Physical touch plays an important affective communication role in conveying a sense of security from the time of infancy to adulthood (Hertenstein et al., 2006). Research has demonstrated the stress-buffering effects of physical touch not only psychologically but also physiologically (Cohen et al., 2015; Grewen et al., 2003). Notably, one study showed that even a stranger’s pat on the shoulder can provide a psychologically soothing effect (Levav & Argo, 2010). As such, the deprivation of physical contact in the pandemic for participants is also a deprivation of the comfort, security, and stress-buffering effects afforded by physical touch. Further, without touch, a participant poignantly described a physical disappearing. This highlights that the relational constitution of the self may extend beyond the concept of interpersonal recognition discussed above (Laitinen, 2002) and include an interactional and embodied dimension encapsulated by Merleau-Ponty’s concept of “intercorporeity” (as cited in Gallagher, 2014).

**Living Alone in the Pandemic.** The profound losses and pervasive isolation have left participants’ lives living alone in the pandemic unrecognizable from the lives they led prior to the pandemic. Participants in this study reported leading busy and enjoyable lives before the pandemic organized around activities outside the home. As well, these participants have been living alone for many years (an average of 21 years) and reported a preference for their independent lifestyle before the pandemic. Eshbaugh (2008) found a diversity in the perceptions of older adult women living alone regarding their living arrangement. In their small sample ($N = 53$), around 40% of the participants perceived living alone positively while most others perceived it neutrally, and a small percentage perceived living alone negatively. Participants from the present study likely fall into the positive group. I contend that this group of older adults living alone may fare worse in the pandemic, at least initially, as the contrast between their pre- and
post-pandemic life may be greater. As well, as these older adults tended to fare well before the pandemic, they are less likely to have already been connected to supportive resources at the onset of the pandemic and may even find it challenging to assume a support-seeking role. Kotwal et al.’s (2021) study may provide some support for my contention. These authors tracked older adults’ loneliness in the first 4-15 weeks of after stay-at-home orders were issued and found that those older adults who reported little change in their lifestyle (e.g., due to social or physical isolation pre-pandemic) also reported no change in loneliness during the study period. Brooke and Jackson (2020) also highlighted the need to attend to older adults who had not reported being lonely or socially isolated before the pandemic as they may be “disproportionately affected” by pandemic measures and the sudden and complete removal of their in-person social contacts. I believe that the present study may be a case in point.

Portacolone et al. (2021) describe applying a notion of precarity in their work with older adults with cognitive impairments living alone. They note that the “markers of precarity include: a chronic sense of uncertainty, limited access to appropriate services, importance of being independent, and compounding pressures difficult to manage alone” (p. 252). In the context of the pandemic, the precarity of otherwise healthy and vigorous older adults living alone may also need to be underscored.

Change and Adaptation

This research also depicted how older adults living alone adapted to the profound changes to the world and in their personal lives in the pandemic. The main ways older adults adapted to the new world included being cautious in the day-to-day, using technology, and transitioning to a home-based life.
**Cautious Day to Day.** Given the fear and anxiety over the virus, participants described carefully engaging with the outside world. They noted taking various safety precautions when going outside and keeping updated on and adhering to public health information and directives. Participants also expressed dismay over the perceived lax behaviours of some in the society. Older adults’ adoption of careful behaviours in the pandemic is documented in other qualitative studies (Brooke & Clark, 2020; Portacolone et al., 2021). Pearman et al.’s (2020) quantitative work found that age is associated with more accurate COVID-19 related knowledge and taking certain precautionary measures. Further, COVID-19 knowledge is associated with lower pandemic stress. Brooke and Clark (2020) also reported participants’ frustrations with those not adhering to pandemic measures. They noted that the behaviours of these people have impacted older adults’ perception of safety outside of the home.

