Older Adults Experiencing Social Isolation and Loneliness During Covid-19: Resilience Through Leisure

by

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AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

ABSTRACT

The purpose of this dissertation was to understand the role of leisure as a resilience strategy to combat social isolation and loneliness among older adult women who lived alone in Kitchener-Waterloo during the COVID-19 pandemic. This research was guided by the following research questions: (1) how did public health restrictions affect older adults during the pandemic; (2) what does resilience mean to older adults and what resilience strategies did they use to stay socially connected during the pandemic; and (3) what role, if any, did leisure play as a resilience strategy in addressing the threats of social isolation and loneliness during COVID-19?

The research approach that was taken was a narrative inquiry using semi-structured, one-on-one interviews held over the phone to collect data from participants. Many participants experienced heightened feelings of social isolation and loneliness due to physical distancing measures and government mandates (i.e., stay-at-home orders) (Lee et al., 2020). Older adults, particularly those living alone, were at higher risk of experiencing social isolation and loneliness due to restrictions on gatherings, physical distancing measures, and concerns about their health and safety (CDC, 2020). The closure of community centres and other social venues further limited opportunities for participants to engage in activities and connect with others. Many relied on regular social interactions for companionship, emotional support, and a sense of belonging, all of which were disrupted by the pandemic.

This research shows that extraverts and introverts had contrasting experiences during the pandemic due to their differing social needs and preferences. While both extraverts and introverts faced challenges during the pandemic, their experiences were shaped by their distinct social preferences and coping mechanisms. Extraverts struggled with reduced social interaction, while introverts navigated a balance between solitude and the need for connection.

Similarly, both unvaccinated and vaccinated individuals navigated unique challenges and considerations throughout the pandemic based on their vaccination status and individual circumstances. Unvaccinated participants expressed experiencing more judgement, shunning, and ostracism than vaccinated participants.

Every participant, regardless of extraversion, introversion, or vaccination status, demonstrated resilience. Using technology to stay connected during a time where face-to-face interactions were near impossible, older adult women exercised their resilience to make it through the pandemic.

Older adult women demonstrated remarkable resilience during the pandemic by employing various leisure strategies to mitigate social isolation and loneliness. Through findings, 5 dimensions of resilience arose encompassing what resilience meant to participants. The dimensions included acceptance, perseverance, adapation, perspective and, and positivity.

Further, three major themes of how leisure was exercised to stay resilient arose, which included using leisure to stay connected, to stay distracted, and to stay active. By engaging in leisure, older adult women not only exercised their resilience and coped with social isolation and loneliness but also demonstrated resilience.

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11/11 ∞

DEDICATION

This doctoral dissertation is dedicated to my baba and maman, my greatest heroes. With love,

-Your Daughter

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CHAPTER ONE: INTRODUCTION

Introduction

During the COVID-19 pandemic, Canadian society adapted dramatically to new routines and practices as Canadians adjusted to public health restrictions aimed to mitigate the spread of infection. Caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) virus strain (Public Health Ontario, 2019), COVD-19 transmits through droplets and virus particles released into the air when an infected person breathes, talks, coughs, or sneezes (Public Health Ontario, 2020). Though some who test positive show no symptoms whatsoever, aggressive symptoms can appear in those infected and even result in fatality (CDC, 2020) Accordingly, governments, guided by public health officials, established constraints on personal behaviours to lessen the spread of disease.

From the start of the pandemic, older adults (those 65 and older) were targeted to maintain strict physical distance guidelines because of their high-risk susceptibility to contracting COVID-19. Physical distancing involved keeping at least six feet apart from others, isolating at home as much as possible, and limiting interactions with others, including family and friends from other households (Galea, Merchant & Lurie, 2020). These public health measures were deemed particularly important to protect segments of the population that proved to be susceptible to COVID-19. As the world quickly recognized, the mortality risk of COVID-19 was strongly age-related, with the death toll particularly impacting older adults (Li et al., 2021). In Canada, between the end of March 2020 and mid-May 2021, older adults aged 65 and over accounted for 64% of deaths, with 93% of those attributed to COVID-19 (Statistics Canada, 2021). Today, older adults remain at risk for COVID-19 complications because of their higher rates of age-related diseases and comorbidities compared to the rest of the population (Centers

for Disease Control and Prevention, 2020; National Council on Aging, 2020). Already susceptible to most illnesses, including the common flu, older adults are particularly at risk for contracting COVID-19 (through transmission), which can lead to severe illness, a longer recovery time, and possibly a premature death (CDC, 2020).

As Moustakas (1961, p. 26) declared, old age is also "fertile soil for loneliness." Stay-at-home orders, physical distancing, and quarantining during the pandemic only exacerbated the risk of older adults experiencing social isolation and loneliness (Wu, 2020). Social isolation means the objective absence of social relationships upon which an individual can draw for meaningful support (Smith & Christakis, 2008), whereas loneliness refers to the subjective (i.e., perceived) absence of such relationships (Victor, Bowling & Scambler, 2009). Described as "debilitating psychological conditions characterized by a deep sense of emptiness, worthlessness, lack of control and personal threat," both are regarded as serious public health crises among the older population (CDC, 2020). Indeed, an estimated 30% of Canadian older adults experienced social isolation and/or loneliness pre-pandemic (Keefe et al., 2006) with an even higher percentage experiencing it during the pandemic (Wu, 2020). Reduced social networks, increased health issues, lack of transportation, and widowhood put older adults at risk under normal circumstances (National Academies of Sciences, Engineering and Medicine, 2020); the pandemic only made matters worse. Whatever the source, the toll of social isolation and loneliness is striking.

Even so, remarkably, many older adults remain resilient despite the risk factors they face. Here, I adopt the University of Waterloo's definition that resiliency is a "process of using internal and external resources to manage challenging circumstances" (University of Waterloo Resilient, 2020). Ungar and Theron's (2020, p. 442) further speak to resilience as "both the capacity of

individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their wellbeing, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways." Resilience, under this premise, is a dynamic, adaptive, ongoing, and negotiated process that is flexible, plastic, and changes over time (American Psychological Association, 2020; Wiles, Wild & Allen, 2012). Not surprisingly, many older adults consider themselves resilient because of the adversity with which they contend (Wiles, Wild & Allen, 2012). Those who live with chronic illnesses, physical disabilities, personal loss, or any issue that comes with aging often see themselves as "resilient" (Wiles, Wild & Allen, 2012). Moving through the literature, it is apparent that seeing yourself as resilient is being resilient, and accordingly, resilience is one of the factors that helps older adults adjust to the transitions that occur in older adulthood (Wells, 2010). Resilience helps them negotiate, adapt, and overcome challenges, hardships, and losses (Wiles, Wild & Allen, 2012). Understanding resilience from the viewpoints of older adults in a specific context (in this case the community during the pandemic), therefore, promises to shed light on the resilience strategies, resources, and protective factors that older adults exercise in their daily lives (Wiles, Wild & Allen, 2012).

In response to the elevated risk of social isolation and loneliness that older adults experienced during the pandemic (Wu, 2020), leisure seemingly offered the potential to serve as a resilience strategy. Used effectively, leisure allows individuals to develop competencies, resources, and positive emotions (Carruthers & Hood, 2007). Moreover, it can help individuals manage and relieve stress, find new direction, and buffer against negative life events (Iwasaki, MacTavish & MacKay, 2005). Of course, leisure can also worsen social isolation and loneliness (Glover, 2018). Solitary leisure pursuits, such as watching screens, can isolate individuals and

constrain meaningful social engagement (Toepoel, 2013). Whatever the outcome, a gap remains in the literature to explore the role of leisure as a resilience strategy for older adults to address social isolation and loneliness. This dissertation focuses on addressing this gap.

Another meaningful gap in the literature exists with respect to the experience of older adults in the community during COVID-19. With long-term care homes (LTC) identified as "COVID hotspots" (McMichael, 2020), most of the attention, allocation of resources, and COVID relief naturally focused on LTC and the quality of care for residents. Though the crisis in LTC warrants much needed attention and aid, the plight of older adults living in the community remains largely ignored, despite there being five times more older adults living in the community than in LTC (Condon & Herschaft, 2020). My focus in this research, therefore, will be at the community level. Proactive and preventative approaches to improve the quality of life of older adults living in the community, not only by concentrating on physical issues, but also social issues (e.g., social isolation) (Bowling & Gabriel, 2004), have the potential to make significant inroads in addressing problems. If health care professionals, policy makers, academics, and government organizations were to shift their attention to the social issues of aging, they would necessarily identify social isolation and loneliness among older adults as urgent problems to address.

All told, these gaps point to the need to examine the interplay of social isolation, loneliness, resilience, leisure, and older adults in a community setting, especially during a *pandemic*. While I endeavour to reach academic audiences in the gerontology and leisure fields with this dissertation research, I also aim to bridge this gap and shed light on the very real social isolation and loneliness crisis for older adults that has only been heightened during the pandemic. The plight of older adults living in the community experiencing social isolation and loneliness is

nothing new to the field of gerontology, but the introduction of leisure as a resilience strategy bridges the two fields—leisure studies and gerontology— and draws attention to the very real problem of social isolation and loneliness that has only been heightened during the COVID-19 pandemic.

Purpose and Research Questions

The purpose of this dissertation, therefore, is to understand the role(s) of leisure as a resilience strategy to combat social isolation and loneliness among older adults who live alone in Kitchener-Waterloo during the pandemic. Accordingly, I will attempt to answer the following research questions: (1) how did public health restrictions affect older adults during the pandemic; (2) what does resilience mean to older adults and what resilience strategies did they use to stay socially connected during the pandemic; and (3) what role, did leisure play as a resilience strategy in addressing the threats of social isolation and loneliness during COVID-19?

Gaps to Address

Although a growing body of research in gerontology and leisure already speaks to the social isolation, loneliness, and distress that older adults experienced during the COVID-19 pandemic (Krendl & Perry, 2020), it ignores how leisure boosts and/or reduces resilience under such circumstances. With the resilience literature mainly focused on children and adolescence (Li & Ow, 2022), this research will shed light on older adults and the resilience they possess. Understanding leisure as a resilience strategy, moreover, has the potential to allow for a better understanding of how older adults sustain healthy function and use leisure to alleviate stress. By

focusing on resilience, this research will explore how older adults negotiate leisure, adapt, change, aspire, and challenge their social circumstances (Maluccio, 2002) during a pandemic.

As a Director of Programs and Support Services/Allied Health who works in long-term care, I see firsthand the role that leisure plays in bettering the lives residents every day. Looking at the community, I can only imagine that leisure does the same for older adults living there, especially during the pandemic. At the end of my dissertation, I would like my study to contribute to the gerontology, positive psychology, and leisure literature. By shedding light on the use of leisure during the pandemic to combat social isolation and loneliness, I want to bring leisure to the forefront of gerontology and show its importance as a resilience strategy. I would hope that not only academics learn from my scholarship, but also members of the community. Although social isolation and loneliness are not new concepts to the field of gerontology, I echo Glover (2018, p. 32) who wrote, "leisure studies as a field . . . would benefit tremendously from greater attention paid to the topic of social isolation. While sound research on social isolation does exist within our literature, the topic remains surprisingly underexamined." This dissertation hopes to fill this gap.

CHAPTER TWO: LITERATURE REVIEW

Introduction

I chose to focus on leisure as a resilience strategy to address social isolation and loneliness during the pandemic for personal reasons. I worked in long-term care (LTC) during the height of COVID-19, when the outbreaks were at their worst and every resident in the home in which I worked tested positive for the virus. Outside of my shifts, I dropped off groceries and medication to two of my older adult neighbours and grandmother. During this heightened period of positive cases, fear spread among the older adults who belonged to my social network, yet they were able to see themselves through the worst of it. One word came to mind whenever I thought about the older people in my life: *resilient*. And leisure served as one of the important ways I witnessed the residents in LTC, my neighbours, and grandmother exercise resilience. Leisure pursuits helped the older adults in my life adapt to the pandemic and alleviate their social isolation and loneliness. My observations suggested there was something about leisure; it appeared to be a meaningful way for older adults to protect themselves from the scourge of social isolation and loneliness.

Stereotypes of older adulthood as an age of disease, depression, and dependency dominate Western culture, which obscures the reality that older adults can be healthy, age well, and exercise resilience (Angus & Reeve, 2006). The health risks associated with the pandemic, however, threatened the wellbeing of older adults, not just because of the risks of contracting COVID, but also because physical distancing restrictions put older adults at risk of both social isolation and loneliness, which could lead to a decline in physical and mental health, and overall wellbeing (Malone et al., 2020). The impact of the absence of, or reduced social contact with,

family, friends, and community during the pandemic caused COVID-19 to be recognized as a *geriatric health emergency* (Malone et al., 2020). I am interested in how older adults confronted this geriatric health emergency, successfully or otherwise, with leisure.

For the literature review that follows, I engaged in a streamlined search to fit the scope of my proposed research. Established research databases and search engines were utilized, primarily PubMed and Google Scholar, as well as updated mainstream websites to find recent content such as World Health Organization (WHO), and Centers for Disease Control and Prevention (CDC). Search engines were chosen for the variety of publications available, relevance of research, and orientation with standard literature review methodology. In doing so, I identified sources that included one or more of the following search terms in Google Scholar and PubMed dated between 2020 and 2023 (to align with the pandemic): "social isolation," "loneliness," "older adults," "seniors," "COVID-19," "leisure," and "resilience." These chosen search words were determined by considering key areas of interest, specifically focusing on social isolation and loneliness among older adults during the pandemic. I then cited each study and included full reference information. Doing so enabled me to identify relevant gaps and consider how to build off this extensive literature review. My work brings together the different academic fields of leisure, positive psychology, and gerontology in hopes of highlighting overlapping themes and merging them together. I also shed light on the gaps in previous literature, build off work I believe my work can strengthen, and offer my contribution to the greater pandemic literature.

Social Isolation and Loneliness

In my work in LTC during the pandemic, I witnessed the pain of social isolation and loneliness in older adults. My decision to focus on older adults in the community stemmed from the fact that they are more prone to experience both social isolation and loneliness when living alone (CDC, 2020). Data from the Canadian census shows that 24.6% of seniors aged 65 and above live alone in the community with no family or friends (StatCan, 2016). Older adults in the community were less likely to receive scheduled care check-ins, have visits from friends of family in order to adhere to physical distancing, recreational programming (due to stopped or lessened program services during the pandemic), so they were more likely to not only be lonely, but also socially isolated.

Social isolation refers to the objective absence of social relationships upon which meaningful support can be drawn (Smith & Christakis, 2008), whereas loneliness refers to the subjective perception of isolation (Victor, Bowling & Scambler, 2009), possibly (though not always) reflecting a disconnect between the social ties an older adult has and those they desire (Valtorta & Hanratty, 2012). Older adults are more vulnerable to a decline in social networks due to a variety of life changes, loss, and health issues (Cohen-Mansfield et al., 2007). Some of these common changes include an increased likelihood of living alone in older age, multiple role loss through retirement or the death of a spouse, mobility problems, sensory loss, financial difficulties, and poor health (Keefe et al., 2006).

Social isolation is a complex phenomenon comprised of physical, social, emotional, and psychological dimensions (Keefe et al., 2006). It functions at the individual, community, and societal levels, and affects mainly the older adult population (Keefe et al., 2006). Despite its

pervasiveness in later life, older adults do not experience loneliness and social isolation in the same way. Older adults, in other words, are not a homogenous group and differ greatly in terms of age, physical status, preferences, sociocultural differences, and other factors (Fakoya, McCorry & Donnelly, 2020). Though I speak to social isolation and loneliness together throughout my work, I note that older adults can be socially isolated, but not feel alone. Some older adults can have fewer social relationships, but feel satisfied with them, while other older adults enjoy being alone (Suicide Prevention Resource Center, 2020). Meanwhile, some older adults may not be socially isolated, but still feel lonely. That is, though they may have family or friends in their personal networks, they may feel they cannot rely on those ties when in need of support. Furthermore, not all chronically lonely people develop depression or anxiety related to maladaptation (Jakobsen et al., 2020). Some accept this way of existence and may adapt well (Jakobsen et al., 2020).

To understand social isolation and loneliness among older adults in Canada, I consulted Keefe et al. (2006) who drew on a National Population Health Survey for a profile of older Canadians at risk of experiencing social isolation and loneliness. Keefe et al. noted that, although being socially integrated into the community and having meaningful relationships can strengthen the quality of life of older adults, social isolation and loneliness remain serious risks for the older population, thereby making them important public health concerns (Keefe et al., 2006). The first step in addressing social isolation and loneliness in older adults is to pinpoint risk factors that make older adults more susceptible. For this reason, I turn to these risk factors next.

