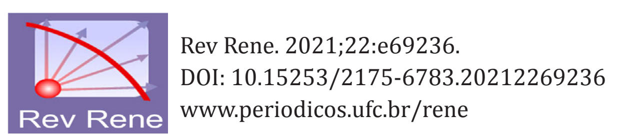
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Original Article

Elderly people's experience facing social isolation in the COVID-19 pandemic

Vivência de idosos diante do isolamento social na pandemia da COVID-19

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ABSTRACT
Objective: to unveil the experience of the elderly with social isolation in the pandemic of COVID-19. **Methods:** qualitative study, with 14 elderlies in social isolation. The content was recorded and processed using the software Interface de R pour les Analyses *Multidimensionnelles de Textes et de Questionnaires.* **Results:** six classes were obtained, the first focused on spirituality and pre-pandemic pleasurable activities; the second was related to missing the extra-household routine and family life; the third, to the construction of a new routine; the fourth, to the strategies adopted for the prevention of COVID-19; the fifth, to the signs/symptoms experienced during the infection; and the sixth class, to the fear of dying. **Conclusion:** the experience of the elderly was permeated by the adaptation of routine, adoption of preventive measures and feelings of anguish in the face of uncertainties.
Descriptors: Nursing; Aged; Social Isolation; Coronavirus Infections; Pandemics.

RESUMO
Objetivo: desvelar a vivência de idosos diante do isolamento social na pandemia da COVID-19. **Métodos:** estudo qualitativo, com 14 idosos em isolamento social. A coleta foi realizada por contato telefônico, cujo conteúdo foi gravado e processado por meio do *software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires*. **Resultados:** obtiveram-se seis classes, a primeira voltada à espiritualidade e às atividades prazerosas pré-pandemia; a segunda foi referente à saudade da rotina extradomiciliar e do convívio familiar; a terceira, à construção de nova rotina; a quarta, acerca das estratégias adotadas para a prevenção da COVID-19; a quinta, sobre os sinais/sintomas vivenciados durante a infecção; e a sexta classe, pelo medo de morrer. **Conclusão:** a vivência dos idosos se mostrou permeada pela adaptação da rotina, adoção de medidas preventivas e sentimentos de angústia ante as incertezas.
Descritores: Enfermagem; Idoso; Isolamento Social; Infecções por Coronavírus; Pandemias.

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Introduction

The Coronavirus Disease 2019 (COVID-19) pandemic, caused by the new Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2), has been noticed in China, in the city of Wuhan. The public health impacts of this fast and easily spread virus are emerging, so the World Health Organization classified it as a pandemic in March 2020, and in Brazil, the first case of the disease was detected in February[1]. Worldwide, 156,496,592 cases of COVID-19 and 3,264,143 deaths have been confirmed by May 8, 2021. Of these, 15,003,563 positive cases are from Brazil[2].

The recommendations and measures of social distancing and isolation, mask use and hand and surface hygiene, even with the vaccine, remain as a preventive strategy for the population[2]. The absence of specific therapeutic interventions for the disease, associated with its rapid transmission rate, supports the continued recommendation that individuals should, whenever possible, stay home to contain the spread of the disease. Although effective in controlling infections, this strategy has potential repercussions on the new routine that people start to experience, in a way that can influence health[3].

In this context, it is noteworthy that the distance can affect the elderly population that, in face of the multidimensionality of aging, presents a substantial risk of mental health sequelae associated with the process of social isolation[4]. Besides psychological problems, such as depression, anxiety, and panic syndrome, which may arise in the elderly due to social isolation, it also increases the risk of developing obesity, systemic arterial hypertension, dyslipidemia, diabetes mellitus, stress, insomnia, cardiovascular and cerebrovascular diseases[5].

For the elderly who live alone, restrictions on meetings because of COVID-19 can be devastating. Many of these subjects rely on exercise programs, religious communities, senior centers, or family visits as their only social connections. Prolonged isolation can put them at greater risk for emotional and physical illness[6]. Social relationships exist in the ethereal world of emotion, words, and connection, all of which are not synonymous with physical proximity. As the COVID-19 pandemic progresses, it is necessary to mitigate the negative effects of social isolation among the elderly before it becomes a chronic problem[7].