**Using Technology.** Participants in this study reported increased use of technology to keep connected with family and friends as well as to engage in former activities that have transitioned online or new activities such as attending concerts or taking classes. While most are grateful for technology, some have also noted challenges in transitioning to online activities. Brooke and Clark (2020) also found that older adults engaged in a variety of activities online. Kotwal et al. (2021) emphasized the importance of technology adoption in adjustment. In their study, the subgroup of older adults that experienced persistent loneliness described discomfort adopting new technology. Strutt et al.’s (2021) study with community-dwelling older adults in Australia (N = 201) found that 63% of older adults adopted new technologies in the pandemic. They also found an association between new technology adoption and better quality of life and emotional health. Leist (2013) notes that older adults new to online platforms tend to “perceive a lack of control” (p. 380) which may prevent them from technology adoption. This may have
contributed to the challenges some participants reported in the process of adopting new technology.

**Transitioning to Home-Based Life.** Given that participants’ lives were largely organized around activities outside of their homes before the pandemic, many reported challenges transitioning to a home-based life. Participants reported monotony, boredom, and a lack of motivation, contributing to a largely sedentary lifestyle at home. Visser et al.’s (2020) study on the self-reported impact of the pandemic on physical activity and nutrition in Dutch older adults found that approximately half of their sample ($N = 1119$) reported a decrease in physical activity and exercise since the pandemic. Notably, those who lived alone were found to have higher odds of reporting a decrease in physical activity. Some of the participants in the present research reported challenges in maintaining physical activity in the pandemic due to isolation. Indeed, Hartmann-Boyce et al. (2020) noted the importance of the social element in improving motivation and adherence for exercise.

**Ageing in the Pandemic**

Another core finding of this research is that age seemed to be highlighted in the pandemic for older adults living alone both in terms of a heightened sense of their own ageing and experiences with more overt ageism.

**Heightened Sense of Ageing.** With the experience of a shrinking or suspended temporal horizon in the pandemic and a context highlighting older adult vulnerability, participants became more cognizant of their ageing. Some participants expressed pessimism relative to their age given the uncertain future in the pandemic. A key theme in Brooke and Clark (2020)’s study is “acceptance of a good life but still a life to live” with their participants also reflecting on their age and future (p. 4398). Seifert (2021) measured older adults’ self-perception of aging and
found an increase in negative self-perception of aging and decrease in positive self-perception of aging after the Swiss government recommended physical distancing measures. In the same study, living alone was also found to be a risk factor for negative self-perception of aging. Swift et al.’s (2017) Risks of Ageism Model posits that ageism contributes to negative aged-related self-perceptions. Participants reports of intensifying generational divide and ageism in the pandemic likely play a role in increases in older adults’ negative self-perceptions over age.

**Intensifying Ageism.** Ageism can be defined as “the stereotypes, prejudice, and discrimination directed towards people on the basis of their age” (Mikton et al., 2021). Participants reported encountering different forms of ageism in the pandemic including negative rhetoric aimed at exclusion, the pervasive framing of older adults as vulnerable, and in-person encounters with ageist behaviours. Many scholars called for attention to ageism and its impacts on older adults in the early months of the pandemic with the prevalent narrative of vulnerability and reports of intensifying inter-generational tension and blatant ageism (Ayalon et al., 2020; Monahan et al., 2020; Previtali et al., 2020). As participants described with their experiences, “ageism is not a new phenomenon” (Previtali et al., 2020, p. 507). Scholars caution that the increased ageism in the pandemic may further reinforce existing interpersonal and intrapersonal negative stereotypes (Previtali et al., 2020). At the same time, participants’ descriptions of gestures of kindness from the younger generation are corroborated (Monahan et al., 2020) and more inter-generational solidarity is called upon as a response to ageism (Ayalon et al., 2020). Visintin’s (2021) empirical study found that the quality of younger adults’ contact with older adults pre-pandemic was associated with their adherence to pandemic measures. The author thus contends that a focus on inter-generational solidarity may also benefit public health.
Coping and Resilience

In the face of the heightened distress, isolation, change, and ageism brought by the pandemic, older adults living alone demonstrated tremendous resilience. They confronted these challenges with a variety of coping strategies and showed emotional adjustment over time.