Risk Factors

There are several risk factors that influence social isolation and loneliness for older adults. Risk factors are associated with negative or undesirable outcomes in each population (Luthar, Cicchetti and Becker, 2000). According to the National Senior's Council Report (2014), the most *common* factors are:

- Living alone;
- being widowed;
- experiencing the death of a spouse;
- dealing with cognitive impairment;
- experiencing mobility problems;
- having multiple chronic health problems;
- having no children or contact with family;
- lacking access to transportation;
- living with low income;
- changing family structures;
- living arrangement (rural areas can have transportation issues);
- experiencing critical life transitions, including retirement or loss of a driver's license;
- lacking access to community services and programs.

Other risk factors are not as common, but equally in need of attention. With respect to gender, men and women age and experience social isolation and loneliness differently. Older adult women are more likely to be socially isolated and lonely if they have less support with their routine activities (e.g., shopping, transportation, cooking etc.), reduced physical capabilities, and

live alone (Keefe et al., 2006). By contrast, older adult men are more likely to be socially isolated or lonely if they have low emotional support (Keefe et al., 2006). But both men and women experience concerns or fears about going outside alone and safety issues, which can cause them to become isolated or feel lonely (National Seniors Council, 2014).

Social isolation and loneliness can also emerge from attitudes and stereotypes in society. The pandemic showed we live in an ageist society, as illustrated by the disrespectful tweets that trended at the time (Elliott, 2021) and the disregard communicated about the severity of the virus when it was thought to just affect older adults (Elliott, 2021). Older adults are more likely to experience discrimination and abuse based on their age, class, race, sex, and income, which may restrict their activities and relationships (Viswanathan, 2003). The National Seniors Council's Report (2014) also showed that Indigenous and immigrant older adults are at higher risk of social isolation and loneliness than others. Both groups may have limited social networks and challenges in accessing appropriate community programs and services due to stigma, stereotypes, language barriers, and an understanding in negotiating community services and programs (The National Seniors Council Report, 2014). Seemingly, we "exist within a system unprepared to address the unique needs and realities of different aging bodies" (Brotman, 2006, p. 8), which increases the risk factors for social isolation and loneliness.

Effects of Social Isolation and Loneliness

I have referenced the risk factors for older adults, but to really shed light on the crisis of social isolation and loneliness, acute and chronic effects need to be addressed. Social isolation and loneliness disturb an older adult's quality of life, physical health, mental health, and overall wellbeing (Lee, Steinman & Casey, 2020). Acute effects of social isolation and loneliness can

result in a higher risk of depression, emotional distress (Yoon et al., 2016), stress (DioGiovanni et al., 2004), low mood, irritability, and insomnia (Lee e al., 2005). Prolonged effects of social isolation and loneliness can lead to a 50% increased risk of developing dementia, a 29% increased risk of heart disease, and a 32% increased risk of stroke (National Academic of Science, Engineering & Medicine, 2020), hypertension, obesity, depression, substance abuse, suicidal ideation or attempts, cognitive decline, or even premature death (National Senior's Council Report, 2014). The emotional distress of feeling lonely or rarely encountering another person can sometimes result in a premature move to an LTC home to prevent any of the prolonged effects of social isolation and loneliness from happening (National Senior's Council Report, 2014).

The dynamic nature of social isolation and loneliness is both fluid and constantly changing. Older adults' experiences of social isolation and loneliness can change over time or worsen during certain periods (e.g., holiday periods, wintertime, evenings, and nighttime) and life transitions (Halls & Havens, 1999). Echoing Ungar (2005), I note that resilience refers to how one can navigate between available resources, which differs by context. The context of the pandemic represents a period in the lives of older adults that exacerbated social isolation and loneliness.

Social Connectedness

When we are not socially isolated or feeling lonely, we are *socially connected* (Cacioppo et al., 2006). Haslam et al. (2015, p. 1) defined social connectedness as "the sense of belonging and subjective psychological bond that people feel in relation to individuals and groups of others." Even so, social connectedness is an intangible construct and therefore hard to measure

because of its multidimensional character (Woolcock & Narayan, 2000). From an evolutionary perspective, a socially isolated and lonely individual feels unsafe and tends to be highly sensitive to danger (Cacioppo et al., 2006). To feel safe and secure, our ancestors formed social connections by working in groups to diminish the effects of stressful experiences (Cacioppo et al., 2006; Cohen & Wills, 1985; Wolins and Wolins, 1993). This sense of security persists today.

In contemporary society, we still have a need to connect with others and make social connections to cope with stress. These social bonds serve as protective factors in the face of adversity (Wilson & Williams, 2013). Known as *social connections*, they are the links and commonalities that bind a group of people together and provide individuals with sense of belonging and closeness (Karlan, 2007). Pinker (2014) emphasized the importance of face-to-face contact, which she demonstrated is crucial for learning, happiness, resilience, longevity, and ultimately, surviving. Humans thrive off social connections. Pinker (2014) listed the benefits of social connections, including the connections of friendship and love that help with healing, extending our lives and keeping us healthy and free of disease, and promoting happiness. Being surrounded by meaningful relationships, friends, families, and communities creates the hard-wired networks we need to live a happy and healthy life (Pinker, 2014).

Social Innovation

Older adults are most at risk for COVID-19. With weaker immune systems because of age, older adults have been disproportionately impacted by COVID-19, with higher susceptibility to severe illness, hospitalization, and in many cases death (CDC, 2020). According to the World Health Organization (WHO, 2020), fatality rates for those over 80 years of age are five times the global average. Public health minimized the spread of COVID-19 through

lockdown of communities, face mask mandates, quarantines, and physical distancing (Hartley & Perencevich, 2020). Although they proved effective at reducing the spread of the virus, these measures disproportionately impacted vulnerable older adults' health wise, socially, and economically (Lloyd-Sherlock, et al., 2020). Wu (2020) argued the fear of getting sick, the lack of social connections, and disruption in routines led to a greater need for mental health support of older people than ever before.

To help with previous experiences of loneliness and social isolation among older adults in the community, *social innovation* has been identified by experts as a potential solution and promising way of addressing social isolation and loneliness in Canada. It refers to partnerships, planning, and implementing ideas with organizations and sectors to address social isolation and loneliness at a community level (National Seniors Council Report, 2014). These initiatives can encourage older adults to engage in healthy habits, cultivate meaningful relationships, connect with the community, and develop social resources (National Seniors Council Report, 2014). Social innovation and participation in social gatherings serve as stimuli that increase interactions, which stimulates sensory systems, self-esteem, emotional and psychological support (Loyola et al., 2017). Social innovation also enhances protective factors that prevent social isolation and loneliness, including being in good over health, feeling safe in the community, enhancing communication skills, having meaningful relationships, having access to community services, feeling beneficial to society, and feeling connected to others (Office for Seniors, ND).

Social innovation is an intentional way that community organizations and older adults collaborate and combine resources to create new plans that address social problems in creative ways (National Seniors Council Report, 2014). With its community focus, social innovation

promises to highlight the role of the community in allowing older adults to be heard. However, the pandemic has challenged social innovation by creating barriers to any advancements. Volunteering, community programs, and gatherings lessened, stopped completely (Government of Ontario, 2020), or transitioned online where some older adults already struggle with access and require help with technology (Vaportzis, Giatsi Clausen & Gow, 2017). In focusing their resources on the pandemic, government and other sectors pushed social innovation for older adults to the back burner in favour of other priorities. As a result, social innovation failed to be the best solution for alleviating social isolation and loneliness for older adults during the pandemic. Older adults had to look elsewhere for solutions.

Social Engagement

Social engagement, (sometimes known as social participation or social involvement) is the basis of social connections and community participation (Luo et al., 2020). Staying socially active in groups helps increase older adults' social connectedness (Cornwell et al., 2008), and provides them with the ability to frequently interact with their social environment (Carr et al., 2018). Social engagement provides a sense of belonging and fulfillment (Luo et al., 2020; Carver et al., 2018) and "attaches social identity and roles to older adults, by creating a sense of shared identity with others" (Cruwys et al., 2013, p. 180).

Existing research has shown that social engagement has a positive impact on the mental and physical health, and overall quality of life for older adults (Brustio et al., 2018; Cybulski et al., 2017). Socially active and engaged older adults are more likely to keep themselves mentally healthier, are at less risk for depression (Haslam et al., 2015), have less emotional stress (Dumitrache et al., 2017), have greater self-esteem (Scott et al., 2020), have more reasons for

living (Carver et al., 2018), have a lower risk of mortality (Penninkilampi et al., 2018), and have better strategies to cope with stress (Liu et al., 2019), than those who have a secluded lifestyle (Steptoe & Fancourt, 2019). Social engagement activities such as visiting friends, chatting with neighbours, and seeing loved ones, have all been connected to living a longer life and have been shown to act as a buffer against the negative outcomes of aging (Kodzi et al., 2011). Social engagement positively affects the overall health and wellbeing of older adults (Sun et al., 2016).

The social engagement of older adults has become recognized as crucial for the positive maintenance of their mental and physical health globally (World Health Organization, 2002). As many older adults live alone, are retired (or don't work or work minimal hours) and partake in fewer social engagements in their later years (Zhong et al., 2017), the significance of social engagement is obvious in later life (Liu et al., 2019). When older adults connect with others who share the same passions and enjoyments, social bonds and meaningful relationships are formed, which serve as protective factors against loneliness and poor mental health (Kodzi et al., 2011). Social engagement provides not only a good support system for older adults, but also a stronger sense of purpose and belonging (Carver et al., 2018).

Older Adults Experiencing Social Isolation and Loneliness in the Community

The focus of this dissertation is on older adults who reside in the *community* and how they exercised leisure as a resilience strategy to combat social isolation and loneliness during the pandemic. With the pandemic disrupting regular habits, many older adults lost routine ways to connect with support networks and health and social service providers and spent increased time alone (Wu, 2020). Even prior to the pandemic, the National Health and Aging Trends Study report released in early 2020, just before the outbreak, stated that 28% of older adults aged 65

and older in the US (9 million) who lived in the community were already socially isolated or lonely at that time (National Academies of Sciences, Engineering & Medicine, 2020). In terms of geographical location, older adults who live in the community with limited resources are at even greater risk of feeling lonely or being socially isolated, which only worsened during the pandemic (Chen et al., 2020). Approximations of the extent of social isolation and loneliness among older adults living in the community vary in the literature, with rates as high as 60% reported in some cases (Savikko et al., 2005). Social isolation and loneliness have always been prevalent in older adulthood due to a natural decline in social integration that comes with the process of aging and age-related transitions (Steed et al., 2007).

Though a great deal of focus went to LTC homes in terms of social isolation and loneliness, "community-based long-term care also plays an important role for many frail older adults. These community services and programs cover adult-day care, respite care, homemakers, meals on wheels, and home health services. For frail older adults living alone, meal delivery staff may be the only person they meet on a daily basis" (Wu, 2020, p. 2). Living in the community presents an array of challenges (more need for transportation, less options for care services, etc.). With this in mind, we need to be conscious that the social isolation and loneliness resulting from the pandemic can increase the risk of these negative outcomes, which affects the health and wellbeing of community dwelling older adults (Wu, 2020).

Two reoccurring themes in the literature on older adults and social isolation and loneliness warrant repeating because of their combined salience as a serious social problem. In the words of MacLeod et al. (2021, p. 18), "the COVID-19 pandemic has compounded and worsened social isolation among older adults; and the impacts of intensifying social isolation

within this population have the potential to be long-lasting, with subsequent consequences for both mental and physical health outcomes." Social interactions provide older adults with feelings of belonging, togetherness, and communality (Tronick, 2017), so their absence has serious health consequences (see discussion above). With physical distancing restrictions limiting or even eliminating these social outlets for older adults, social disconnection is bound to happen and worsen the personal situations of those already dealing with some level of social isolation or loneliness (Holt-Lunstad, 2020). In addition to social disconnection, resilience and purpose in life may decrease over the long term without the presence of routine support systems, leisure pursuits, and relationships (MacLeod et al., 2021). This absence may lead to a possible "social recession," a long-lasting ruin in social contact resulting from heightened social isolation (Holt-Lunstad, 2020).

A pandemic and even a post-pandemic environment has factors increases mental health challenges among isolated seniors that includes living alone, loneliness, and disconnectedness from society; and loss of social opportunities (Wand et al., 2020). In this research, I am focusing on older adults who live in the community because experiences of social isolation and loneliness are connected to an older adult's context, including their social, cultural, and *living* environments (Hand et al., 2017).

Resilience

Returning to the experience I shared at the start of this chapter, I chose the concept of resilience as a focus for this research because of the remarkable inspiration I gained from observing older adults in my life. The literature defines resilience in multiple ways. Arrington and Wilson (2000, p. 224) agreed there is no "consensus among researchers regarding a singular

definition of resilience." While some scholars view it as innate, something with which one is born, one's neurobiology, and one's psyche (Connor & Davidson, 2003), others believe it is created as product of one's privilege, social status, and socio-economic status (Hu, 2016). Still others think of it as something constructed, something that can be altered or brought forth based on one's attitudes and perspective (Luthar, Cicchetti & Becker, 2000). While all these ways of understanding resilience fit for certain scholars and their contexts, they do not reflect the complex nature of resilience or the determinants of resilience (e.g., social, and cultural factors) that shape how an individual responds to adversity. For my framework and understanding of resilience, I look to the University of Waterloo's definition that resiliency is a "process of using internal and external resources to manage challenging circumstances" (University of Waterloo Resilient, 2020). Understanding this as the central definition, I draw on Ungar and Theron (2020) who recognized that "in the context of exposure to significant adversity, resilience is both the capacity of individuals to navigate their way to the psychological, social, cultural, and physical resources that sustain their wellbeing, and their capacity individually and collectively to negotiate for these resources to be provided in culturally meaningful ways" (p. 442).

The "resilience construct" is a theoretical framework which examines why many individuals can draw upon resources to deal with negative experiences (Luthar, Cicchetti, & Becker, 2000; Ungar, 2004). Resilience is a process that is diverse amongst all individuals. It often involves using internal resources (i.e., humour and optimism) and external resources (i.e., sense of belonging and mentorship) (University of Waterloo Resilient, 2020). Considerations surrounding resilience should take into thought internal psychological traits, but also external social factors, including gender, ethnicity, and socioeconomic status (Ward et al., 2011). These considerations respect that a person is not necessarily born with resilience, nor does it

automatically remain static through one's life. Resilience can be a "storehouse" of strategies that an individual builds up in facing adversity, which may be useful (but not all) future circumstances (Ward et al., 2011).

Resilience, in this sense, is a broad and contextually heterogeneous construct (Ungar, 2003) associated with terms such as positive coping, adaptation, and persistence (Greene, 2002). Earlier works about resilience assumed a binary approach in objectively considering if resilience was merely present or absent, when realistically, resilience ought to be thought of as a continuum (Pietrzak & Southwick, 2011) that changes over time (Kim-Cohen & Turkewitz, 2012). Moving away from such a binary approach, resilience research pioneers, such as Norman Garmezy, Lois Murphy, Michael Rutter, and Emmy Werner, sought to understand what constituted resilience and what made individuals resilient (Masten, 2013). Resilience is a complex construct that may have different meanings for individuals, families, societies, and cultures (Southwick et al., 2014). Resilience is complex, relative, and contextual (Ungar, 2004), and some individuals may be more or less resilient during different periods of their lives, depending on the context. For example, Southwick et al. (2014, p. 5) noted, "resilience for a traumatized Cambodian refugee may be different than resilience for an American who lives through a hurricane, or than an individual suffering with chronic schizophrenia." As Ungar (2003) acknowledged, social and cultural factors play a role in determining what are perceived as good and bad outcomes, which make the construct of resilience a contextually specific and societal and culturally biased construct.

How older adults have reacted to the pandemic varied. Although all faced adversity (e.g., risk of contracting the virus, physical distancing, stay-at-home orders), responses differed within

the older adult population. Van Breda (2001, p. 14) asked, "why, when people are exposed to the same stress which causes some to become ill, do some remain healthy?" To grasp a holistic understanding of resilience and its theoretical assumptions that align with the context of my research, I concur with Greene (2002) that resilience is linked to life stress and people's unique coping capacity; it involves competence in daily functioning; it is influenced by diversity, including ethnicity, race, gender, age, sexual orientation, economic status, religious affiliation, and physical and mental ability; it is affected by the availability of internal and external resources; and it is influenced by power dynamics. Resilience goes beyond adverse situations and just "bouncing back." It embodies a response to traumatic events (e.g., a global pandemic) and how individuals utilize resources and strategies to cope and adapt (Bonanno, 2005).