To promote the health of the elderly during and after the pandemic, the development of coping strategies to mitigate health risks requires that the subjective aspects of the experience of the elderly facing social isolation be considered, so that resources and targeted health interventions can be planned and have a greater chance of effectiveness. Therefore, the question is: what is the experience of the elderly with social isolation in the pandemic of COVID-19?

Thus, this study aimed to unveil the experience of the elderly with social isolation in the pandemic of COVID-19.

Methods

This is a qualitative study, conducted in July 2020, in Redenção, located in the region of Maciço de Baturité, Ceará, Brazil. Initially, the sample size was 21 elderly people, but only 18 participants were eligible according to the inclusion and exclusion criteria. After contact, two participants dropped out, one for family reasons and the other for being bereaved. Therefore, the study was composed of 16 elderly people. Then, due to the data saturation method, there was a suspension due to the fact of integrating more participants because of recurrent and/or redundant data[8]. Thus, the final sample was composed of 14 elderly individuals.

Inclusion criteria for the study were individuals aged 60 years or older, who had a telephone set and were in social isolation due to the COVID-19 pandemic. The exclusion criteria were being hospitalized

and having reduced cognitive ability, since this would make it difficult to understand when answering the survey. To evaluate cognition, the Mini Mental State Examination was used[9].

Data collection occurred remotely, and the interviews were conducted by the authors themselves through telephone contact. The data were identified in the registration forms of the Community Health Agents in the Family Health Center of the municipality. Then, an appointment was made with the family members and caregivers, and all the calls were recorded after the research objectives, risks, and benefits were explained, and after the participants' authorization. Each call lasted an average of 30 minutes and were made during the weekdays in the morning and afternoon. It is worth mentioning that it was not necessary to make more than one contact with the same elderly person.

For the collection of information, a semi-structured script was prepared for the interview, which is composed of two parts: the first refers to the clinical and epidemiological data with variables about age, gender, marital status, level of education, family income and clinical and psychological manifestations related to the disease. The second part, with the guiding question: how is it for you to live in social isolation in the pandemic of COVID-19?

The audio recorded content was transcribed in full, the text resulting from the transcription composed the corpus processed in the software Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires (IRAMUTEQ) 0.7 Alpha 2.3.3.1. Multivariate analysis was performed by Descending Hierarchical Classification, in which the segments grouped by means of Chi-square in groups called classes are visually presented as a dendrogram, to present the relationship between the classes and the words that compose them.

The compatibility of processing the corpus in IRAMUTEQ was corroborated by the fact that the text had 1,075 forms distributed in 5,661 occurrences, for which the utilization was 71.8%. To protect the identity of the participants, the names were replaced by the letter I followed by numbers randomly assigned to the subjects.

The study followed the rules of Resolution 466/2012, of the National Health Council with approval from the Research Ethics Committee of the Paulo Picanço College under protocol number 4,152,406/2020, thus meeting the ethical criteria in research with human beings, with the use of the Informed Consent Form.

Results

Of the 14-elderly interviewed, ten were women and the prevalent age bracket was 60 to 79 years (n=11). As for education, seven had incomplete elementary school education and four had complete education; two had complete high school education and one was illiterate. Regarding marital status, eight were married. As for the group they lived with, eight lived with their spouse and/or children, four lived with children, and only two lived with a caregiver. The participants' family income ranged between one and two minimum wages. Regarding comorbidities, seven were hypertensive, two diabetic, and five hypertensive and diabetic. Regarding the performance of the cognitive functions that make up the Mini Mental State Examination, the participants (n=14) reached the average score required for the variable's language, memory, and temporal orientation. In the field of education only one participant did not reach the expected score.

IRAMUTEQ grouped the text corpus into 160 segments and as is recommended by the Descending Hierarchical Classification, six classes were obtained, as shown in (Figure 1), organized into six classes.