Coping Strategies. Participants used a variety of coping strategies including taking precautionary measures, focusing on gratitude, reflecting on perspective gained from past experience, ensuring social connection, helping others, and starting new routines. Thus, participants may be more prone to use approach rather than avoidant coping (Roth & Cohen, 1986). Minahan et al. (2021) found avoidant coping to mediate the relationship between pandemic-related stress and adverse psychosocial outcomes (depression, anxiety, and loneliness). Pearman et al. (2020) found that older adults endorsed more proactive coping than younger adults and high proactive coping was associated with lower pandemic-related stress for older adults relative to younger adults. In terms of specific types of coping, consistent with the findings, social connection has been found to be associated with better psychosocial outcomes (Minahan et al., 2021) and the quality of the social engagement appears to be important (Strutt et al., 2021). Finally, previous research has found an association between support-giving and better well-being in older adults (Thomas, 2010).

Resilience. As noted before, evidence is pointing to older adult resilience in the pandemic in comparison with younger adults (Vahia et al., 2020). Though I contend that older adults living alone may face greater challenges than older adults living with others in the pandemic, participants in this study have nevertheless demonstrated remarkable resilience. Here I consider resilience as “positive adaptation, or the ability to maintain or regain mental health, despite experiencing adversity” (Herrman et al., 2011, p.259). Despite heightened fears and
isolation participants faced confronting the pandemic alone, they were proactive in approaching these challenges and showed emotional adjustment over time. As well, several participants described applying emotion regulation strategies they developed in past adversity. Similarly, Hamm et al.’s (2020) mixed-methods study with older adults with pre-existing depression found that while participants reported increased anxiety and depression in the pandemic, they emphasized the importance of coping strategies developed previously in helping them manage distress in the pandemic.

One model that has been empirically tested (Carstensen et al., 2020) in relation to older adult resilience in the pandemic is the Socioemotional selectivity theory (Carstensen et al., 2003). The theory posits that the temporal constraints older adults perceive regarding their future prompt motivational shifts focused on goals that are emotionally meaningful and positive emotional states. Consistent with this model, participants from this study relied on emotionally meaningful relationships and using cognitive strategies that focus on the positive (e.g., gratitude) as their primary coping while reporting a heightened awareness of temporal constraints in the pandemic.

**Implications for Future Research**

This research characterized the phenomenon of living in the pandemic for older adults living alone as evolving and multi-faceted. This highlights the importance of increased work with a longitudinal design as well as qualitative work. The overwhelming majority of extant literature on the psychosocial impacts of the pandemic is quantitative and cross-sectional. If the phenomenon is evolving as this research and others (e.g., Kotwal et al., 2021) have documented, longitudinal work is essential. This is also important given the pandemic is still ongoing and if it becomes protracted further its future impact is unknown. As noted, quantitative evidence seems
to be converging on the resilience of older adults as a group in the early months in the pandemic. This study provided a more nuanced portrayal showing both the distress experienced by older adults living alone in the pandemic and how they navigated the challenges toward adjustment. Future qualitative work focused on coping and adjustment could provide further insight into the sources of older adult resilience in the pandemic.

This research highlighted older adults living alone as a subgroup of older adults that may be overlooked in current literature. Given extant literature that has also documented the relative vulnerability of this group in the pandemic (Parlapani et al., 2020; van Tilburg et al., 2020; Wong et al., 2020) more work focused on this subgroup of older adults is imperative. Further, this points to the need to better understand other subgroups within the broad older adult category that may be faring differently in the pandemic, such as the oldest old (i.e., aged 85+).

A point regarding the research process is worth noting for future research with older adults. In this research, I found the participants to be highly engaged in the research process. This was perhaps partly due to the collaborative design of this research, however, the participants’ keenness in participation was likely the main reason for such engagement. As noted, some participants described their motivation for participating in this research as to have their voice heard as older adults. This suggests that the research process could be an empowering one for older adults. This is important particularly given the experience of ageism older adults reported in this study. Participatory research methodology may be particularly apt in this context.