Social Connections and Resilience

The literature I reviewed in this chapter suggests resilience is enhanced through social connections with others (Van Breda, 2018; Masten, 2014; Castro & Zautra; 2016; Greene, 2002). Researchers confirmed over the past two decades that meaningful relationships, strong support networks, and social connections help individuals deal with stressful situations and adapt to adverse conditions, which are critical components of resilience (Masten 2014; Steele & Steele, 1994). A strong link between resilience and social connections sheds light on the importance of social relationships for positive health outcomes that work at the individual and community level in times of adversity to help individuals deal with challenging times and strengthen their resilience during the adaptation process (Castro and Zautra, 2016). Thus, while going through a challenging period, social networks become essential to building resilience (Sippel et al., 2015). Physical distancing restrictions and isolating practices negatively impacted social connections for

many older adults during the pandemic (Van Orden et al., 2021). All forms of connection are important to health, including incidental sociability with familiar strangers, such as conversations at the grocery store check-out line, largely disappeared for older adults because of COVID (Van Orden et al., 2021).

Components of Resilience

Components of resilience include thriving, hardiness, internal and external resources, adversity, competence, risk and resource factors, and vulnerability and protective factors. Thriving as part of resilience research is associated with strengthening the positive psychology movement, with its emphasis on "thriving versus merely surviving" (Bauman, Adams and Waldo 2001, p. 5). Thriving refers to decreased reactivity or faster recovery from stressors, a consistent higher level of functioning, and a reflection of the skills, knowledge, resources, confidence, and strategies (Carver, 1998). "Hardiness" is synonymous with thriving, but embraces an individual's ability to make the best of difficult circumstances and incorporates a sense of meaningful purpose, a belief that one can influence one's surroundings, and the ability to learn from both positive and negative experiences (Bonanno, 2004)

Internal variables in resiliency refer to self-factors, personality factors, or individual resources which have an impact on how individuals deal with a predicament (e.g., coping mechanisms) (O'Leary, 1998). External variables have influence over a person's ability to remain resilient in the face of adversity (e.g., social support) (Masten, 2005). Adversity refers to negative contexts and experiences that have the potential to disrupt or challenge adaptive functioning and development (Obradovic, Shaffer, & Masten, 2012), which may be chronic (e.g., racism) or acute (e.g., victim of theft) (Yates, Tyrell & Masten, 2015). Competence refers to the

capacity to adapt successfully and meet contextual, developmental, and cultural expectations for a particular individual, group, or social structure (Havighurst, 1972; Masten, Burt, & Coatsworth, 2006), which can mean something different in each context or cultural setting (Masten, 2014)

Risk factors can be subjective insofar as what is harmless to you may not be harmless to me. They are associated with negative or undesirable outcomes in each population, while resource factors support positive or desirable development across individuals (Luthar, Cicchetti and Becker, 2000). Furthermore, vulnerability factors refer to moderators that increase the negative effects of risks, whereas *protective* factors mitigate risk effects, taking on greater salience in adverse contexts (Pianta, 1999). Protective factors include individual (e.g., humour, self-esteem, optimism) (McClain, Gullatt & Lee, 2018) and external mechanisms (e.g., family, friends, social relationships) (Ledesma, 2014). Each type of factor does play a role within resilience, whether desired or not.

Resilience Predictors

Resilience predictors refer to the resources, strategies, and processes to which individuals have access that further strengthen their resilience (Maercker, Hilpert & Burri, 2016). There is no single accepted set of predictors of resilience, but many authors (see Greene, Galambos & Lee, 2004; Staroverky, 2012; Wagnild & Young, 1990;) discuss predictors that can strengthen the chances for older adults to exercise resilience. Three categories of predictors, in particular, appear to contribute to resilience: individual dispositional characteristics; family support and cohesion; and external support systems (Olsson et al., 2003). Protective psychological predictors include intelligence; problem-solving skills; a sense of mastery; a balanced perspective of one's life and experience; perseverance; the act of persistence despite adversity; self-reliance, a belief

in oneself and one's capabilities; meaningfulness; strong internal resources; keeping things in perspective; setting goals and taking steps to achieve those goals; high self-esteem; high self-efficacy; a sense of purpose of life; creativity; humor; and a sense of curiosity (Greene, Galambos & Lee, 2004; Wagnild & Young, 1990; Boardman, Blalock & Button, 2008). Individuals who have these characteristics draw on resources that can strengthen these characteristics and assume an overall optimistic outlook on not only the adversity with which they are confronted, but also their overall existence, which tends to be more resilient as a result of their tendency to stay more positive (even when face with overwhelming obstacles) (Staroverky, 2012).

Staying optimistic also strongly relates to having faith and having a meaning in life, a reoccurring theme in the resilience and gerontology literature. Many authors speak to meaning in life as an important predictor of resilience in older populations (Resnick, Gwyther, & Roberto, 2018). Individuals who feel as if they have meaning in life are more likely to adapt and recover from failure; a sense of meaning means lower likelihood of giving up (Starvorsky, 2012). Heisel and Flett (2016) found meaning in life to be a predictor of resilience and increased wellbeing older adults (Heisel & Flett, 2016). Coupled with faith, a lot of older adults find that faith (e.g., religion or spirituality) gives their lives more meaning (Greene, Galambos & Lee, 2004). While faith is not a required predictor of resilience in individuals, older adults particularly find their faith helpful in adapting to challenges and overcoming fears and doubts (Staroverky, 2016). This notion of faith in older adulthood as a resilience predictor was demonstrated by Green, Galambos and Lee (2004) who found that over half of their participants (55%) identified faith and spirituality as essential to their resilience process during disruptive life events.

As mentioned above, social connections serve as one of the most important predictors of resilience. Resilience predictors, including perceived social support, meaningful interpersonal relationships, a willingness to extend oneself to others, and community integration are all social predictors of resilience (Boardman, Blalock, & Button, 2008). Social supports are critical in predicting an individual's resilience as those who have more social connections also have more external resources, coping and self-efficacy support, and altruism (Staroversky, 2012). Community and social support from family and friends is especially crucial for older adults (Belanger et al., 2016). If older adults feel as if they have emotional support, connections, and others upon whom they can depend, they are more likely to exercise resilience, especially when faced with adversities (Atchley, 2000).

Resilience and Coping

A clarification that warrants attention before moving forward is the difference between resilience and coping (Smith et al., 2015; Zapater-Fajari, 2021; Fletcher & Sarkar, 2013). Though an important relationship exists between the two, the distinction matters. Coping refers to "the thoughts and behaviours used to manage the internal and external demands of situations that are appraised as stressful" (Folkman & Moskowitz, 2004, p. 745). In older adulthood, coping protects individuals by avoiding or adapting to psychological harm from adverse experiences (Pearlin & Schooler, 1978). Resilience, by contrast, influences how a stressful event is appraised. Under this premise, coping can be defined as the behavioral and cognitive approaches used to manage stress after the appraisal (Zapater-Fajarí, 2021).

Coping strategies may be thought of as mechanisms through which resilient individuals exercise resources in the face of adversity (Thompson et al., 2018). Resilience is related to

exercising coping strategies (Tomas et al., 2012), which allows for resilient older adults to use coping styles during stressful events (Southwick et al., 2005). With the strong relationship between resilience and coping and between coping and stress regulation, older adults with high resilience tend to develop positive coping behaviors in the face of adversity (Zapater-Fajarí, 2021), which results in a positive influence of overall health and wellbeing (Tomas et al., 2012; Smith et al., 2015).

Resilience typically results in a positive response after an adverse experience, whereas coping can trigger both positive and negative responses (Fletcher & Sarkar, 2013). In positive psychology, all individuals have the capacity to use positive emotions to cope (Frederickson, 2000) and to be resilient (Masten, 2001). However, resilient individuals can exercise positive emotions to support their coping (Tugade & Fredrickson, 2002), which makes the process of responding to stressful situations an intuitive process (Tugade & Fredrickson, 2002).

Critique

Claims of poorly conceived definitions of resilience (Kaplan, 2005) have led to severe criticisms of the ambiguity and validity of resilience as a concept (Fletcher & Sarkar, 2013). Inconsistent definitions of resilience have contributed to epistemological and ontological uncertainty, which has resulted in claims that resilience as a concept is poorly theorized (Ungar, 2019). Resilience research which valorizes resilience without considering macro level structures that create or maintain adversity has fallen in line with a neoliberal agenda (see Harrison, 2013) insofar as it focuses on "individual responsibility for success and ignores the structural and institutional barriers confronting young people living on the margins" (Allen et al., 2014, p.). This critique extends to older adults, as well. The grand narrative of older adults and how they no

longer contribute economically or socially to society and are medical burdens, (Allen et al., 2014) falls in line with the neoliberal agenda of shifting blame onto older adults, with the state taking no responsibility of caring for who should be their most respected citizens.

Though I see resilience as a process, there is a section of literature that contextualizes resilience as a trait, something one either has or does not have, and something for which one is responsible alone. This emphasis on the individual leaves a lot of responsibility and pressure on the individual for change and adaptation (France, Bottrell & Armstrong, 2012). Resilience is particularly critiqued for "the way in which societal and political context is minimized in that "resilience" is usually individualized and the way resilience gels with the politics of neo-liberalization" (Garrett, 2016. p.1918). This neoliberal understanding puts responsibility of growth through adversity strictly on the individual, leaving the state free to disregard adverse social systems and dynamics, lack of access to resources and poor-quality education. With this critique in mind, I aim to recognize resilience as a process that relies on resources and competences that derive from status, power, and privilege. Resilience, in other words, is multi-dimensional and influenced by more than just the individual (Ungar, 2004).

Resilience in Later Life

Much of the resilience literature focuses on childhood and adolescence without nearly as much of a focus on later life (Li & Ow, 2022). Resilience does not stop at childhood, adolescence, or early adulthood; it translates to every part of the life course (Lavretsky, 2014). Neglect of older adults and their resilience positions the topic as a gap in gerontology (Cuevas, 2020). Though not commonly grouped together, resilience is strongly associated with an aging process (MacLeod et al., 2016), especially during a stressful life event such as the pandemic

(Wu, 2020). Now, more than ever, I believe older adults are being recognized for their tremendous resilience.

Positive psychology and gerontology make a handsome couple. I say this because most (not all) of the gerontology literature focuses on deficits and pathologies in old age. Resilience, however, "draws from a strength perspective, a philosophical standpoint that recognizes the inherent power and resilience of individuals and communities" (Browne, Mokuau & Braun, 2009, p. 55). By merging the two gerontology and positive psychology together, resilience emerges as an essential component of wellbeing (American Psychological Association 2020), given that wisdom, life experiences, and positive attitudes of older adults facilitate resilience (Byun & Jung, 2016). Resiliency research shows that "as individuals grow older, greater resilience may lead to a more meaningful and satisfying old age" (Wagnild & Collins, 2009), which has been evident during the pandemic as older individuals have been less prone to adverse mental health outcomes related to the COVID-19 pandemic than younger individuals (Rohr et al., 2020; McGinty et al., 2020; Pierce et al., 2020). The main reason for this outcome may be because older adults have higher resilience, which allows them to cope better with stressful life experiences (Lee et al., 2020).

In older age, there are common physical changes (e.g., mobility issues), life events (e.g., bereavement), clinical problems (e.g., co-morbities), and financial challenges (e.g., retirement) that require one to be resilient (Resnick & Inguito, 2011). Resilience is strongly associated with less depressive moods, low risk of disease, high mental function, and longevity (Zapater-Fajari, 2021; MacLeod et al., 2016). MacLeod (2017) revealed resilient older adults use adaptive coping styles, gratitude, happiness, optimism, contact with family and friends, a sense of purpose,

positive relationships, mobility, and a belief in aging successfully to help themselves through negative events. Pillemer (2017), moreover, found taking the long view, not worrying, and just preparing, being generous, and enjoying small daily pleasures contributed to resilience. Such strategies were likely used by older adults during the pandemic (Pillemer, 2012).

Though resilience likely aided with the recovery of physical, cognitive, and mental health during COVID-19, preventing functional declines, frailty, anxiety, depressive moods, loneliness, and social isolation worsened during the pandemic (Chhetri et al., 2020; Lim et al., 2020). In all probability, these afflictions resulted in lower resilience in older adults who already suffered from chronic conditions or functional limitations (Lee et al., 2020). The pandemic-induced fear, stress, loneliness, and social isolation likely lowered the resilience of older adults to further risk overall health and vulnerability (Plagg et el., 2020). Ultimately, however, these "adversities provide opportunity for resilience, making it central to aging" (Resnick, Gwyther, & Roberto, 2010, p. 6).

In older adulthood, leisure plays a significant role in building and maintaining resilience (Cocozza et al., 2020) by preventing and alleviating stress, fear, loneliness, and social isolation (Toepoel, 2013). Engagement in leisure activities can prevent and alleviate loneliness and lead to greater wellbeing and resilience in older adults regardless of age, gender, and marital status (Cocozza et al., 2020; Dupuis & Smale, 1995;). Leisure activities that build social connections, including volunteer work, shopping, eating, and drinking rituals, reading, and gardening, can strengthen resilience (Cornwall et al., 2008; Liu, 2009; Pettigrew, 2007; Toepoel, 2013). To engage in these leisure activities, older adults may create an intentional leisure space, which is considered a "therapeutic landscape to re-charge themselves physically, psychologically, and/ or

emotionally, which facilitates a sense of balance, survival, and/or resilience to cope proactively with or counteract stress" (Iwasaki, MacTavish & MacKay, 2005, p. 3).

The resilience literature on older adults cites a "paradox of old age" that warrants discussion because of its relevance to my dissertation research. In describing this paradox, Edwards, Hall and Zautra (2012, p. 2) noted that, despite "losses and physical declines experienced in later life, older adults report feeling content, and they have lower rates of psychopathology than the general population. Researchers have argued that this feeling is due to resilience, and that an understanding of resilience can lead to ... healthier, happier people and communities." Gerontological research does focus on resilience and how older adults deal with life transitions, losses, and change, and how these experiences establish older adults as "the strongest of the strong" (Hamarat et al., 2002, p. 356). Drawing on the positive psychology literature, gerontologists consider resilience useful in understanding how older adults negotiate the adversities in older adulthood (Wild, Wiles & Allen, 2013) and the factors that can explain individual differences in the stress responses (MacLeod et al., 2016).

Greve and Staudinger (2015, p. 797) asked "why does the "paradox of wellbeing" still prevail? Why do the majority of older and elderly people not get sick or show any significant decline in their wellbeing or mental health?" Many studies show that emotional wellbeing tends to increase or remain stable in older adulthood (i.e., the paradox of aging) (Cartensen, 2019), and is related to resilience (MacLeod et al., 2016). As Lazarus and Folkman (1984) noted, individual responses to stress depend on an individual's judgement of the situation and the resources and strategies that are available to them to manage the stress. Though my intention is not to ask why

about sickness or decline in wellbeing generally, I would like to understand how older adults exercise resilience through leisure to combat social isolation and loneliness during the pandemic.

The COVID-19 Social Connectivity Paradox

Another recent "paradox" relevant to my research refers to the *COVID-19 Social Connectivity paradox*, a new concept Lee, Steinman, and Casey (2020) used to describe the conflicting harm continuum resulting from recommended physical distancing. It posits that a set of actions concomitantly protects, but also harms older adults during the pandemic (Lee, Steinman & Casey, 2020), in effect creating what planners refer to as a "wicked problem." Physical distancing restrictions and stay-at-home orders disrupted older adults' ability to connect socially with others (Smith, Steinman & Casey, 2020). To protect themselves from COVID, older adults avoid many individuals, places, and activities they relied upon for companionship, support, and resources. Family members and friends of older adults, moreover, stopped in-person visits to avoid exposing their older loved ones to the virus (Donovan & Blazer, 2020; Smith, Steinman & Casey, 2020). Within this paradox, "frequent interaction with others prevents social isolation, but also leads to higher risk of COVID-19 infection. Conversely, reduced interaction due to social distancing and staying home leads to greater isolation, yet lower risk of exposure" (Smith, Steinman & Casey, 2020, p.). This situation, no matter how it played out, creates a stressful life event for older adults during the pandemic.