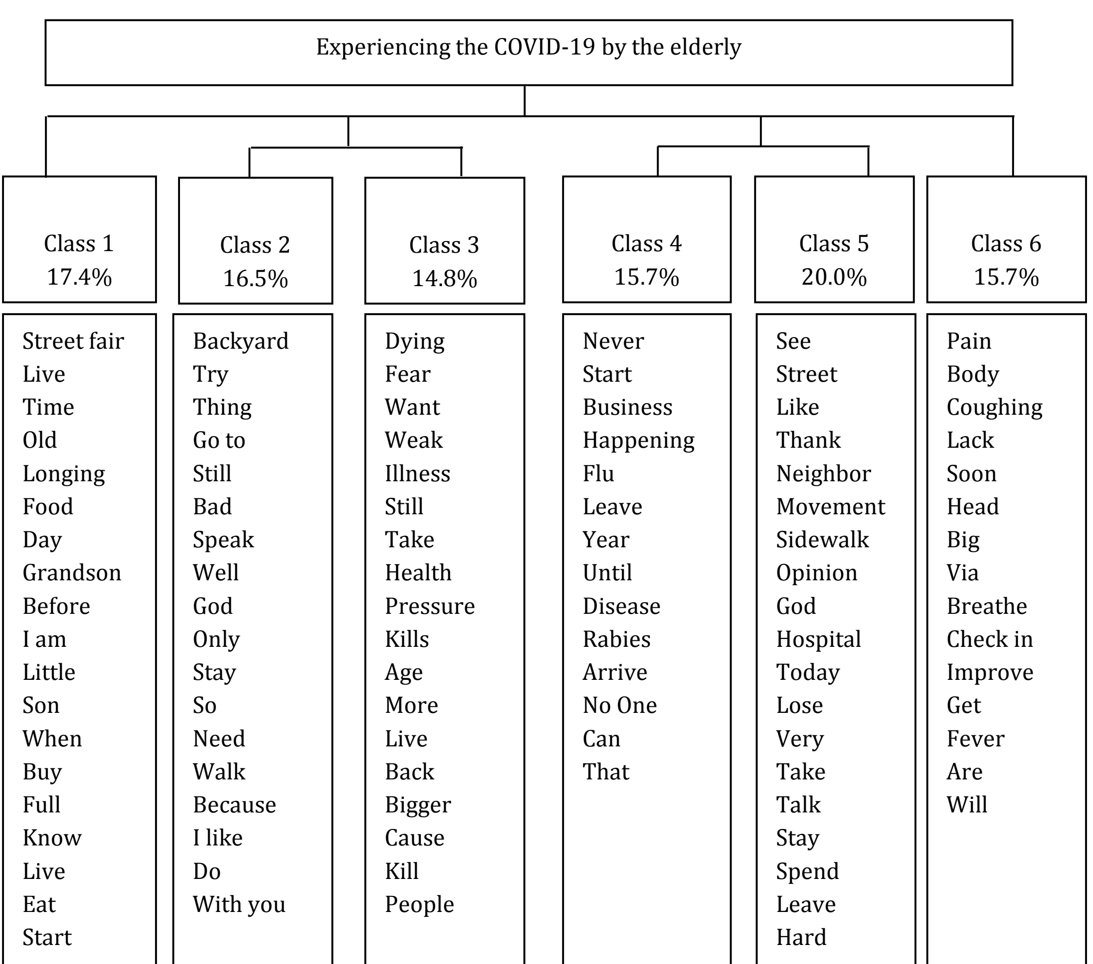

Figure 1 – Dendrogram of the classes of words about the experience of the elderly with COVID-19. Redenção, CE, Brazil, 2020

Class 1: Longing for the extra-household routine and family life

The Class 1, formed by 17.4% of the words, referred to the nostalgia for the extra-household routine and for family life. The elderly reported nostalgia for leaving home, going for walks, and developing routine activities such as going to the market and shopping. The participants of the study had to redefine their routine to adapt to the pandemic moment and thus develop measures to cope with the social isolation experienced: *I miss leaving home, going out, walking around, I even miss my sidewalk, who ever saw that, my daughter, and my grandchildren, I miss them here at home* (I13). *I felt like leaving home to go to the market and to the street fair* (I2).

In addition, they mentioned the longing for the familiarity with family members and expressed the usefulness of phone calls as a positive coping measure, since they had the possibility of talking by audio and video with relatives, especially their grandchildren. They also reported that social isolation has caused them suffering due to the need to keep away from their relatives: *I miss the noise here at home, the children in the backyard, I am already a great-grandmother, can you believe it? A beautiful little girl, my oldest grandson's daughter, I wish I could stay with them, I hope this ends soon, that is all I ask* (I14). *Our family helps us too much. I miss them terribly, I only see them by cell phone, when my little girl calls, or my oldest. It has been a suffering to stay away from them* (I13).