**Limitations and Strengths**

A key limitation of this research is the homogeneity of the sample. All participants were female, White, educated, and reported being financially stable. As such, the phenomenon captured in this research may not reflect the experience of older adults living alone that are of a
different demographic profile. Particularly, emerging evidence suggests that women and men may experience the pandemic differently. For example, Wang et al.’s (2020) meta-analysis of literature on the factors related to psychological morbidity in the pandemic found women to have higher odds of anxiety and depression than men. Relevant to the current study, an external reviewer who provided comments on the final analysis noted a possible difference in the experience of older men living alone in the pandemic relative to women based on clinical experiences with the study population (A. Kupferschmidt, personal communication, March 19, 2021). As well, some studies have documented differential experiences of older adults based on racial/ethnic background such as the fear of racially based violence in the pandemic (Portacolone et al., 2021).

A second limitation of the study is the self-selection of the sample. This research documented marked distress and challenges faced by participants in the pandemic. It is possible that those who volunteered for the research experienced more difficulty in the pandemic which prompted them to share their experience. As well, as participants volunteered to participate in the study without compensation, it is possible that this group is particularly proactive and community minded. As such, findings on the proactive coping of participants must be considered with this in mind. Lastly, as participants responded to recruitment materials via email and comfort using email was an inclusion criterion, this sample may be more versed in technology than other older adults. As noted, technology adoption has been found to be important in adjustment in the pandemic (e.g., Strutt et al., 2021) and participants’ comfort with technology may have impacted results.

The qualitative nature of this research precludes generalization beyond the sample. However, it needs to be emphasized that this was not the aim of this inquiry. Indeed, in adopting
a qualitative, phenomenological methodology, this research is aimed to capture the complexity of the participants’ lived experience in the pandemic and through concrete detail and thick description generate resonance (Tracy, 2010) or transferability (Lincoln & Guba, 1985) for the readers’ specific contexts.

The key strength of this research is its phenomenological approach. The bracketed and open-ended exploration allowed for the largely unknown phenomenon of living in a pandemic to fully emerge from participant experiences. As well, the context of this exploration was particularly apt for a phenomenological inquiry as participants were interviewed as the phenomenon was unfolding, which enabled the data gathered to be close to the lived, immediate experience of participants.

Another strength of this study is the extent of participant engagement in the research process aided by the highly motivated participants described above. The hermeneutic interview was conducted with 10 out of 12 of the participants during which participants reviewed a detailed analysis of their first interview with the researcher and provided comments that were integrated into the overall analysis. As well, all participants were sent a summary of the final core themes and invited to provide feedback. In this sense a thorough member reflection process was implemented and not only was consistency between the findings and participant understandings ensured but participant reflections during the second interviews also enriched the analysis.

Conclusion

This phenomenological inquiry explored the lived experience of older adults living alone during the initial 4 months of the COVID-19 pandemic. The phenomenon was found to be evolving and multi-faceted, characterizing how older adults living alone related to different
aspects of the pandemic, including the virus, their lives, the new normal, and the society. The multiple facets of the phenomenon were captured by 5 core themes: 1) Confronting a mysterious threat; 2) Shrinking existence; 3) Navigating a new world; 4) Recognizing older adult identity in society; and 5) Adjusting to the new normal. These core themes spoke to an experience marked by emotional distress, loss and isolation, change, ageing, and resilience.

This research adds to the expanding literature on the psychosocial impacts of the pandemic by providing a rich, descriptive portrayal of the lived experience in the pandemic. Importantly, this work focused on older adults living alone, likely an overlooked group in current literature.
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Appendices

Appendix A  Recruitment Poster

Are you an older adult living alone? We’d like to hear from you!

We are looking for retired older adults aged 65+ living alone to participate in our research study examining the subjective experience of older adults in the COVID-19 Pandemic.

What’s involved? 2 interviews (~1 hour each; over 3 months) with a researcher over the phone or online sharing your experience during the COVID-19 Pandemic.