Presumably, the chronic effects of the COVID-19 Social Connectivity Paradox will affect older adults for years to come because of physical distancing measures and the potential reappearance of the virus through its variants (Smith, Steinman & Casey, 2020). Consequently, "immediate solutions are needed to improve social connectivity and connectedness among older

adults both now and beyond the time of pandemic cautions" (Smith, Steinman & Casey, 2020, p.). Here, leisure has the potential to play a role in alleviating (or exacerbating) pandemic-induced social isolation and loneliness, yet very few government documents or websites have referred to leisure as a strategy to combat social isolation and loneliness, as this was made obvious when conducting my extensive literature search. The pre-pandemic routines of older adults were shattered, yes, but were new routines incorporating new or existing leisure pursuits created? What role has leisure played in helping break this binary of the Social Connectivity Paradox? These questions deserve exploration.

Older Adults, Leisure, Social Isolation and Loneliness

As an alternative to social innovation, I look to *leisure* in this research as a solution (or contributor) to social isolation and loneliness among older adults during the pandemic. For the purposes of this research, leisure refers to an "uncoerced activity engaged in during free time, which people want to do, in either a satisfying or a fulfilling way (or both)" (Stebbins, 2009, p. 1). Typically, freely chosen and intrinsically motivated, leisure is distinct from "work" (Edginton et al., 1995). Social isolation, loneliness, social networks, and social relationships and their relationship with leisure have been touched on in the leisure field (Arai, 2000), but more attention should be shifted to covering social isolation and loneliness with respect to leisure (Glover, 2018). This call for a shift in attention stems from the fact that there is a lack of explicit focus on these crises in the leisure field, yet social isolation and loneliness pervade more than ever as a societal problem (made worse because of the pandemic).

Focusing on older adults, leisure plays a meaningful role in extending their ability to live independently in the community, in decreasing their risk of disability, in reducing their feelings

of loneliness, and in improving their health and life satisfaction (Kim et al., 2007; Kleyman, 2004). Many leisure researchers demonstrate the health-promoting effects of leisure for older adults, including physical, psychological, spiritual, and social health (Kleyman 2004; Stav et al., 2012; Kim et al., 2007; Chang, Wray & Lin, 2014). Older adults who engage in leisure activities foster positive social interactions and closer social relationships with others around them, therein alleviating feelings of loneliness and being socially disconnected (Chang, Wray & Lin, 2014).

Sadly, aging is associated with diminishing network size, closeness to other individuals, and the number of non-primary-group ties to which individuals are connected (Cornwell et al. 2008). To increase or maintain social integration and avoid loneliness and social isolation in later life, leisure activities, including eating rituals, reading, gardening, shopping, volunteering, cultural activities, and the use of the internet, all support older adults in remaining socially active, alleviating feelings of loneliness, and reducing their risk of social isolation (Pettigrew, 2007; Cornwell et al., 2008; Bourdieu 1984; Firth and Mellor 2007). Although this literature translates well to a pre-pandemic existence, little is known about how different forms of leisure can contribute to social integration and alleviate social isolation and loneliness in the context of a pandemic. This project aims to fill this gap.

Resilience Strategies

My view of resilience as a process relies on a model of resilience in which older adults exercise specific resilience strategies (Ungar & Theron, 2020) when they experience a disruption from an adverse situation (Henderson & Milstein, 1996). Resilience strategies are used when individuals gain new insights to minimize the impact of adversity for future encounters (Gu & Day, 2007). Despite the myriad of resilience strategies identified in the literature, I wish to focus

on those highlighted by Sing, Hays, and Watson (2011) and Castro, Kelly, and Shih (2010) whose work, I believe, best suits the context and population of older adults residing in the community during the pandemic. The resilience strategies to which they speak include help seeking (knowing when to ask for help), problem-solving (approaching a problem with resources and strategies) and seeking rejuvenation (how to unwind and relax) (Castro, Kelly & Shih, 2010). Further resilience strategies include connection with a supportive community and cultivating hope for the future (Sing, Hays & Watson, 2011). However, an important resilience strategy missing from this list is *leisure*.

Admittedly, some resilience strategies may not receive attention within the literature because of their lack of acceptance or because of questionable practices. These alternative coping strategies are referred to as "hidden resilience, the functional but culturally nonnormative substitute adaptations" (Ungar, 2004, p. 8). These strategies may include antisocial behaviours that aid the resilience process by contributing to resilient outcomes (Ungar, 2004). Ungar (2004, p. 12) cited "troubled youths, for example, [who] frequently report "antisocial behaviours" (such as drug use, self-harm and gang membership) as resilience processes, because they result in experiences of meaning, belonging and power." Although frowned upon in our society, Ungar makes an important call in recognizing that what may be a resilience strategy for one individual, may not be a strategy for the next. Strategies are socially constructed, and all depend on privilege, power, context, and location (Ungar, 2004). Accordingly, hidden resilience warrants attention in my research as a possible resilience strategy participants describe in discussing their use of leisure to address, avoid, or cope with social isolation and loneliness.

Leisure as a Resilience Strategy

The focus of this project is on the potential for leisure as a resilience strategy exercised by older adults to combat social isolation and loneliness induced by the pandemic. Leisure enables individuals to manage and relieve stress, help individuals find new direction, and buffer against negative life events (e.g., a global pandemic) (Iwasaki, MacTavish & MacKay, 2005). Moreover, leisure can help counteract stress and facilitate coping (Iwasaki et al., 2014), while providing individuals with a sense of fulfilment, personal autonomy, positive emotions, and the ability to acquire valuable skills (Roberson, 2010). Leisure also serves as a form of escapism from everyday life (Hutchinson et al., 2003) by generating optimism and hope for the future with a sense of rejuvenation and renewal (Kleiber, Hutchinson & Williams, 2002; Iwasaki, MacTavish & MacKay, 2005). To further promote resilience, leisure restores one's previous self-value while simultaneously allowing for exertion of control over one's own environment, autonomy, and development of competencies (Coatsworth et al., 2005; Newman et al., 2014; Iwasaki, MacTavish & MacKay, 2005).

Leisure contributes to a sense of community, as well. Community explains what bonds us to others and stems from our fundamental need as humans for meaningful social connection, to be part of a group, and to belong (Baumeister & Leary, 1995). People desire to be more secure, and community offers a sense of security (Bauman, 2001; Delanty, 2010). Leisure brings people together with shared interests to socialize and build meaningful relationships and serves as an essential vehicle for the realization of community (Glover, 2016), and our ability to connect, gather, and group. Leisure within the community brings people together who share the same values, identities, or interests, while offering a chance to belong (Bauman, 2001). It operates as a "sphere of sociability" in which community members not only connect and feel like they belong,

but can also build, maintain, and sustain relationships that generate social capital (Glover & Parry, 2008). People form these relationships through leisure "not because they [necessarily] set out to build community, but because when people engage in sustained, recurrent interaction, particularly while doing things they enjoy, relationships inevitably grow" (Klinenberg, 2018, p. 7).

Understanding the importance of community and sense of belonging aligns with the field of positive psychology. Positive psychology suggests positive events or activities such as leisure can promote coping with stress and resilience (Carruthers & Hood, 2007). Engaging in purposeful leisure activities allows individuals to develop competencies, resources, and positive emotions (Carruthers & Hood, 2007). Positive emotions lead to leisure engagement, coping with stress, and adaptive coping, which ultimately cultivates resilience (Folkman, 2008). Leisure engagement contributes to resilience (Cocozza et al., 2020), especially "passive, recuperative leisure counteracts stress by serving a 'balancing function' (e.g., 'to relax'), 'choice' (e.g., 'to be free to do what I like'), or 'mood-feelings' (e.g., 'to feel better mentally')" (Trenberth & Dewe. 2002, p. 69). Furthermore, leisure coping, and leisure autonomy beliefs promote a sense of autonomy and perceived control, which reflects how resilience is cultivated (Iwasaki et al., 2005; Iwasaki & Mannell, 2000) during the pandemic in response to a lack of perceived control felt in relation to mandates and policies.

Iwasaki and Mannell's (2000) model of hierarchical dimensions of leisure stress coping distinguishes between leisure coping beliefs (i.e., drawing on leisure in times of stress) and leisure coping strategies (i.e., situation-specific coping behaviors and cognitions available through leisure) (see Figure 1). In this model, Iwasaki and Mannell (2000) suggested a new

conceptualization and measurement of the dimensions of leisure stress coping and classified several ways leisure can support an individual's capacity to cope with stress. In their words, "dimensions of leisure stress coping proposed (e.g., a self-determination disposition, leisure empowerment, leisure companionship, leisure palliative coping) are based on an integrative review of social psychological research and leisure research on stress and coping" (Iwasaki & Mannell, 2000, p. 1). This model supports my research by providing insight into how leisure serves as a resilience strategy.

A few gaps in the model warrant consideration, though. The model fails to speak to different types of leisure friendships and the effects they can have on coping (e.g., older adults not seeing familiar strangers or acquaintances leading to a potential lack of sense of community). In addition, they do not speak to various social relationships that exist. The model, along with most of the leisure literature, privileges face-to-face interactions to build social connections, with an assumption that connecting from a distance is a less effective strategy at building social relationships (Putnam, 2000). I acknowledge that other authors, including Pinter (2014), show tremendous evidence that in-person connections are far superior from a health perspective to online connections. Although I agree, in-person connections may not be possible during the pandemic, as online platforms of connections have been privileged to minimize risk of the virus, the online world must be acknowledged and incorporated into a social and leisure model.

Though I respect the effort that has been made in the literature to acknowledge online relationships and long-distance ones, many of the components in Iwasaki and Mannell's (2000) model do not translate to a virtual realm or to a physically distanced one. The big gap here is how does this model address the leisure, coping, and social needs of individuals in a pandemic, a

time when online connections enabled many older adults to connect with others? The quality of these connections' warrants discussion with study participants who describe online connections as a coping strategy.

Figure 1

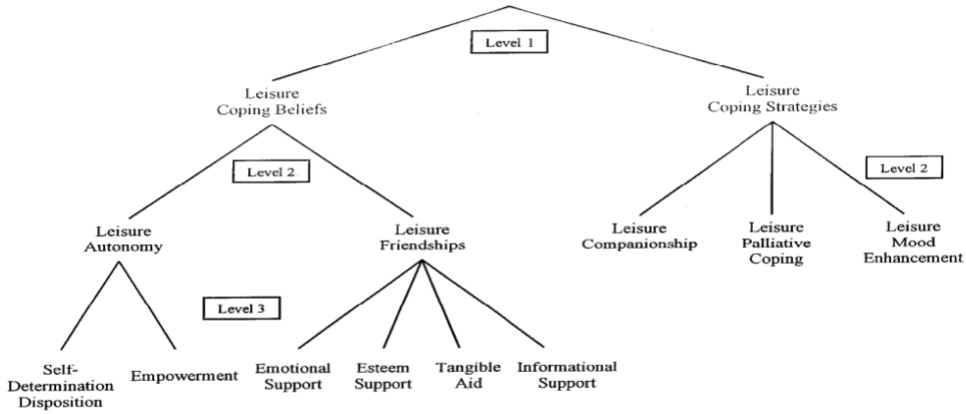


FIGURE 1 Hierarchical dimensions of leisure stress-coping.

Source: Iwasaki and Mannell (2000)

The Complex Relationship between Leisure and Social Isolation and Loneliness

Though it may seem counterintuitive, leisure can also worsen social isolation and loneliness. Putnam (2000) argued that the type of leisure activity can have implications for social connectedness, as leisure itself can be isolating or limit one's social network to close friends and family without bridging to others. Productive activities (active and creative ones) (Putnam, 2000), eudiamonic activities (personal enrichment), and hedonic activities (nothing more than fun or pleasure) (Fine & Corte, 2017) may be considered better for encouraging social connectedness but saying so is overly simplistic and fails to consider the social context. If an

older adult engages in a solitary activity aimed at personal enrichment, it can easily isolate him or her. Moreover, just because an activity is characterized as productive—a moral judgement, to be sure—does not preclude it from isolating its participants and leading them to feel lonely. Pleasure or fun, furthermore, does not necessarily equate with social connectedness. Interestingly, consumption (i.e., passive consumerism) and solitary leisure pursuits (watching screens on a computer or cellphone) are positioned as activities that further isolate individuals (Toepoel, 2013), but these activities are not inherently lonely. Though Putnam and Fine and Corte speak to which activities promote and detract from social connectedness, it is fair to say that *any* type of leisure activity could promote or detract from social connectedness.

Putnam (1995) also vilified screens (e.g., television) as a source of social isolation and for taking the place of outside activities, social gatherings, and conversations. Programming on screens can create **p**arasocial ties, relationships that are one-sided, where one person extends emotional energy, interest and time, and the other party, the persona, is completely unaware of the other's existence (Riles & Adams, 2020). Parasocial relationships are most common with celebrities, organizations (such as sports teams) or television stars (Riles & Adams, 2020). Though judged negatively, these one-way relationships may make older adults feel less lonely and more connected, despite being superficial (Hartmann, 2016). Of course, they can be particularly disconcerting if they overtake an individual's close ties, including family, and friends (Rojek, 2016), and make older adults more objectively social isolated. As a reminder, even though social isolation can be "accompanied by feelings of loneliness, not all socially isolated people feel lonely (e.g., people who have no friends, but feel a strong, imaginative connection to a celebrity)" (Glover, 2018, p).

Concerns do pervade those technologies, such as advances in screens, online social networking, and streaming, can drive a wedge between our individual interests and our desire to connect with others socially. This individualization of our use of leisure time has the potential to disrupt meaningful relationship building. But the platforms people use have a distinctly social function, thereby making people more connected than ever before. As Glover (2018) noted, "though passive leisure can be isolating in an objective sense, those who engage in it may not necessarily *feel* lonely. Contemporary leisure forms like viewing blogs, web chat rooms, and Instagram posts offer insight into the lives of strangers and propagate new relations of presumed intimacy" (p. 7, original emphasis). Different types of leisure activities and social relationships, in other words, combine to make an impact on social isolation and loneliness (Toepoel, 2013), one that is more complex than assumed. Furthermore, aside from the type of leisure activity, Van Ingen and Van Eijck (2009) argued the type of *company* during a leisure activity contributes to staying socially connected. Either way, the complexity of leisure as a strategy for older adults to connect with others warrants exploration.

Clearly, the relationship between leisure and social isolation and loneliness is complicated. The relationship between the two is difficult to define as any type of leisure, even those that involve other social actors, can presumably contribute to loneliness (if not social isolation). For example, I may belong to a leisure group, but may feel as though I have no meaningful relationships within the group. Alternatively, solitary leisure activities, though isolating, may not make me feel lonely because I may feel a connection to parasocial ties or enjoy time away from others. Speaking to this complexity is helpful because it is unknown how leisure was exercised by older adults during the pandemic. Accordingly, this complexity will be something on which I will focus in this research.

A Social Recession?

A great deal of research emphasizes the need to assess social isolation and loneliness among older adults during the pandemic (Lewis et al., 2020) with new perspectives emerging that focus on this public health crisis and its negative long-term effects. Public health experts predict a "long-term societal impact compared to an economic low period and referred to as a *social recession* or the long-term collapse in social contact and fraying of social bonds that could lead to worsening chronic isolation as the loss of interaction continue over time" (Klein, 2020, p.6, original emphasis in text). Other authors, including Shah et al. (2020), agree with the long-lasting effects of the pandemic, but refer to it as "Lockdown Loneliness", which refers to the loneliness caused by worsening social isolation due to physical distancing and loss of social relationships. I prefer referring to this concept as a social recession, as it is a play on an economic recession, but will likely be more difficult to evaluate and reverse (Klein, 2020).

A social recession is likely to have chronic impacts on the physical, mental, emotional, and spiritual health of older adults (Klein, 2020). Due to the pandemic, older adults reduced their exercise, which could lead to reduced mobility and higher fall risks; they had less access to healthy and fresh food options, which impacted their heart health and weight; and they experienced a reduction in socialization and support services (e.g., caregiving, preventative care appointments and procedures), which led to loneliness, social isolation, and depression (Steinman et al., 2020). Feeling lonely or being socially isolated coupled with the fear of contracting COVID-19 can lead to chronic stress, which introduces an increase in morbidity, mortality, major depressive disorder, suicidal ideation, and suicide attempts (McClelland et al., 2020; Moccia et al., 2020; Sani et al., 2020). The pandemic caused fear and inaccuracies in risk perceptions (Giallonardo et al., 2020; Shigemura et al., 2020), particularly in COVID-19–

positive patients, as the experience of hospital isolation and illness, uncertain physical conditions, and fear of dying acted as risk factors which in turn turned into anxiety, depression, and PTSD (Bo et al., 2020; Xiang et al., 2020).