Class 2: Building a new routine

Class 2, with 16.5% of the words, was related to the construction of the new routine. The elderly reported developing activities such as taking care of the plants, organizing the house, cooking, talking to their spouse and walking around the backyard, to improve the negative aspects related to social isolation and, thus, to develop new routines during the pandemic of COVID-19*: I always try to distract myself, take care of the plants in the backyard, walk around the house, talk to my old lady, we call the boy, and so the time goes by, I'm even learning how to cook, who ever imagined such a tidying up* (I13)*. Can you believe that I have even gone for a walk in the backyard of my house so as not to stand still?* (I6)*. I do not do many things at home, but what I do manage, no matter how little it is, is useful, I like to walk around the backyard and sit in my laundry room drinking my good coffee, I know that better days will come, I believe* (I10)*. I leave the house clean, it calms me down, I fold my clothes, and try to make the time go by faster, I have been cooking more, some recipes that I see on TV to see if I brighten my day more* (I8)*.*

The study participants also mentioned tasks that they started to perform after hospitalization. They also expressed an increase in communication with the spouse, which enables an improvement in interpersonal relationships and fosters strategies to mitigate the harm of social isolation: *After I came home from the hospital I started to crochet, take care of my plants and swing in the hammock* (I7)*. After I came back from the hospital, I stay more on TV, I talk a lot with my old man* (I8)*.*

Class 3: Fear of death

The Class 3, with 14.8% of the words, portrayed the participants' fear of death. The elderly showed a feeling of despair followed by crying when they were infected by SARS-CoV-2 and contemplated death, which made them more distressed by the sadness and fear of loss of family life: *I was very afraid, I know I'm not young, but I don't want to die now, when we found out I was infected, I was desperate, I cried a lot* (I13)*. I was very afraid of dying when I had to go to the hospital, I thought I would never go home again, I would never see my children again, I had never felt something so bad, it was hard* (I12)*.*

The participants associated the fear of death with the need to care for the spouse. Some elderly had only the partner as caregiver, so the lack of one of them would result in losses to the family arrangement and corroborates the feeling of sadness and loneliness*: I cannot die, I take care of my partner who has the most fragile health* (I1).

Class 4: Strategies for preventing COVID-19

Class 4, represented by 15.7% of the words, denoted strategies for preventing COVID-19. The research participants reported activities such as hand washing, mask wearing, and social distancing as measures to prevent SARS-CoV-2 infection. Moreover, they reported being surprised with the techniques adopted and said they had never experienced the need for these interventions to protect themselves against a disease: *...This thing of washing hands, wearing masks, I have never seen this since I was 67 years old* (I11)*. To not catch the disease, you must wash your hands and stay inside, who has ever seen that?* (I12).

The elderlies expressed in their speeches the need for changes in routine to adapt to the prevention strategies of COVID-19. They reported having stopped doing activities such as shopping due to the need for social isolation. In addition, they mentioned the concern on the part of their children to protect their parents, since they fit into the risk group: *...Now it is my youngest who does the shopping, before I used to solve everything, but, they are too worried, my goodness, sometimes I get too much pressure, the way they talk, it seems like the end of the world to them, I even understand, but I don't agree, I know how to take care of myself, that is why I am alive until today* (I15)*. In the beginning I even stayed on the sidewalk, but after the disease arrived in town my daughters forbade me to go out even on the sidewalk* (I1)*.*

Class 5: Spirituality and pleasurable activities pre--pandemic

Class 5 stood out with 20.0% of the words, di-

rected to spirituality and pleasurable activities pre-pandemic. The elderly reported an increase in spiritual activities and the possibility of strengthening their beliefs based on their experiences, such as hospitalization, feelings of fear, insecurity: *I have more faith today, I pray more and thank you too* (I12). *I am glad God healed me, even today I cry thanking God* (I8). *I do not miss a mass on TV, I like to thank God for so many blessings received* (I13).