Principal Investigator: Dr. Richard Young
Co-Investigator: Mindy Chiang
University of British Columbia

Interested? Contact Mindy Chiang at the following email: mindy.chiang@ubc.ca for more information

We look forward to hearing from you!

Please note that if you choose to like, share, or comment on this post or respond to this post online, you will be publicly identified with the study.
To avoid this, we recommend that you reach out to the researchers directly at the email address provided above.
Appendix B  Telephone Screening

Date of screening call:
Name/contact info:

Introduce myself & explain that I am returning his or her call regarding the research project on the experience of older adults living alone in the COVID-19 pandemic. First of all, how did you hear about our study?
Thank you for your interest in this study. The purpose of this call is to explain the study to you and to determine whether your experience fits with the purpose of the project. There is potential for this phone call to take up to 20 minutes. Is it alright to proceed or would another time be more suitable?

For you to be included in this study I first need to ask you some questions about yourself. If you don’t meet the criteria, the information you have provided will be destroyed. Is it alright to proceed?

Questions:

1. What is your year of birth?
2. How many years have you lived alone?
3. How would you describe your current employment status?
4. This research study requires that you participate for 2 one-hour interviews either online or over the phone. Are you comfortable doing so?
5. Do you have access to email and are comfortable using it to receive documents?
6. Did you or anyone in your close family or friend circles contract COVID-19?

(At this point, the determination is made to either proceed with the informed consent process or to respectfully thank the potential participant and close the conversation).

You meet the criteria for the study and I would like to invite you to participate. I would like to walk you through the informed consent form which provides more information on what is involved in this study, your rights as a participant, and the limits of confidentiality to which I must abide. You have the chance to decline consent after the process.

Are you interested to proceed with this process? Do you have any questions at this point?
Appendix C  Consent Form

Title of Study:  The lived experience of older adults living alone in the COVID-19 Pandemic

Principal Investigator:  Dr. Richard Young, Professor, Counselling Psychology, Registered Psychologist
Department of Educational & Counselling Psychology, and Special Education
Faculty of Education
University of British Columbia

Co-Investigators:  Mindy Chiang
M.A. Student, Counselling Psychology
University of British Columbia

Dr. Sheila Marshall, Professor, School of Social Work
University of British Columbia

Dr. Beth Haverkamp, Associate Professor, Counselling Psychology, Registered Psychologist
University of British Columbia

Introduction:
Thank you for your interest in participating in this research study, which explores the lived experience of older adults living alone in the COVID-19 pandemic. This research is carried out as part of the requirements for the Co-Investigator Mindy Chiang’s Masters of Arts degree in Counselling Psychology at the University of British Columbia. Mindy’s research supervisor and the Principal Investigator of this project is Dr. Richard Young.

Purpose of this study:
The purpose of this study is to understand how older adults who live alone, like yourself, experience the COVID-19 pandemic. What we learn from the study can help professionals to provide better supports to older adults in similar situations in the future.

You do not have to be involved in this research study if you do not want to. You can leave the study at any time. Furthermore, we will discuss your wishes as to whether you would like the information you have provided to-date to be included in our final analysis.
**Study procedures:**
If you agree to participate in this study, you will have 2 interviews with the primary researcher on the phone or online based on your preference. During the first interview, you will be asked to share your experience living through the COVID-19 pandemic. The interview will take approximately 60-90 minutes.

About 3 months after the first interview, the primary researcher will contact you through email to invite you to have the second interview on the phone or online based on your preference. During this interview, the researcher will present you with an analysis of what you shared in the first interview with some themes summarizing the first interview. You will be asked to review these themes with the researcher and provide your perspective on the analysis. The interview will take approximately 60 minutes.

The total time involved for the whole program will be approximately 2-3 hours over around 3 months. The interview sessions will audio-recorded for transcription.

**Potential risks:**
We might talk about sensitive or personal things during the session. If a question makes you feel uncomfortable, or you don’t want to talk about it, you can choose to not answer a question, and you can ask to stop the session at any time. We will provide a list of community counselling and COVID-19-related resources before the first session in case you would like additional support at any time during your involvement in the study.