This phenomenon of a social recession in our future is reason enough to focus attention on the social isolation and loneliness that older adults endured during the pandemic. Feeling disconnected from society and losing regular social opportunities is a problem our society must shed light on and offer interventions, support, and aid, and truly think about how we can alleviate social isolation and loneliness for older adults (Wand et al., 2020). The literature speaks to how interpersonal interaction and social connectedness help individuals overcome post-pandemic complications (Boyraz et al., 2020), which warrants continued attention. Because older adults are the most vulnerable and susceptible to the virus, their hesitation to return to a pre-pandemic existence may take longer than those who are younger. For this reason, I believe leisure warrants exploration as a potential resilience strategy to combat social isolation and loneliness.

Contribution to the Literature

In terms of my positionality statement, who I am as a doctoral student has extended into who I am in every aspect of my life. As someone who currently works in long-term care as Director of Programs and Support Services, I am also chair of the palliative committee, coordinate with community stakeholders to advocate for the older adult population and champion their value to society, to highlight what older adults endured during this pandemic. In other words, outside academia, I have a voice in the community to advance older adults and have dedicated my entire career to protecting and providing a platform for the issues relevant to this population. These roles influence my research as I can mesh theory and practice together.

Strengthening my knowledge, education, and practice through my doctorate and my position as a director, really creates a harmonious relationship. It is a privilege and honour for me to do so, and so in undertaking this dissertation, I hope to contribute to the literature and use it to make a difference in both my academic and workspaces.

A reoccurring theme during the pandemic is the salience of social interactions for human existence (Agashe, Kumar & Rai, 2021). The pandemic raises deep concerns about the pervasiveness of social isolation and loneliness, which disproportionately affects older adults. Remaining physically distant from others can paradoxically be both protective and harmful (Lee, Steinman & Casey, 2020). The physical distancing restrictions because of COVID-19 deteriorated the everyday lifestyles of older adults in the community due to already diminished social networks and factors, including living alone and limited transportation (Wu, 2020). My research contributes to the literature by bridging the fields of gerontology, leisure studies, and positive psychology, and highlighting the potential for leisure as a resilience strategy that can possibly combat social isolation and loneliness. Perhaps this dissertation can also be used as a resource for community health care design professionals and researchers in addressing COVID-19 issues and improving social connections for older adults through COVID-19 friendly programs or modifying existing ones to make them "pandemic friendly" (e.g., physically distanced programs).

In terms of its contribution to theory, practice, or policy, my research aims to draw attention to social isolation and loneliness among older adults. The pandemic touched on what gerontologists have been saying for decades, that social isolation and loneliness for older adults

is a crisis. With a better-late-than-never acknowledgement, providers must screen for social isolation and loneliness and take proactive steps to alleviate it (Harden et al., 2020).

I find it baffling to date that social isolation risk has not been integrated into routine clinical care the way other preventable public health risk factors have been (Perissinotto et al., 2019). To ensure that older adults are assessed, identified, monitored, and supported "screening for social isolation in clinical care can help improve care, outcomes and population health by providing more precision in diagnoses and treatment, foster better and more shared decision making about treatments that are feasible and appropriate, identify stressful social risk factors so clinicians can connect older adults to helpful community-based public health and social services to address (with their consent), and improve clinical systems' ability to tailor their supports and services to their population's needs" (Adler, 2015, in Smith, Steinman & Casey, 2020, p. 4).

We must modify our existing strategies to improve connectivity in a time of recommended physical distancing, implement approaches for meaningful relationships and social connectivity, and capitalize on the strengths of older adults during the pandemic to ensure they engage in connectivity (Lee, Steinman, & Casey, 2020). Further qualitative research seems warranted as a strategy to gain rich insight into how older adults experience adversity, what they recognize or appraise to be adversity, and what strategies they exercise to overcome adversity (Van Kessel, 2013). More qualitative research is also needed to gain knowledge about meaningful resilience strategies (Zapater-Fajari, 2021), which is why I intend to focus on leisure. Resilience-informed research, like my own, helps target neighbourhoods and communities with interventions that may have positive effects on individuals (Norris et al., 2008), through social capital and neighbourly relationships which may foster optimism and positive coping (Zautra et

al., 2008). Further, after this project is done, I am hoping to gain a better understanding of how leisure works to alleviate or exacerbate this public health crisis of social isolation and loneliness and potentially strengthen resilience among older adults. I also hope that other leisure scholars begin to incorporate social isolation and loneliness into their work, as currently they are scarcely addressed explicitly in the leisure literature (Glover, 2018).

CHAPTER THREE: METHODOLOGY

Qualitative Methodology

This chapter outlines the research approach I utilized to theoretically ground, collect, analyze, and interpret data in this dissertation. Specifically, this dissertation involved the collection of qualitative or non-numerical "data" as I sought to understand subjective experiences of older adults who used leisure as a resilience strategy to address their social isolation and/or loneliness. This qualitative study was conducted to shed light on the crisis of social isolation and loneliness among older adults during the pandemic and how leisure helped alleviate it. More specifically, the purpose of this qualitative dissertation was to understand the role(s) of leisure as a resilience strategy to combat social isolation and loneliness among older adults who live alone in the Kitchener-Waterloo area during the pandemic. In chapters 4, 5, and 6, I answer the following research questions: (1) how did public health restrictions affect older adults during the pandemic; (2) what strategies did they use to stay socially connected during the pandemic; and (3) what role did leisure play in addressing the threats of social isolation and loneliness during COVID-19?

Qualitative research was justified as the approach used in this dissertation because, as Ungar (2003, p. 21) stated, it served as an effective means to "discover unnamed processes, to attend to the contextual specificity of health phenomena, to increase the "volume" of marginalized voices, and to produce thick enough descriptions of lives lived to allow for the transfer of findings between contexts. These strengths contributed to my project by producing a thick description of participants' lives, which aims to advance this research area (Hand et al., 2017) by drawing necessary attention to the serious public health crisis of social isolation and

loneliness (CDC, 2020) and shedding light on the marginalized voices of older adults that are frequently silenced due to ageist stereotypes that dominate the grand narratives in society (Bookman & Kimbrel, 2011). Through qualitative research, I was able to grasp a greater understanding of participants' lived experiences and develop meaningful and trusting researcher/participant relationships. This chapter speaks to the methodology, methods, participants, and critiques I exercised for this dissertation.

Narrative Inquiry

Narrative inquiry refers to "almost anything that uses, for example, stories as data, narrative or story as representational form, narrative as content analysis, narrative as structure, and so forth" (Clandinin, 2016, p. 11). Narrative inquiry is a research methodology rooted in a wide range of philosophical, psychological, phenomenological, poetic, and pedagogic perspectives (Leggo, 2004). Narrative inquiry is often used in the social sciences to focus on the composition of a story to represent experiences and events (Leggo, 2004). Narrative inquiry allows for a rich description of experience and an exploration of the meanings that participants take away from their experiences. Moreover, it employs storytelling as a form of communicating participants' realities to audiences and amplifies voices that are typically silenced (Wang & Geale, 2015). By using "the narratives format to present findings, researchers can access rich layers of information that provide a more in-depth understanding of the particulars of the participants' points of view" (Wang & Geale, 2015, p. 1). I used narrative inquiry to collect, analyze, and interpret the stories of older adults to understand how older adults exercised leisure as a resilience strategy to combat social isolation and loneliness during COVID-19.

The term narrative refers "to a discourse form in which events and happenings are configured into a temporal unity by means of a plot" (Polkinghorne, 1995, p. 5). Narrative,

firstly, “has a finite and longitudinal time sequence, that is, it has a beginning, a series of unfolding events, and (we anticipate) an ending. Secondly, it presupposes both a narrator and a listener whose different viewpoints affect how the story is told. Thirdly, the narrative is concerned with individuals; rather than simply reporting what they do or what is done to them it concerns how those individuals feel and how people feel about them” (Greenhalgh & Hurwitz, 1999, p.1). These characteristics make narrative inquiry unique as a methodology, relative to other qualitative approaches.

Narrative Epistemology

My research questions listed above focus on my research participants as agentic constructors of knowledge. In this sense, I acknowledge that each narrative I collected from participants is unique, and that each story, each telling of each story, and each audience member’s interpretation of each story can result in a novel reconstruction of events in time and space (Belser, 2004). Narrative methodology operates within a paradigm that recognizes the contours of intersubjective meaning and embraces a narrative epistemology, whereby knowledge is not “found,” but rather constructed (Belser, 2004; McAdams, 1999). Narrative epistemology is more than just saying that “theory and method are inseparable: because the creation of narrative is essentially an intersubjective and contextual process of perspectival knowledge creation, the dialogue itself constitutes or generates new knowledge, which in turn influences the methodology employed by the researcher. If the narrative method is altered, it alters what knowledge is created in the first place” (Belser, 2004, p. 9).

Within a narrative epistemology, knowledge is generated through the interaction of storyteller and his or her audience within a particular socio-cultural context. The telling of the

story is like "editing the past, and this reconstruction of biography occurs within a given framework of socially sanctioned roles" (Lofland, 1969, p. 149). In this sense, narratives play a critical role in making sense of reality (Meretoja, 2014). What is ethically relevant in narrative epistemology is the "awareness of the role narratives play in organizing our experiences, because such awareness enables critical reflection on how cultural narratives steer our self-understanding and regulate our being in the world with others" (Meretoja, 2014, p. 104).

McAdams (1999) noted that stories do not seek truth in the paradigmatic sense, but rather verisimilitude, truthiness. McAdams (1999, p. 492) coined the term "psychosocial constructivism" to characterize the dynamic reality constructed within a socially negotiated framework. To build on this, Mink (1981, p. 23) stated that, "stories are not lived but told, since life in itself has no beginnings, middles, or ends." Mink concurs with White (1980) who wrote that the world is not given to us in the form of well-made stories, that we create these stories, and we give them referentiality by imagining that in them the world speaks itself. With this in mind, we should be attentive to the difference between experience and narrative. Writing about the distinction, Meretoja, (2014, p. 105) noted that:

> it can be meaningfully said that narrative interpretations of experiences have a constitutive role in our existence. In disentangling these debates, it is worth paying more attention to the way in which both experience and narrative are phenomena constituted by interpretative activity. This shared interpretative structure is a helpful starting point when we begin to explore in greater detail how storytelling on different levels—from small stories through which we exchange everyday experiences to historical narratives that shape cultural self-understanding—takes part in weaving, unraveling, and reconstructing the fragile fabric of our narrative existence.

In sum, narrative is a way of knowing that offered meaningful insights into my efforts of understanding how older adults used leisure as a resilience strategy to address social isolation and loneliness during the pandemic.

Elements of Narrative Inquiry

Plot stands as one of the centralities of narrative. It refers to the way that narrators organize their stories and the meanings they connect to the happenings in their stories, with the plot holding the whole of the story together (Maple & Edwards, 2009). Maple and Edwards (2009, p. 41) used the metaphor of the "washing line" to explain plot:

> sometimes [participants] added more pieces to explain something further, or sometimes they left some items in the basket if they did not feel safe to hang it out at that time. These choices ultimately affected the composition of the plotline and thus the story of their experience. The washing line was tentative and vulnerable to breakage, and sometimes it needed to be restrung depending on audience approval or disapproval or depending on the social setting.

This metaphor provides some insight into the challenges researchers encounter in collecting stories from participants and the need for narrative researchers to work with participants to articulate the plot. Ultimately, the washing line must hold together to understand the plot, which is fundamental to narrative inquiry because its articulation reflects the meaning-making process Ricoeur (1988) described as emplotment, the creative reorganization or reconstruction of reality to grasp together experiences and events in a way that brings together the concordance (i.e., order) and discordance (i.e., disorder) that characterizes participant experiences.

In the context of research, narrative aims for an in-depth consideration of the meaning(s) individuals assign to their experiences, with an emphasis on storied experience obtained usually through interviewing (Salkind, 2010). As a mode of data collection, narratives help acquire rich and free ranging discourse from participants (Salkind, 2010). The kinds of questions narrative inquiries lend themselves to exploring "are concerned with the explicit content of stories (e.g.,

emotional language), the implicit content of stories (e.g., themes), and/or the structural aspects of stories (e.g., coherence)" (Adler et al., 2017, p. 6).

The reflexivity of narrative inquiry in which participants and researchers participate in a process of dialogical reciprocity (Fine, 1994) allows for multiple truth claims to arise through the co-construction of meaning (Lincoln & Guba, 1985). This reciprocal co-construction refers to the interaction between the storyteller and audience, which influences the telling of a story. We tell stories, in other words, as reconstructions and reinterpretations of our experiences, which are retold, reconstructed, and reinterpreted. As Bruner (1990, p. 43) explained, "life is not 'how it was' but how it is interpreted and reinterpreted, told and retold." That participants in this study will tell me about their experiences during the pandemic will, therefore, reflect the current moment in time in which they find themselves.

Narrative researchers study participant experiences with the appreciation that "human beings give meaning to their experience of temporality and personal actions (Polkinghorne, 1988, p. 11). Temporality is the degree to which the narrator situates the characters of their story and their actions in a specific context (Polkinghorne, 1988). Narratives with a linear time structure (a beginning, middle, and end) are prominent in the storytelling literature, whereas hindsight, in drawing on the past in making sense of the present, is a temporal modality central to foundational concepts of sensemaking in narrative (Dawson & Sykes, 2018). Experience "is understood as the continuous interaction of human thought with our personal, social, and material environment" (Dewey, 1958, p. 39). Narrative attempts to understand human experience and the stories that people tell which are the vehicles through which those experiences are studied (Clandinin, 2006). "Narratively, to answer the question, 'What does something mean?'

requires showing how the ‘something’ contributed to the conclusion of the episode. The connections between the events constitute meaning,” wrote Richardson (1990, p. 118). This quote is important because it shows how narrative can be used to understand the meaning of something (e.g., the role of leisure as a resilience strategy to address social isolation and loneliness). In this sense, narrative inquiry helps participants make sense of disruptions related to challenging life circumstances (Riessman, 2008), thereby making it well suited for examining resilience strategies during the pandemic.

Method

Interviews

The narrative turn in social sciences honours stories which rely on interviews (Charmaz, 2008). Interviews require building trusting relationships with participants and going beyond verbal dialogue while simultaneously acknowledging silences, stories, inactions, and actions (Charmaz, 2008). The interview in narrative inquiry lets stories be told, particularly the stories of those who may have been marginalized or estranged from grand narratives, and those whose experiences, insights, perceptions may otherwise not be heard (Kim, 2016). Interviews embrace thoughts, dialogue, and discourse that are later “transformed into texts” (Nunkoosing, 2005, p. 699). To gain familiarity with participants and build a trusting and reciprocal relationship while hearing their stories, I employed semi-structured life story interviews.

Semi-Structured Life Story Interviews

Back in February of 2023, I found people were still weary of the pandemic and this project engaged those who were most vulnerable to COVID-19. For that reason, interviews were held over the phone. An "interview empowers people—the interviewer should not play the leading role" (Wellington, 2015, p. 139) and I regarded semi-structured life story interviews as best suited for this project as they provided that empowerment, flexibility, and an appropriate space for speaking to sensitive topics (more space to talk, not on a strict schedule like structured interviews) (Gattuso, 2003). The specific form of semi-structured interview I used was the life story interview. The life story interview focuses specifically on a period in an individual's life or a certain experience throughout the course of one's life (Clandinin & Connelly, 2000). Fragments of life story served as data for analysis and interpretation, where specific themes or issues that related to larger social issues, such as aging and culture, were identified (Kim, 2016). I engaged in life story with a specific focus on the defined period that older adults lived alone from the start of the pandemic (March 2020) until the time of interviews (February 2023). Life story interviews guided me in honouring the experiences of older adult participants, as it was the personal meaning of experience that this research seeks (Riessman, 2008).

During the data collection process, interviews began by establishing rapport and providing assurances of confidentiality. Rapport "can be facilitated by accommodating yourself to the routines of the informants, establishing what you have in common, helping people out, displaying an interest in them, and acting like a person who belongs (and being yourself)" (Mertens, p. 251). I established rapport by being myself and felt that every participant, based on their reactions to me and my interactions with them, could sense my genuineness. The data collected, as a result, seemed to reflect their authentic selves.

During interviews, I followed Powell and Snow's four principles: I used simple language, avoided coercive techniques, allowed the interviewee to choose what details to discuss, and encouraged an elaborate response (2007). This really helped keep the conversation natural, flexible, and organic. A life story assumes amorphous, conversational, semi-structured interviews as its method. Semi-structured life story interviews incorporate a limited number of open-ended questions to collect data in a relaxed narrative style. These interviews honour personal narratives that reveal how an understanding of an experience is constructed and reconstructed in representing that life as a story (Atkinson, 2007). This method is a subjective approach to conveying the parts of one's life (especially a certain period) (Atkinson, 2007). In my view, this approach allowed me to gain a deeper understanding of older adults' reality constructions, honour an age cohort whose social discourses tend to be less privileged (Fine, 1994), and focus on context. Collecting life stories, I believe, contributed to a greater understanding of populations whose narratives tend to be less valued in the popular discourses of society (Fine, 1994), thereby offering new insights into the lived experiences of older adults who are coping with social isolation and loneliness. To get at my research participants' experiences during the pandemic, I asked the questions in Appendix B. These questions helped explore participants' use of leisure as a resilience strategy to combat social isolation and loneliness during the pandemic.