The participants also talked about the activities related to spirituality that were part of their daily lives before the social isolation, such as religious meetings, dialogues developed with neighbors, visits to friends, observation of human relations near their homes and watching television: *I liked to gather in church to pray the rosary* (I6). *I liked to stay on the sidewalk watching the movement of the street, watching the cars go by, the children playing ball and talking to the neighbors* (I7). *I liked to visit my friends, go to the street, watch the street going by* (I13). *Before going to the hospital, I liked to stay watching television almost all day, I like soap operas. The old ones that are being shown now are particularly good* (I7).

Class 6: Signs and symptoms experienced during SARS-CoV-2 infection

Class 6, represented by 15.7% of the words, was related to the signs/symptoms presented during the infection by SARS-CoV-2. The elderly reported signs/symptoms such as headache, cough, myalgia, chest pressure, dyspnea, fever, and asthenia referring to COVID-19: *As soon as the symptoms started, I suspected it right away, I caught the bug, then came coughing, headache that just needed to explode, a weakness so great that I didn't even want to get up* (I15).

The participants thought that COVID-19 would be like the flu syndrome that is common at specific times of the year, mainly due to climate change. However, later they learned that the mortality of the SARS-CoV-2 infection would be higher: *At first, I thought it was a flu that you get every year, but then I realized that it was extremely dangerous and that it could kill a lot of people. I had a headache, fever, body aches, cough, I could catch the flu even without leaving the house* (I4).

The elderlies also reported the experience during hospitalization, mentioned the rapid worsening of the condition, the need for mechanical ventilation, and associated prolonged dyspnea with risk factors such as overweight: *I felt such a tightness in my chest, my breath ran out right away, my daughter called the hospital right away, I was admitted the same day, I needed that device to breathe, but it only lasted a short time, they managed to control the fever, and I kept getting better, I felt a lot of pain in my body, I'm a little heavy, so my air ran out, but after about 10 days the doctor sent me home* (I12).

Discussion

The study has the limitation of being conducted with users of the Unified Health System, so that the experience of the elderly who use supplementary health care may be different. However, the findings provide subsidies for further research and means to develop strategies to cope with social isolation by the elderly.

Unveiling the experience of the elderly with social isolation in the pandemic of the COVID-19 offers subsidies for holistic actions, which consider the subjectivity of the subjects, to plan care, with a view to mitigating damage and reducing health risks to the elderly. Moreover, the results of such unveiling point to the need for the development of strategies after the pandemic and direct the subjective aspects that should be considered, especially by primary care nurses who, articulated with the other professionals of the health team, will need to act for the promotion of geriatric physical and mental health.

The first class identified refers to missing the extra domiciliary routine and family life. A quantitative study conducted in the United Kingdom that aimed to analyze the impact of social distancing measures in the pandemic of COVID-19 demonstrated that the elderlies are susceptible to the greatest emotional effects resulting from coping measures[10]. Thus, the lack of social interaction with family and friends contributes to the increase of negative impacts on the mental health of this public. Therefore, it is necessary that this fact be considered in the construction of the

care plan for the elderly during the pandemic, and that interventions be developed to mitigate the negative repercussions.

The second class presented refers to the construction of the new routine. The elderly pointed out in their speeches the need to adapt their routine to make their days more pleasant. An observational study developed in the United States discussed risk factors for environmental and social deficiencies that are exacerbated during the pandemic and, throughout the research, the difficulty in establishing a new routine and the need to adapt to the processes inherent to social isolation were pointed out[11].

Corroborating the findings of this study, research conducted in southern Brazil with elderly people at the beginning of the pandemic showed that participants underwent changes in their daily habits. The change in daily life and the fact of social isolation had a direct impact on the lives of the interviewees because they had to adopt several recommendations and care. Moreover, this new context also affected family ties[12].

In this sense, the adaptation of the routine, permeated with recommendations and strategies to avoid contamination by SARS-CoV-2, has made the days of the elderly more tedious, which may contribute to the spread of feelings of greater isolation, sadness and loneliness, which foster the mental health deficit of these subjects. Thus, the community work of health professionals, especially in primary care, needs resignification to mitigate the negative effects of social isolation, but with respect to the coping measures recommended by the World Health Organization[13].

The third class was represented by words that refer to fear of death. A case study conducted in Italy highlighted some of the peculiarities manifested by its elderly population and demonstrated that one of the main feelings experienced by this public in the COVID-19 pandemic is the fear of dying[14].