**Potential benefits:**
Participating, or taking part in this program might help you reflect on your experiences in the COVID-19 pandemic. The information we learn from this research is important to other older adults living alone, service providers, and policy-makers in understanding how to better support older adults in future situations similar to the COVID-19 pandemic.

**Confidentiality:**
We will protect your privacy and confidentiality throughout your participation. Your participation in our program and the content of your sessions will be kept confidential. All of the electronic data files will be encrypted (password protected). All of the information from your sessions will be kept in a locked filing cabinet at the primary researcher’s home office. The only people who will have access to this material are the research team. We will not use your name in any reports or presentations (public talks) published at the end of the research.

At the end of the research study, we want to tell others what we have learned about the lived experience of older adults living alone in the COVID-19 pandemic. We will share the a brief summary with you and organizations that provide support to older adults. We will also share what we have learned with other researchers and professionals. For publication, some academic journals may require that we make accessible the original data to other researchers in a research depository. All of the data shared in this manner will not include any identifiable information (e.g., your name or personal details). Once the data is made publicly available, you will not be able to withdraw your data.
Participating using Zoom:
If you choose to participate in this studying online using Zoom, please note that Zoom servers are located outside of Canada, which means that Zoom will store your name and information regarding your use of the site outside of Canada.

Choosing to stop your participation:
Your participation in this research is your choice. You may stop your participation at any time. You may also have a family member or friend whom you trust speak with us and look over this consent form before you agree to take part in our research.

Contact for information about the program:
If you have any questions or concerns about anything to do with the program you may contact the lead researcher, Richard Young by email: richard.young@ubc.ca.

Contact for concerns about the rights of research participants:
If you have any concerns or complaints about your rights as a research participant and/or your experiences while participating in this study, contact the Research Participant Complaint Line in the UBC Office of Research Ethics at 604-822-8598 or if long distance e-mail RSIL@ors.ubc.ca or call toll free 1-877-822-8598.

Consent:

I understand that my participation in this study is entirely voluntary (I do not have to participate if I do not want to) and, I may refuse to participate or leave the study at any time.

By signing this, I am showing that I have received a copy of this consent form for my own records.

My signature below indicates that I consent to participate in this study.

Name of Participant  (Please Print)
Appendix D  Demographic Survey

First name only: _________________________________

Gender: MALE / FEMALE / OTHER: __________

Year of Birth: _____________________________

How many times did you socialize with friends or family in the last 7 days?
________________________________________________________________________

Approximate yearly income (check only one option):

___ Less than $30,000
___ $30,000 to $49,999
___ $50,000 to $74,999
___ $75,000 to $99,999
___ More than $100,000

What is your highest completed level of education?
________________________________________________________________________

How would you describe your cultural or ethnic background?
________________________________________________________________________
Appendix E  Interview Guide

This interview is largely open-ended and the aim is to have the participant stay as close to their lived experience as possible and to explore their whole experience to the fullest extent. To do so, the participant will be asked to think of concrete experiences, including describing a specific situation, instance or event.

Below are some possible questions:

“Think about your life before the pandemic. How have things changed?”

“Can you describe an experience yesterday that is typical of your life during the pandemic?”

“How did you feel when you first heard about the pandemic?”

“What you described seems important to you. Can you say more about that?”

Some additional prompts:

“Can you give me an example?”

“What did you think about that?”