Reflexivity

My decision to focus on loneliness and social isolation stemmed from Baumeister and Leary's (1995) notion that human beings have an intrinsic need for connection—that is, we desire to feel connected and interact with others. As well, older adults faced social isolation due to the fear of any in-person contact with their loved ones and friends because of the COVID-19

virus, which made loneliness among older adults, (already a serious public health problem prior to the pandemic), an even bigger threat with the occurrence of COVID-19 (Dahlberg, 2021; Glover, 2022). These reasons resonated with me on a personal level. Already well-rehearsed with the loneliness and social isolation older adults face (having worked in community health and long-term care for over a decade) and understanding that to keep myself mentally healthy I need social connections, it piqued my interest in wanting to understand what happens when an essential need (i.e., connecting with others) is seriously constrained because of unexpected circumstances (i.e., COVID-19 pandemic).

Reflexivity is a process that enabled me, as a researcher, to not only see how I came to know the participants, but also to review my own biases and how I imposed my value judgement upon participants (Savin-Baden & Niekerk, 2007). Reflexivity recognizes the collaborative role that both the participants and researchers play in the meaning-making and story-telling process (Dupuis, 1999). It is important to acknowledge that "people are individuals and need to be understood as such, but they cannot be understood only as individuals. They are always in relation, always in a social context" (Clandinin & Connelly, 2000, p. 2). Engaging in reflexivity recognizes the importance of developing trusting relationships between both parties, with an integration of self-disclosure on the part of the researcher throughout the entirety of the research relationship (Dupuis, 1999). Reflexivity understands the researcher's connectivity to his or her interacting world and includes empathy in the research process (Dupuis, 1999). It begins with personal transparencies (understanding the inquiry in the context of my own life experiences and tensions) (Clandinin, 2013) during the analysis to help fully appreciate the lived experiences of participants (Lather, 1986).

I was reflexive throughout this entire project to understand why I chose this research, what this research meant to me, how my own experiences shaped my interpretations of the data I collected and remained conscious to the ways I focused on the experience of research participants (Clandinin, 2013). Currently, as I write this (2024), I am a Director of Programs, Social Supports and Allied Health in a long-term care home. Every day, I see the value and need for social connections, meaningful relationships, and friendship. As someone who also worked in long-term care and community care all throughout COVID, I can appreciate that my values and biases are likely influenced by my experiences, interactions with residents and families, and the broader societal attitudes towards aging and healthcare. It was through this challenging experience of working through COVID with the older population that I created my own bias that older adults are the most resilient people.

My emotional investment in this project affected my interview timeline. I intended on interviewing all participants in the span of two weeks to complete this process in a timely fashion. Some interviews were difficult, emotionally, to conduct. Asking people to recall a time in their lives when they felt lonely and socially isolated triggered feelings of sadness and stress in me. As a few of the participants were anguished to tell me about their stories because of the personal struggles they had to revisit.

This experience underscored for me the importance of empathy in conducting interviews on challenging subjects. It drew out the interview process longer than I would have liked, as it took me five weeks to interview participants. Truthfully, I was apprehensive about feeling sad and needed breaks between interviews. Though I do not feel the five-week duration had a negative impact on this project, it did add stress to me by straying away from my personal timeline. In terms of reflexivity, these experiences affected my interpretation of the data I

collected. The “framing” of analysis all reflected my biases and lived experiences, as I already felt older adults were resilient and had assumptions of older adults and their strengths before engaging in this research through previous experiences (Jamieson et al., 2023).

To add further stress, I worked full-time during by dissertation work. Working a full-time management position and being a full-time student was strenuous on my mental health. I strive to become an executive director of a long-term care home, so I needed the experience of being a director of programs to position me to pursue this ambition. Accordingly, I took the job. I loved my job and my dissertation but doing both at the same time was quite challenging. My stress levels were high, and my sleep hygiene was poor, but I had the appropriate resources and supports to get me through. Although I do not regret taking on full-time employment, it slowed down my dissertation process.

Research Design

My research design serves as the plan and structure that guided my entire research process, from conceptualization to data collection, analysis, and interpretation of findings (Lee et al., 2021). It did so by guiding the process of conducting research by encompassing the structure, approach, and organization of the project to address the research objectives effectively (Lee et al., 2021). What follows is the outline of the methods, procedures, study participants, inclusion, and exclusion criteria, sampling, recruitment, and procedures that were used to address the research questions and objectives.

Criteria

Participants in this study consisted of older adults aged 65 and older (which is consistent with the general age range associated with older adulthood) who lived alone in Kitchener or Waterloo, Ontario, Canada, from the beginning of the COVID-19 pandemic (March 2020) to the time of interviews (February 2023). My interest in those who lived alone was to understand loneliness and social isolation on a level that started with being alone. I was interested to see if being alone led to loneliness or if it had no impact. The specific sampling criteria I used for selecting participants mirrored Lee et al.'s (2021) study:

Inclusion Criteria: community-dwelling older adults aged 65 years or older; inclusive of genders and non-genders (e.g., man, woman, non-binary, Trans etc.); residing alone in the community; healthy or who have chronic disease (e.g., hypertension); mobile (i.e., able to walk autonomously with or without an assistive aid or can self-propel a wheelchair); and without dementia.

Exclusion Criteria: people with the following severe diseases will be excluded from the study: chronic heart failure, recent surgery, dialysis, transplant, or intractable rare disease. These severe diseases require intensive treatment(s), which may contribute largely to social isolation and loneliness. In this study, I would like to focus on those older adults who dealt with the isolation imposed on them by public health restrictions. Older adults who experience unstable mental health disorders (e.g., bipolar disorder, psychosis, schizophrenia, or suicidal plans) will also be excluded from this dissertation research because these factors could similarly work as confounders for boosting social isolation or loneliness (Lee et al., 2021). A screening process

(Appendix A) was used to determine eligibility in the study based on the inclusion and/or exclusion criteria.

Participants

My study focused on 18 women over the age of 65 who lived independently by themselves in the community a year before the pandemic and up until interviews. The participants in my study lived alone due to divorce, widowhood, and living preference. Compared to older adult men, older adult women tend to live alone in the community (Requena, 2019) and are more likely to participate in research studies sharing their experiences (Otufowora, 2021; Negrin et al., 2017**;** Markanday et al., 2013), so it is no surprise my research was dominated by older women. As Canadian older adult women are more likely than men to live alone in the community (Lee & Edmonston, 2019), this perhaps also reflects why more women came forward to participate in this research project.

All 18 participants wanted to support my journey as a student and help in any way they could. Their motivation to do so seemed to stem from a mix of altruism and the connection between the subject and their lived experiences. Negrin et al. (2017, p. 2) suggested altruism "is reflected in participants' desire to help others, to make a difference to existing knowledge, and to change practice" (Coyne et al., 2016). In addition to wanting to help, hit close to them, as they all lived alone during the pandemic. As Clark (2010) stated, people are more likely to participate in research if they are interested in the project, and if they feel they have something meaningful to contribute (Coyne et al., 2016). All participants expressed interest in this research and felt their stories were significant enough to contribute.

Not having any men in my study was a finding in and of itself. While the absence of male participants limited the generalizability of the findings and required careful consideration of sampling bias, the continuation of the research was justified based on the relevance of the research question, ethical considerations, and the importance of insights provided by the actual study participants. I acknowledge the limitations of my sample and findings, yet I maximized the validity and applicability of my research by not only speaking to potential reasons why I did not recruit any men, but also by providing rich and detailed data in my findings.

Sampling and Recruitment

Throughout my literature review process, I determined that research studies like mine had around 15-20 participants. I recruited 18, and many participants were recruited through pre-existing relationships. I kept Tracy's (2013) warning in mind that too few interviews will produce "shallow and stale contributions," while too many will result in a paralyzing amount of data, discouraging "penetrating interpretations" (p. 138). Considering this, I felt 18 was the appropriate number, and if I did not feel I reached information power, I would recruit more participants. I started my recruitment with convenience sampling, a non-random sampling technique in which members of the targeted population who are willing to participate will be recruited for participation (Dornyei, 2007). Convenience sampling targets those easily accessible to the researcher (those who live in Kitchener-Waterloo). A convenience sample consists of a group of participants "sometimes regarded as 'accidental samples' because elements may be selected in the sample simply as they just happen to be situated, spatially or administratively, near to where the researcher is conducting the data collection" (Etikan et al., 2016, p. 4).

After my initial attempts with convenience sampling, I referred to snowball sampling. Snowball, sometimes referred to as "chain referral," sampling is a method whereby a study's sample arises through referrals made among people who know of others who possess some characteristics of research interest (Coleman, 1958). Coleman (1958) described it as a method designed for qualitative research because it allows for the sampling of natural interactional components. By using snowball sampling, I expect to find more participants to be part of this research.

To recruit participants, I promoted this study at community centres, community pools, community libraries, local coffee shops, Facebook, Instagram, LinkedIn, and the long-term home at which I work by placing posters in spaces visible to the public. These community spaces are known to attract older adults (Great Senior Living, 2022), and social media, for those savvier older adults who are comfortable with technology, had the potential to promote my study by getting word out through re-sharing of posts. Once someone expressed interest in the study by e-mailing me, I re-sent the screening questions just to make sure they qualified, then asked for their phone number, and scheduled a time to call them.

Ultimately, I kept in mind that there are direct benefits and risks of this proposed research to participants in this study. Emotionally charged research such as this project did invoke distress, sadness, and grief for some participants (Finlay, 2012). To minimize feelings of distress, I kept Mertens (2009) words in mind that

> Good interviewers will not end an interview with participants in distress. They will wait for individuals to regain composure and then inquire whether they want to take a break or end the interview and perhaps schedule another time to talk more. It may be necessary to stop or postpone discussion on a particularly painful topic or even to end the interview altogether (p. 246).

The interview process was also therapeutic and validating for some participants as they were reminded of their resilience, and their worth by having their experiences validated and by making sense of their lives by talking things through (Mertens, 2009). By reflecting on and articulating the role leisure served as a resilience strategy to combat social isolation and loneliness, participants thoughtfully considered tangible ways they coped throughout the pandemic. Reflecting through the telling of narrative allowed for mindfulness and expression, which lead to meaningful personal insights for some participants (Clandinin, 2013). In addition, to show appreciation for participants' time, effort, and skills, I provided participants with a $20 pre-paid gift card to Wal-Mart.

Recruitment Process

The recruitment materials I used for the project include e-mail script, posters, social media (poster put on Instagram, Twitter, and Facebook). My intention was to recruit 15-20 participants of multiple genders. I put up recruitment posters at one retirement home (Chartwell Terrace on the Square) and one long-term care home (Hilltop Manor), in staff break rooms for staff that met requirements. I also put recruitment posters in my building (Cambridge) as my neighbours are mostly all older adults, the W.G. Johnson/Ted Wake senior's recreation centre (Cambridge), Grind House Café (Cambridge), The Aging Oak (Cambridge), The New York (Cambridge), Quick Subs (Waterloo), Riverview Apartments (Cambridge), KW Seniors Day Program (Kitchener), and Innisfree House (Kitchener). I chose places where I knew drew the older population and took direction from the first couple participants I interviewed, who told me where their older adult friends visit frequently.

I also posted my social media recruitment poster to my personal Instagram page, Facebook page, and LinkedIn page. I posted my social media recruitment poster to the Hespeler Community Facebook Group, the KW community news Facebook group, and the Waterloo community new Facebook group. Further, to try and recruit men, I reached out and put my research out to KW men's only clubs (pickleball, golf, disc golf and squash), Facebook men's only groups (Senior Gay Men of KW and Senior Men of KW), and the maintenance staff room at Hilltop Manor (all the maintenance team members are men, with a 6 of them at the time being over the age of 65).

Recruitment mainly occurred through word of mouth as participants helped me to "snowball or contact additional older people" (Wiles et al., 2011, p. 417). Though my attempt to recruit multiple genders was my original intention, the only responses I received were from women. After 9 weeks I reached out to my committee to seek guidance and support with my decision to only interview women. For the sake of my dissertation timeline, the cost of tuition, and exercising multiple recruitment options, I made the decision to only interview women.

Procedures

I used semi-structured, one-on-one interviews (see more under Methods) held over the phone to collect data from participants. Interviews took on average one hour. Participants were contacted via phone or e-mail, prior to the interview to schedule a convenient time and date that worked best for them. The semi-structured interview began with an introduction, the purpose of my research, details about the study (including use of data), and consent information. I then asked for verbal consent to both proceed with the interview and record them.

Participants were informed the interview was audio recorded and transcribed, and that their identity was kept confidential. Participants were asked to provide verbal consent and were reminded they may ask questions throughout the interview, stop the interview at any time, refuse to answer specific questions, withdraw their responses later, and ask any questions prior to beginning the interview. I asked questions from an interview script and the semi-structure nature of the interview enabled me to explore certain conversation topics more, treating the predetermined questions as a guide. Prior to the conclusion of the interview, participants were asked if they have any questions and asked for their mailing information (to later send out gift cards as a thank you). Audio recorded data was transcribed using transcription software, TranscribeMe, and transcriptions were stored in a secure, password-accessible folder on my laptop.

Privacy

Demographic and background information including, age, gender, ethnicity, occupation, and living arrangement was asked of participants. This information was collected separately from names and other identifying information. Participants were identified through pseudonyms. To keep track of participants and their pseudonyms I created a spreadsheet with participant contact information and kept this document separately and securely from collected responses. The pseudonyms I chose were character names from my favourite TV show, American Horror Story. The list with participant's pseudonyms and their actual names and consent form was stored in a password protected electronic document on my laptop. This document (i.e., key that will link participants' names with their pseudonyms) was stored securely and separately from data. Participants were told they have three months to withdraw, after which, the key, linking participants with their pseudonyms, will be destroyed. With this, there are no limitations to the

promise of confidentiality, no data will be leaving my laptop, and no data will be entered into a database for future use. Finally, individual participant identities are confidential in the release of the study findings, though direct quotations will be used to illustrate themes in the final dissertation and any subsequent publications. Participants were made aware of this intention before consenting to participation.

Consent and Withdrawal

Informed consent was verbally obtained from all participants verbally prior to the interview. Two verbal scripts guided the participant through the verbal consent process. The second part of the verbal script was used as formal documentation of participant verbal consent as documented by me. Participants were notified that, at any time, they may ask questions about their participation and what it means to consent to being involved in this project.

Participants were informed of their right to withdraw from the study in the study's information letter (to be drafted for ethics clearance). If they wanted to withdraw, identifying information would have been removed from the data and stored separately. Additionally, participants will not be able to withdraw consent once papers and publications have been submitted to publishers, which will be after the 3-month grace period. Collected data was stored in a password protected Google Drive for a minimum of 7 years. The anonymized data may be shared publicly but, the participant's identity will be kept confidential. If the participant wished to withdraw from the study, their data would have been flagged and removed from accumulated data and deleted from the sample of anonymized qualitative interviews. Further, no individual taking part in this study would have been unable to provide their own informed consent.

Feedback and Appreciation

To show my appreciation to the participants for taking part in this study, a thank you card was mailed to their address with a token of appreciation ($20 gift card to Wal-Mart). As part of the consent script, I asked if participants would like to be contacted should new content be developed from study results.

Voice

In the broadest sense "voice may be thought of as belonging to participants, researcher, and other participants for whom a text speaks" (Clandinin & Connelly, 2000). Cited in Connelly and Clandinin's (1990, p. 4) work, Deborah Britzman refers to voice as:

> Meaning that resides in the individual and enables that individual to participate in a community… The struggle for voice begins when a person attempts to communicate meaning to someone else. Finding the words, speaking for oneself, and feeling heard by others are all a part of this process…. Voice suggests relationships: the individuals' relationship to the meaning of her/his experience and hence, to language, and the individual's relationship to the other since understanding is a social process.