A study that aimed to reflect on the relationships of the elderly during the COVID-19 pandemic from the perspective of complexity, which aims at the path of hope, supports, and refers to a meshing of the emerging categories in this study, by pointing out that the feelings presented by the elderly due to social isolation include the fear of dying[15].

The fear of dying during the pandemic of COVID-19 is part of the feelings experienced by most individuals, especially the elderly because they are part of the risk group and are more susceptible to infection by SARS-CoV-2, as well as worsening of the case when tested positive. In view of this, interventions in mental health need to be developed by primary and secondary care and care support programs, considering the need to mitigate the risks inherent to the process of social isolation experienced by the elderly.

The fourth class referred to strategies for preventing infection with the COVID-19 virus. A descriptive study conducted in Turkey reported on measures to prevent infection with SARS-CoV-2, among which it highlighted that frequent hand washing, use of 70% alcohol, and social distancing have proven effective in reducing viral transmission since the declaration of a pandemic in March 2020[16].

Given this, the elderlies participants of this study demonstrated to know the recommendations of strategies for the prevention of infection by the COVID-19 virus. Having knowledge about disease prevention is one of the expected outcomes in population groups that have access to information, this needs to be monitored and disseminated in reliable media and by experts on the subject[17].

In addition, the relevance of health education is emphasized, developed by professionals, especially nurses, for being responsible for comprehensive care in all life cycles. Thus, in view of the news broadcast, many of them without scientific basis, it is necessary to check whether the measures such as hand washing, use of masks, and others are being carried out properly.

The fifth class relates to pre-pandemic spirituality and pleasurable activities. A literature study conducted in the United States on protection strategies for religious elderly during the pandemic of COVID-19 showed that religious beliefs and practices are kno-

wn to help individuals cope with times of stress and are associated with lower anxiety and greater hope, especially in elderly populations[18]. Spirituality is one of the sources of comfort, is described as a positive aspect for the improvement and strengthening of patients and is included in the interventions provided in the Nursing Interventions Classification[19]. Thus, optimizing spirituality as a coping measure against the social isolation of the elderly is one of the strategies that can be used by nurses. In addition, it is pointed out that the spiritual and religious context of the elderly should be considered by nurses for the exercise of cross-cultural care and the construction of a singular therapeutic plan.

The sixth class presented content related to the signs and symptoms experienced by the elderly during infection by SARS-CoV-2, which were headache, cough, myalgia, chest pressure, dyspnea, fever, and asthenia. These findings are like a study developed in Wakayama, Japan, which discusses the clinical characteristics of patients with COVID-19, highlighting that cough was less frequent, gastrointestinal symptoms were more frequent, and that almost 20% of the patients developed severe pneumonia. They also concluded that only respiratory flu-like symptoms are not sufficient to diagnose the disease[20]. Thus, it is noteworthy that health professionals need to be aware of the emergence or camouflage of signs and symptoms in the elderly, for clinical management of Coronavirus in this public.

Another finding of this study was related to the fact that the experience of the elderly is permeated by the imposition of family members to the elderly, to comply with social isolation, which also contributes to changes in the autonomy of this public, which are characterized as another negative factor of the experience of the elderly in social isolation due to the pandemic of COVID-19. Thus, the family relationship with the elderly during the pandemic needs to be the target of planning and multidisciplinary intervention, so that possible conflicts do not culminate in damage to the safety measures of the elderly population.

Conclusion

The study showed that the experience of the elderly facing social isolation due to the pandemic of COVID-19 was marked by feelings of anguish before the uncertainties and fear of dying; missing the extra-household routine, the family life and the pleasurable activities that were performed in the pre-pandemic period. The elderly coping showed to be based on spirituality and the construction of a new routine, besides the adoption of strategies to prevent the disease. It was also possible to unveil that some elderly experienced signs/symptoms of SARS-CoV-2 infection.

Collaborations

Gomes MAC contributed to the conception and design, data analysis and interpretation, writing of the article, and relevant critical review of the intellectual content. Fernandes CS and Fontenele NAO contributed to the writing of the article and relevant critical review of the intellectual content. Galindo Neto NM, Barros LM, and Frota NM contributed to the final approval of the version to be published.

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