“In what way?”
Appendix F  Sample of Initial Analysis Document

<table>
<thead>
<tr>
<th>Initial themes - 2008</th>
<th>Pandemic experiences</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Loss of significant part of life</strong></td>
<td>daily expedition to library before pandemic</td>
</tr>
<tr>
<td><strong>Loss of carefully organized activities outside of the home</strong></td>
<td>volunteer came to end</td>
</tr>
<tr>
<td><strong>A feeling of lack</strong></td>
<td>being alone with only internet lonely</td>
</tr>
<tr>
<td><strong>Unfamiliar shift in well-being</strong></td>
<td>fast shift in mood in a day</td>
</tr>
<tr>
<td><strong>A bear in hibernation</strong></td>
<td>more you sit around less you want to do</td>
</tr>
<tr>
<td><strong>Life in a new world</strong></td>
<td>few routines</td>
</tr>
<tr>
<td><strong>Sedentary lifestyle in pandemic</strong></td>
<td>transition of format of project challenging</td>
</tr>
<tr>
<td><strong>Online engagement with others odd</strong></td>
<td>visit to garden centre like a holiday</td>
</tr>
</tbody>
</table>
Appendix G  Sample of a Portion of the Mind Map
Appendix H  Summary of the Final Analysis

The lived experience of older adults living alone in the COVID-19 pandemic
Research conducted by Mindy Chiang, M.A. student in Counselling Psychology, UBC
(under the supervision of Dr. Richard Young, UBC)

Draft summary of the overall findings

Participants: Participants are 12 retired older adults living alone in British Columbia (BC). All participants are female (all prospective participants who contacted the researcher were female). Participants are aged between 68 to 85 (Mean age: 74) and all have lived alone for over 10 years (Mean years living alone: 21). All participants have high school level education or above and 7 have master’s level education. The majority of the participants live in BC’s largest urban centre.

Research design: van Manen’s approach to hermeneutic phenomenological research\(^1\) guides the research design for this study, particularly the methods of data collection and analysis.

Research context: The first round of data collection began in mid-July 2020, approximately 4 months after the declaration of a public health emergency by the provincial government of BC. The province entered Phase 3 of its Restart Plan several weeks prior to this on June 24, 2020, which meant the easing of pandemic restrictions for individuals and businesses. The first round of data collection was completed in early August 2020. Participant interviews were conducted online via Zoom or over the phone. The length of the first interviews ranged from 46 to 81 minutes (Mean length: 61 minutes).

Results: In this study, we explored the central research question: What is the lived experience of older adults living alone in the COVID-19 pandemic? Below is a summary of the themes that emerged as core to this experience based on thematic analysis of data from the first interview across all participants. Bear in mind that this is reflective of data collected in July-August 2020.

<table>
<thead>
<tr>
<th>Core theme 1: A shrinking existence</th>
<th>Multiple losses</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Loss of structure</td>
</tr>
<tr>
<td></td>
<td>Loss of community</td>
</tr>
<tr>
<td></td>
<td>Loss of freedom to travel</td>
</tr>
<tr>
<td></td>
<td>Loss of identity</td>
</tr>
<tr>
<td></td>
<td>Grief, sadness, emptiness</td>
</tr>
<tr>
<td></td>
<td>Absence underscores presence</td>
</tr>
<tr>
<td>Limited future</td>
<td>Inability to plan</td>
</tr>
<tr>
<td></td>
<td>Nothing to look forward to</td>
</tr>
<tr>
<td></td>
<td>Life on hold</td>
</tr>
<tr>
<td></td>
<td>Sense of ageing amplified</td>
</tr>
<tr>
<td></td>
<td>Sedentary lifestyle</td>
</tr>
</tbody>
</table>

### Core theme 1: Home-bound life

<table>
<thead>
<tr>
<th>Home-bound life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of motivation</td>
</tr>
<tr>
<td>Forced change in lifestyle</td>
</tr>
<tr>
<td>Safety of home</td>
</tr>
<tr>
<td>Desire for change</td>
</tr>
</tbody>
</table>

### Core theme 2: Confronting a mysterious threat

<table>
<thead>
<tr>
<th>Core theme 2: Confronting a mysterious threat</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexpected stop to life</td>
</tr>
<tr>
<td>Initial shock and disbelief</td>
</tr>
<tr>
<td>Sudden change</td>
</tr>
<tr>
<td>Disoriented and unanchored</td>
</tr>
</tbody>
</table>

| Ongoing fear and anxiety                     |
| Fear of contracting COVID-19                 |
| Constant underlying tension                  |
| Virus mysterious and ethereal                |
| Age amplifies fear                            |
| Concern for family                           |

| Powerlessness and vulnerability               |
| Lost and helpless alone                       |
| Existing conditions add to vulnerability      |
| Challenges reaching out for help             |