The voices of both researcher and participant are heard in a collaborative process involving mutual storytelling within narrative inquiry (Kim, 2016). Engaging in narrative inquiry, I always kept in mind the ethics that incorporate negotiation, respect, mutuality, and ingenuousness to multiple voices (Clandinin & Connelly, 2000). With voice, I thought about balance, as there was potential for me to come off as a *dominant* researcher voice who could be faulted for misusing subjectivity (taking over the participant's story by interrupting, or jumping in with your own story, etc.) *or* a *weak* researcher voice that runs the risk of not thinking through what participants have said (Clandnin & Connelly, 2000). I recognized the potential challenge I could have had in acknowledging my own voice in the inquiry intended to tell of the participant's storied

experiences and to represent their voices, yet I mirrored Clandinin and Connelly's (2000) notion that voice dilemmas can be settled with judgement. I felt that as a researcher, I captured the multiplicity of voices heard, and made judgements that included my voice without overpowering the participants' voice (Clandinin & Connelly, 2000).

Life story is told by the person who lived and experienced it, with the context, setting, audience, the particular situated purpose of a story, performativity, and the narrative resources available to tellers frame what might be said and how it can be narrated, which can impact voice (McAdams, 2006). As most narrative analysts who touch on voice would agree, narrative representation involves a version of event and experiences, shaped by the audience (me as the researcher) (Clandinin, 2006).

Quality

The quality of the research in this dissertation is important to conducting a meaningful project. Elliott, Fischer, and Rennie (1999) identified criteria for quality qualitative research, so that participants, methods, and procedures are carefully described, and self-reflexivity is practiced. Their criteria included presenting the data in a coherent manner and supporting each theme with data excerpts and double checking over the work. These strategies ensure less room for misinterpretation.

Information Power

Considerations about study aim, sample specificity, theoretical background, quality of dialogue, and approach for analysis help decide whether adequate information power will be acquired with more or fewer participants in the sample (Malterud et al., 2016). Information power suggests that the more relevant information a sample has, the smaller number of participants is needed (Malterud et al., 2016). With respect to my sample, I felt all 18 participants offered relevant information in line with my study aims and fit with my theoretical understanding. Moreover, they held a high quality of dialogue, which supplied rich data and themes.

Malterud, Siersma and Guassora, (2016) reference information power in relation to the specificity of experiences of participants included in the sample and the quality of the interview dialogue. A study with "strong and clear communication between researcher and participants requires fewer participants to offer sufficient information power than a study with ambiguous or unfocused dialogues" (p. 3). My interview dialogues had both strong and clear communication, so I felt comfortable with 18 participants. My questions and understandings were framed by theory, and my analysis involved a thorough exploration of narratives (Malterud et al., 2016).

After 18 interviews, I felt I had enough available information to address my research questions effectively and that the quality and depth of information I had gathered contributed to my study's overall power to generate meaningful insights and findings (Guest et al., 2006). I felt after 18 interviews, I had hit theoretical saturation, as I had reached a point where no further recurring themes emerged, and similar concepts kept arising (Faulkner & Trotter, 2017). After 18

in depth interviews, I felt I had saturated all that I could have learned about that topic and had reached theoretical saturation.

Trustworthiness

I kept trustworthiness at the forefront of the process of my research. Trustworthiness is a substitute term to replace the positivistic terms of validity, reliability, and generalizability (Lincoln & Guba, 1985) and is a way that qualitative researchers can demonstrate that their research findings are worthy of attention (Lincoln & Guba, 1985). It is the researcher's responsibility (in this case, me), to ensure trustworthiness. As a qualitative researcher I demonstrated how data analysis has been conducted through recording, systematizing, and disclosing the methods of analysis with detail to enable the reader to determine whether my research process is credible (Attride-Stirling, 2001). Lincoln and Guba (1985) broke down the concept of trustworthiness into parts consisting of credibility, transferability, dependability, and confirmability. Nowell et al., (2017) added audit trails to these criteria, which I included in my project, too.

Credibility is determined when readers are confronted with the experience, and they can recognize it (Guba & Lincoln, 1989). Credibility "addresses the fit between respondents' views and the researcher's representation of them" (Tobin & Begley, 2004, p. 4). Transferability refers to the generalizability of inquiry. As Lincoln and Guba mentioned (1985), the researcher cannot know where the findings will be transferred, but it is up to me, as the researcher, to provide thick and detailed descriptions so that those who seek to transfer the findings to their own sites can judge transferability. Dependability requires the researcher to ensure the research process is logical, traceable, and clearly documented (Tobin & Begley, 2004). Confirmability reminds me

as the researcher to make sure my interpretations and findings are clearly derived from the data. And finally, an audit trail provides readers with evidence of the decisions and choices made by me as the researcher regarding theoretical and methodological issues throughout the study, which requires a clear rationale for such decisions (Nowell et al., 2017; Koch, 1994). All these components were used in my dissertation project to contribute to the trustworthiness of my study.

Rigour

As I engaged in a qualitative research inquiry, I was conscious of rigour, a way to establish trust or confidence in the findings of a research study (Thomas & Magilvy, 2011). I ensured rigour by engaging in a mutual understanding of participants' stories in a way with which they were comfortable through allowing them to guide the interview and providing a safe space of no judgement. Through clarifications, re-asking, and paraphrasing what was said, I verified participants' stories for accuracy of understanding (Dodge, Ospina & Foldy, 2005). Rigour was also safeguarded through audio recording interviews, as I transcribed every word said by participants (Dodge, Ospina & Foldy, 2005). Using a software app to transcribe interviews, I went through the transcription again by listening to the interview to verify accuracy. This approach aimed to verify the participant's interpretation of their truths and realities, while also used to "clarify earlier comments with recent insights if they appear to be different" (Atkinson, 2002, p. 134-135). Moreover, I engaged in "repeated listening's to taped interviews and readings of transcripts," and focused my analysis of critical "episodes" to verify "internal consistency" (Mishler, 1990, p. 427). Once I finished my findings and discussion, I came back to my methodology chapter and re-wrote any changed I made.

Narrative Analysis and Analysis of Narratives

Consistent with narrative inquiry, I used both narrative analysis and analysis of narratives the approach to analyze the data I collected. Narrative analysis is a method of analyzing narrative data to produce coherent stories (Kim, 2016). Narrative data can be derived from journals, conversations, autobiographies, and transcripts (Kim, 2016). With the understanding that many occurrences of significance happen principally in the form of overt verbal behaviour from communication, socialization, and interpersonal relations (Kim, 2016), narrative analysis is about the "configuration of the data into a coherent whole" (Polkinghorne, 1995, p. 15). Narrative analysis shows the meaning of a lived experience in a final story and while participants may not communicate their experiences as stories, those experiences can be communicated as stories when given a narrative structure. Analysis of narratives is where I collected stories as data and analyzed them using a more conventional qualitative approach (Polkinghorne, 1995). This conventional process resulted in of the identification of themes based on the narrative data collected (Polkinghorne, 1995).

Transcription

Transcription of oral narratives were audio recorded and responses were transcribed to preserve all information that may affect interpretation (e.g., pauses, emphasis, nonverbal cues) (Reissman, 1993). Once my interviews were finished, I transcribed audio files of the interviews and got full transcripts, with data from semi-structured interviews. Starting the narrative analysis process, I first transcribed the narrative data with a formal analysis of the text (Glaser & Strauss, 1967). I found that transcribing was essential to the process because text data in the form of direct quotations were used to tell and illustrate participant stories. I engaged in the

practice of indwelling, reading the data numerous times, and listening to all relevant recordings to assure quality, clarification, and elucidation (Reissman, 1993). After transcription, I then inferred meanings through identification and analysis of plotlines, thematic structures, and social and cultural referents (Kim, 2015)

Coding

I then moved to coding. The steps I took with coding included: (1) coding narrative blocks about similar life events expressed by participants; (2) grouping and reading narratives with same life event to note similarities and differences; (3) creating nested story structure codes for a life event; (4) collating each life event by its story structure code; (5) comparing across story structure, keeping overarching narratives intact, and paying attention to how story structure codes relate across a life event; (6) telling the core narrative by taking the structure and writing a core narrative for each life-event that encapsulated the commonalities among participants (Delve Ho & Limpaecher, 2020). After coding and during analysis process, I decided where I could find a story in the data and identify narrative themes. I also identified the structure of a story in a data-driven, inductive way.

Representation

Non-Fictional Composite Story & Analysis of Narratives

The findings from my data are represented in two chapters. First, chapter four reflects a narrative analysis whereby the data are represented through a non-fictional composite story or a general story that speaks to common experiences. Here, I moved from story analyst to honorary storyteller (having the privilege of re-telling the stories of participants). To represent the data through a non-fiction story, I started by putting together the plot and integrating events and

occurrences into an ordered whole with a thematic thread (Kim, 2015). My intention was to have this nonfiction story about older adults and their experiences bring readers on a journey, encouraging them to connect with the experiences of older adults during the pandemic, portrayed from a third-person angle (Richardson, 2001; Goodlad & Sartori, 2013).

Second, in chapter five, the data are represented through an analysis of narratives whereby I collected stories as data and analyzed them using a more conventional qualitative approach (i.e., deconstructed the stories I collected; see Polkinghorne, 1995). This conventional process resulted in of the identification of themes based on the narrative data collected (Polkinghorne, 1995). This chapter focused on the meaning of resilience for participants, what resilience and coping strategies participants used to stay socially connected during the pandemic and delving into the role that leisure played as a resilience strategy in addressing the threats of social isolation and loneliness during the pandemic.

Critique

Though I am confident in my choice of narrative, I also acknowledge and see merit in the critiques of this methodology throughout the literature. Narratives can be perceived as "overly personal and interpersonal" (Clandinin & Connelly, 2000, p. 181), as a lot of literature in this realm of research is based on "quantitative data and positivist assumptions about cause, effect and proof" (Pinnegar & Daynes, 2007, p. 3). I acknowledge that storytelling can restrict the teller within his or her own story, confirming his or her apparent marginalization (Goodson, 1992), and validate existing oppressions and marginalizations and feed existing structures of domination (hooks, 1991), while reproducing "a contradiction-filled, a colonizing discourse of the 'other' and can be a 'tool of domination' which 'others'" (Fine, 1994, p. 70). To avoid "othering," I

structured my interview guide and conducted interviews by giving participants opportunities to expand on their stories without interruption and did my best to ensure they felt safe and comfortable through frequent check-ins (asking how they were feeling, if they wanted to proceed), and asking if they needed any resources or supports for anything they were experiencing (i.e., loneliness).

Of course, with any methodology, there are limitations. Narrative is sometimes seen not to be "theoretical enough" (Clandinin & Connelly, 2000 p. 42). Moreover, critics argue the stories within narrative neglect to offer theoretical foundations that support creation of new understandings (Behar-Horenstein & Morgan, 1995). With narrative inquiry, it can be problematic to decide the relationship between the narrative account, the interpretation, and the retold story (Denzin, 1997). Narratives told rely on a narrator, with an emphasis on trust, truth, and memory, that sometimes may be difficult to navigate in a clear and concise manner. I am cognizant of the possibility that stories told by participants can potentially be challenging to interpret in terms of the relationship between the storytelling in the interview and the story-making in the presentation of data (Savin-Baden & Van Niekerk, 2007). This outcome can result in the negotiation of data interpretation and the representation, which can be a complex task, if there is a disagreement or difference in understanding.

Verisimilitude

As a narrative researcher, I am not seeking to learn facts, *per se*, as "a narrative is not simply a factual report of events, but instead one articulation told from a point of view that seeks to persuade others to see the events in a single way" (Riessman, 2008, p. 187). In this sense, that a story told by a participant is true or not, in any objective sense, is not the point of narrative

inquiry. Rather, the truth of the story is found as insight into the what the storyteller is trying to persuade his or her audience of. This persuasion reveals meaning. With this in mind, I did my best to understand how and why a storyteller uses rhetorical and performative devices because they speak to the messaging the storyteller wishes to convey. As the author of the final text of the narratives represented in this dissertation, I was also conscious of verisimilitude. Verisimilitude is "a criterion for a good literary study, in which the writing seems 'real' and 'alive,' transporting the reader directly into the world of the study" (Creswell, 2009, p. 250). I did so by describing place in detail (participant homes), going into detail about participant emotions, and using descriptive words that best captured participants' feelings, thoughts, and moods.

Limitations

Readers should be aware of a few limitations to the proposed research. First, "older adult" is a broad term encompassing everyone who is 65 and older (Jindai, 2016). Social policy recognizes this age range can be further broken down into younger old (65-74), the old (75-84), and the older old or oldest old (85 plus) (Taylor, 2011), yet most of the literature and policies refer to anyone over the age of 65 as older adults, seniors, or elders (all in one category). The participants I interviewed all ranged, with some in their 60s, some in their 70s, and some in their 80s. This range can prove to be a limitation for this study. Someone who is 66 and someone who is 86 are both older adults but may experience their lives very differently at these different stages, including dealing with different illnesses, different cognitive and physical abilities, and different living arrangements. With such a difference in life experiences both prior to older adulthood and during, the variations in life experiences can also lead to different levels of resilience among older adults. Variations in resilience can affect the response to the pandemic and social isolation and loneliness and furthermore, participants may have different perspectives,

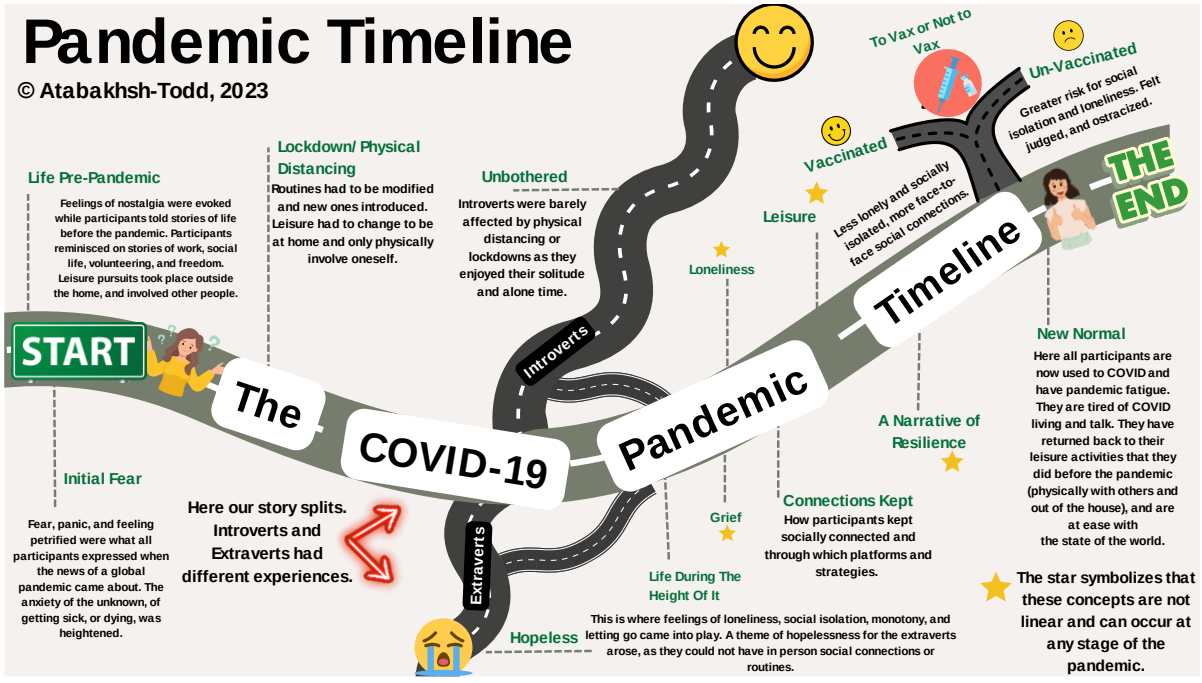
ideas, or definitions of resilience and there can also be a blurred understanding of the distinction between social isolation and loneliness among participants.

In terms of the research process, research quality is heavily dependent on the individual skills of the researcher and more easily influenced by the researcher's personal biases and idiosyncrasies. This can make rigour more difficult to maintain, assess, and potentially affect rigour with the researcher's presence during data gathering (which can affect the subjects' responses). Moreover, some other limitations included: the volume of data made analysis and interpretation time consuming. 18 interviews with each of them being an hour long, it took some time to go through multiple times to find themes and interpret them. Finally, all these limitations sometimes make qualitative research not as accepted or understood the way quantitative research is within the scientific community. Although I recognize how valuable qualitative research truly is, I kept these challenges, limitations, and critiques in mind during the research process.