### Core theme 3: Navigating a new world

<table>
<thead>
<tr>
<th>Core theme 3: Navigating a new world</th>
</tr>
</thead>
<tbody>
<tr>
<td>Engaging with a new world</td>
</tr>
<tr>
<td>Cautious in the day-to-day</td>
</tr>
<tr>
<td>Unwelcoming world: Doors closed</td>
</tr>
<tr>
<td>Online transition of activities</td>
</tr>
<tr>
<td>Unease re-engaging with the world</td>
</tr>
<tr>
<td>Heightened awareness of others’ behaviours</td>
</tr>
<tr>
<td>Contingent broadening of the world</td>
</tr>
</tbody>
</table>

| Uncertain and somber future                  |
| Realistic pandemic outlook                   |
| Limited sense of control over future         |

| Reflecting on the bigger picture             |
| Interconnection with broader context highlighted|
| Re-examining lifestyle choices               |
| Existential reflections                      |

### Core theme 4: Adjusting to the new normal

<table>
<thead>
<tr>
<th>Core theme 4: Adjusting to the new normal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment as a process</td>
</tr>
<tr>
<td>Varying degrees of adjustment</td>
</tr>
<tr>
<td>Acceptance</td>
</tr>
<tr>
<td>Gratitude and perspective</td>
</tr>
<tr>
<td>Ensuring connection</td>
</tr>
<tr>
<td>New goals and routines</td>
</tr>
<tr>
<td>Maintaining some sense of control</td>
</tr>
</tbody>
</table>
**Factors that help and hinder adjustment**

<table>
<thead>
<tr>
<th>Individual circumstances that help:</th>
<th>financial stability; close connections nearby</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal factors that help:</td>
<td>resilience; independence; introspective nature</td>
</tr>
<tr>
<td>External circumstances that help:</td>
<td>government response; re-opening; weather</td>
</tr>
<tr>
<td>Factors that compound challenge:</td>
<td>existing health conditions; recent transition</td>
</tr>
</tbody>
</table>

**Core theme 5: Place in society as older adult highlighted**

<table>
<thead>
<tr>
<th>Generational differences highlighted</th>
<th>Inter-generational tension surfacing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Different experience for young people</td>
<td></td>
</tr>
<tr>
<td>Existing ageism reinforced</td>
<td>Narrative of vulnerability</td>
</tr>
<tr>
<td></td>
<td>Seniors’ lives expendable</td>
</tr>
<tr>
<td></td>
<td>Feeling excluded from society</td>
</tr>
<tr>
<td>Advocacy and helping among older adults</td>
<td>Advocating for choice and inclusion</td>
</tr>
<tr>
<td></td>
<td>Value in older adult voice and wisdom</td>
</tr>
<tr>
<td></td>
<td>Older adults helping one another</td>
</tr>
<tr>
<td>Appreciating gestures of goodwill</td>
<td>Goodwill and consideration from young people</td>
</tr>
<tr>
<td></td>
<td>Helpful age-based responses from organizations and businesses</td>
</tr>
</tbody>
</table>

**Second interview:** 10 of the 12 participants completed a second interview where the initial analysis of their individual conversation was reviewed and discussed. The interviews ranged from 18 to 43 minutes (Mean length: 30 minutes) and took place from November 2020 to February 2021. Participants largely agreed with the themes presented in the second interview and elaborated on those they saw as particularly salient. The individual analyses were finalized based on the discussions in the second interview and were then used to develop the overall analysis presented above.

Given that the second interview took place 3 to 6 months after the first interview, participants were also asked to describe any differences in their experience in the pandemic since the first interview. While pandemic conditions worsened in BC during this period, most participants reported increased adjustment, particularly emotionally. Some participants also described being able to increase activity and build structure and connection creatively within the context of continued restrictions. Finally, many participants expressed increased optimism for the future, especially with the vaccine rollout on the horizon.