CHAPTER 4: FINDINGS FROM A NARRATIVE ANALYSIS

The following chapter is a narrative analysis of participant interviews. To undertake this narrative analysis, I conducted participant interviews, reviewed the transcripts, and configured the data by means of a common plot to display the linkages among thematic elements, while retaining a narrative structure (Polkinghorne, 1995). This chapter is based on the timeline outlined in Figure 4. The story that follows, and the presentation of the findings, retains the structure of that timeline. The timeline starts in March of 2020 when the pandemic first began, continues through quarantines, lockdowns, and physical distancing, and ends in February of 2023, the time when I conducted interviews. Though the narrative contains the same events, it branches off during stay-at-home orders, a time that highlighted participants' roles as either extraverts or introverts. In many ways, the narrative conveyed reflects stories of resilience, loneliness, and leisure throughout the pandemic.

Figure 4: Pandemic Timeline



Life Pre-Pandemic

Before COVID became ubiquitous and the world was overwhelmed by the pandemic, participants in this study lived different lives with different routines, schedules, and interactions. While all 18 participants lived alone in their own homes, some worked full time, some volunteered, and some had active social lives, all before March 11, 2020. This section profiles their lives before COVID.

Before March 11, 2020, Jude lived by herself in her quaint townhouse with her cat, Crookshanks. Jude enjoyed an active lifestyle as an energetic 71-year-old. Her life consisted of "traveling around the world . . . doing wildlife expeditions, working as a citizen scientist, and helping with wildlife." In my conversation with her, she radiated a zest for life. Jude smiled while she reminisced about her life pre-COVID. Back then, she worked as a nurse for over 40 years—dedicating herself to helping people—and took on an active role in her community. She was eager to share her past, and she spoke with passion while doing so. She told me:

> As a 71-year-old, I'm a very active, healthy individual. I've had a medical background profession and used to dealing with lots of people all my life. I had an active social life. I was reasonably happy with what I have got and where I am. And all the things that I was loving and interested in in my community, I was very grateful for. So, I was a soprano in a corner. I was going to aqua set once a week. I did hike with my buddies. I'm an avid hiker. I did ballroom dancing. Each week, square dancing, walking my dog every day in nature areas. I did some of the classes each week. Met friends in cafés and restaurants. This was my life. I had a good community setting, and I didn't like living alone, but this is where my past led me, and I was making it work. I reached out to the community. I was volunteering at the humane society, teaching children about animals and humane treatment of animals. I was into lots of things, little school gatherings, and everything. And my life was going along.

Setting an example of what life can look like in older adulthood and challenging stereotypic norms, Jude, like the other participants, agreed that life before the pandemic was full of social connection and steady routines.

Similarly, Lana established she had a “great life . . . a very adventuresome life,” while Myrtle worked “5 days a week” and spent time “at the office, you know, nine-ten hours.” Meanwhile, Mary was “busy” with “a lot of friends to go out at night.” Most participants volunteered, had active social lives, served on committees, worked 9 to 5 jobs, and regularly attended club meetings. Sure, life still had its challenges that came with living alone, but as Vivien said “I live alone, so, I'm used to that . . . I wasn't at home very much before the pandemic. I was on the go all the time.” All participants felt “free before the pandemic. I felt free to make a decision and do what I wanted,” as Zoe put it. All participants spoke to the busy and fulfilled lives they experienced before the pandemic. Nostalgically, they recalled how much they enjoyed everything they did. The sense of autonomy with both work and social interactions were common themes in recounting their lives before COVID. Little did they know how much their lives would change with the unexpected arrival of a global pandemic.

Initial Fear

During our conversations, participants took themselves back to March of 2020 when they first heard about a novel virus that originated in Wuhan, China. The participants expressed growing fears about the threat of this novel coronavirus, which dominated all news, media, and social platforms. It was a time of uncertainty and fear for all participants and re-visiting this part of their past brought forth feelings they had suppressed for some time.

The Initial Global Fear

When asked to recall the arrival of COVID-19, Jude paused and collected herself before she spoke. The tone of the conversation changed. Her voice began to tremble as she discussed

the start of the pandemic. She recalled “the way the media portrayed it—and I saw these people dropping dead—dead bodies in China, which is what was portrayed to us. It was all part of the mass formation cycle. And I soaked right in.” For other participants, like Jude, it was almost as if March of 2020 was a glitch in time. A glitch during which a permanent rain cloud hovered over the world, and everything was dark, grey, and frightening.

The fear of the unknown and grave concerns about what the pandemic was going to bring were common themes among the participants. The monitoring of its spread across the globe caused tension, which made Myrtle think of the pandemic as

> a threat . . . you're watching what's going on in Italy, and it was just like something out of a sci-fi movie where, you know, an apocalypse kind of thing. A night where everybody can go out and shoot everybody if they want. I forget what the name of those movies were . . . you know, it felt like 9/11 and a bit, you know, when they landed all the airplanes that day. And nobody could be in the air.

Myrtle’s initial fear resembled what all other participants felt. The fear of the unknown, the labelling of a “pandemic,” and the thought of getting sick or dying were at the forefront of news and media outlets, as well as participants’ minds.

Participants’ sense of fear was clear when the virus first arrived and began spreading close to home in Canada. As Vivien recalled, “it wasn't just in China. It was everywhere in the world. And all the people that were dying from it. Then I thought, oh, wow, this is something, you know. This is really serious.” Due to this paralyzing fear, most participants recalled remaining inside their homes alone with little to no physical interaction with others to stay healthy and safe. Constance expressed how she did “not leave the house” for days at a time as she was afraid of the novel coronavirus, which was the shared reaction among all participants.

The Fear of Getting Sick

The fear of contracting COVID and getting sick was an anxiety all participants expressed. No one knew what would happen if they caught COVID. As Delphine explained,

> Initially, at the start of the pandemic, it was a really, really challenging. Because we were all terrified. I mean, if I get it, am I going to die? . . . It was very stressful initially . . . Because if you go back to the beginning of the pandemic, nobody knew what to expect. Nobody knew what to anticipate, right? We were all very, very frightened.

Jude shared the same fear. She recalled how

> I didn't look at anybody because they might be infected. I might catch it from their eyeballs. So don't look, don't speak. Just go. Don't touch anything, and come home and get your food in. And that's what I did. And, yeah, I was literally scared. It's there. It's right outside my door.

The fear of getting sick was enough to make most participants stay home and away from everything and everyone. Having been told they were in the age group most susceptible to COVID, all participants felt extra weary and on edge. Myrtle viewed her top priority at the start of the pandemic as "not to get sick," and the fear of getting ill led her to isolate herself at home and keep away from her loved ones.

The Fear of Going Out

The fear of getting sick created the fear of leaving the house. Jude recalled how she was

> scared to go outside . . . But I had to go out. How will I get my groceries? Oh my God, I don't know how to get my groceries! So, I would get my mask on, and I would drive to the local whatever it is and go in quick, keep my eyes down.

Madison, like Jude, felt frightened to leave the house. She recalled how afraid she was to get sick, which led her to feel "terrified. I was quite frightened to go out and to be in public." This fear had implications for participants' mobility. Madison felt anxious every time she had to leave her house. She recalled her experience going to a medical clinic where everybody was in "HazMat's. It was

terrifying. It really hit me emotionally. Like, I was really quick to cry because it was all so unreal and terrifying. It was frightening . . . I could not control myself . . . I just felt like I was in some sci-fi movie or something. It was just so bizarre. I just felt like I was outside my body." The fear of leaving the house and going out in public was exacerbated by the fear of getting sick or possibly dying from this new disease.

The Fear of Dying

Myrtle was terrified when the declaration of a global pandemic was announced as "it frightened me, really, because people were dying from it. And when, you know, when you're older, I was afraid I was going to be one of them." Similarly, Eunice "thought it was going to be the death of everybody." She compared COVID to "those movies where they breathe the air, and they turn into zombies," a portrayal seemingly advanced by the news media. She and other participants felt that COVID was like a "horror movie" insofar as everyone who tested positive seemed to be at risk of dying immediately. As Billie put it, "people were dying . . . it was really scary." This "horror movie" felt surreal for most participants. Madison recalled an experience at the start of the pandemic when

> we were ordering groceries at that time and picking up groceries because I didn't want to go into the grocery store, even though the grocery store was open. But driving by stores like Food Basics and Zehrs and seeing the massive lineups outside, I would just burst into tears.

Madison like other participants felt overwhelmed by the emergence of COVID-19. This scary feeling, this *fear* among participants, was pervasive as they were all afraid to go out, get sick, and die.

Feeling Petrified

All these fears left participants feeling petrified. Here, I use the term petrified deliberately because participants felt immobilized by their fear, which caused them to experience a figurative state of paralysis. Jude spoke to feeling petrified when "everything shut down, my life shut down. I was in fear. I didn't know who to turn to because I lived alone. I couldn't talk with anybody. Because we were all closed off from everything." Jude felt her fear heightened because she

> Couldn't have any outlets on anxiety because I was alone, and because I couldn't speak to anybody, and everybody was in fear of everybody else . . . So you just lose all sense of hope. And what is the use in living? This is not my world. How could my world be changed in less than a year, two years? There seemed to be no end to it.

Participants felt they had lost control of their lives as they could no longer engage in their regular routines, leisure activities, or social interactions. They felt incapacitated insofar as they could not move or do anything, other than stay in their home away from the outside world. Delphine explained this feeling, which caused her to become "disconnected from my family and friends." Zoe felt "shut down and crushed" as her "new life at home" was not where she felt she would be spending her older adulthood. The fear and anxiety were so intense that participants felt they were frozen, immobile, and unable to "think or move," as Delphine put it. She, like others, became quite afraid and began to question her future.

Fear of Others

The fear that participants felt made most of them feel shut off from everything and everyone. Some were both physically and socially isolated, which led to a sense of hopelessness. Even walking in the neighbourhood was characterized by fear. Myrtle recalled "walking during COVID that first summer and walking on the other side of the road from somebody that I didn't

know." Like Myrtle, Delphine remembered how people "would deliberately cross the street when they saw anybody. I mean, people automatically bee-lined in another direction . . . That speaks to the fear that everybody had." Violet experienced the same reaction; she recalled how people "would avoid you when you were walking" on the street. Doing so limited interactions with others, as Jude explained:

> I would go out with my dog, and I'd see somebody walking towards me. And I said, I said, "Good morning. Good morning. Nice day, isn't it?" I would, and those would be the only words I would speak. Maybe in a week. "Good morning" and "hello." And I noticed when they saw me coming along, they walked six, ten, 12 feet, and in a way like I had malaria or something. And this was just, it was horrible.

The fear of encountering others on a walk was a reality that participants experienced regularly. Like Violet, Vivien listened to the news quite a bit and expressed how lonely she was at home: it was "tough, you know, to stay that far away from people." The "social distancing, I think, was, you know, one of the hardest ones" for Vivien. It was challenging because people kept away from each other for fear of contracting the disease. It was more than just physically distancing, though, it was *avoiding* people altogether, refusing to be six feet apart, in the same space, or anywhere near another person.

Myrtle felt the same about her fear of others. She mentioned that

> I can follow rules, but I don't like to be restricted. I guess that's, you know, being on my own all these years. But, first of all, the lockdowns were scary, where you couldn't go out and do anything.

Zoe also spoke about her dislike of being restricted and how frightening the lockdowns were for her. She mentioned how horrible it was that

> I couldn't go anyplace I wanted to go. I thought, this is the golden years? To be able to go on a cruise, stay on a cruise all winter. I can't go on one. I can't get on an airplane. I can't visit my grandchildren in Vancouver.

This fear of others negatively impacted socializing for participants. Zoe's quote speaks to the importance of socializing for older adults. It also underscores the frustration and disappointment about not being able to live out older adulthood in a social manner. This fear of others placed limitations on participants' interactions with others. It also made everyone participants encountered a "suspect," as strangers were treated as if they were sick with COVID. This fear and reaction had negative implications for interacting with others and generated an overall fear of others, which contributed to feelings of loneliness and social isolation.

The fear of getting sick, of dying, of going out, and of others led participants like Violet to go from being "very active and being out with the public and volunteering and being helpful to the society to being lonely and home." Fear led to them to avoid others and stay isolated at home. However, slowly, but surely, participants became acclimated to pandemic living.

Lockdowns/Physical Distancing

Some of the routines, daily habits, and small pleasures in life were taken away once the pandemic hit. For Misty, her routine became "strange because I couldn't go visit my kids" as she was unable to go for dinner with them like she did before the pandemic. Eunice was unable to keep her routine beauty appointments: "I couldn't get [my eyelashes] done. That upset me." Violet gave up driving and sold her car because "I didn't use my car. So, there was a big difference." And when Vivien's routine was disrupted, she felt "a little frustrated because there were things like getting your hair cut that you couldn't do." Her small pleasures were taken away.

Restrictions on Social Contact

Perhaps one of the most common themes that arose from the interviews was the restrictions on social contact. Though public health issued formal restrictions (physical distancing, stay at home, etc.), it was largely up to people to police themselves. Some chose to accept the restrictions, while others resisted them. For most participants who chose to follow the restrictions, their social contact with family, friends, and neighbours was reduced tremendously.

Delphine found the pandemic quite challenging because of her extroverted personality. Being "socially isolated from all my family, all my friends" made the first year of the pandemic extremely "socially isolating." For Constance, following the restrictions meant that she:

> Didn't get to see my mom for a long time. I didn't get to see my family, my sister. For a very long time, I wanted to do some traveling, you know, because my daughter was away. And I wanted to go to see her at her school or her place where she was. And I couldn't do that. So, a lot of that stuff that I would have done that I, you know, would have made me feel good. It was taken away.

Delphine, Constance, and Sally, like most participants, felt that by following public health's restrictions, their social connections, familial ties, and social life were "ruined," as Delphine put it. Participants felt they needed to be responsible, play a role as a member of society, and "do their part" as Constance put it, in slowing down the spread of COVID-19, yet the resultant lack of connection generated harmful feelings of loneliness.

Lack of Physical Touch

Physical distancing had implications for physical touch or the lack thereof. Whether sexual, romantic, or platonic, physical contact mattered to the participants, yet it was curtailed by the pandemic. When people transitioned from social distancing to physical distancing so that they could still see people, but not touch them, the restrictions still affected them negatively.

The continued restrictions were extremely stressful on participants. Sally felt very physically and socially isolated from her family. She spoke of her inability to see her son and how upset that made her feel. Sally recalled how she "hadn't seen my son for nine months. So, it got to the point where, you know, I couldn't even hug my son. And it was very, very challenging." Hugging her son was an important gesture of love and affection that she felt was taken away from her. She questioned why she was unable to be around him, which led her to angrily respond "are you fucking kidding me? I can't even hug my own fucking son!" Sally felt she was unable to "be a family. We can't even just be connected and hugging." The pandemic, as a result, made her feel socially isolated and lonely. Like Sally, Delphine described the pandemic as "very, very challenging and isolating" because she "couldn't go near my family. I couldn't go near friends." And like Sally, it made the pandemic "very hard." Delphine was unable to hold or hug her granddaughter, which caused her to cry on numerous occasions.

Madison recalled her Christmas of 2021 and how dim and unhappy it was in her home. She choked back tears as she recounted her holiday experience: "Because I lived alone it was like, I can't hug anybody, I can't kiss anybody, I can't be close to anybody. It was very difficult . . . no physical touch, no hugging my kids, no hugging my friends. That lack of physical was very lonely because I'm quite a huggy person." Similarly, Constance struggled with her lack of physical touch with family and friends. She spoke through tears about how long and hard the days became once the physical distancing restrictions were put in place. She remembered how her

> other sister being away in the states, I couldn't see her at all. It was like three years before I could see her, right? So, it was really isolating in that. I mean, I tried to keep in touch with people by phone calls, but again, it's not the same as being in person. And I'm a person that loves to have social events and dinner parties or get togethers or go out for breakfast and stuff and that really bothered me.

Being away from her daughter, two sisters, and mother made the pandemic all that much more isolating for Constance.

Physical touch in an intimate form was missed, as well. Lana admitted she wished she was having sex. The biggest routine disruption for her was her lack of sex during the pandemic and that she just "didn't have sex." With her husband's passing and her inability to go out and meet people, Lana felt she was unable to maintain her routine of a healthy sex life, which spoke to the consequences the public health restrictions had on one's intimate life. Misty, like Lana, also "missed having sex." For the longest time, she would not even "hug" anyone she was dating as she was adamant in following public health restrictions. Physical touch, in many forms, was important for some participants to feel socially connected and bonded, and yet it was unavailable to them, which made the pandemic an even greater struggle.

Lack of physical touch in an intimate form especially contributed to loneliness for two participants in this study. I even had to check my own bias (as I was surprised to hear Sally was using dating apps) when Sally, a 67-year-old was telling me about her feelings of loneliness. She felt her dating dwindled because people were too afraid to meet up during the pandemic. She was unable to receive that emotional and social connection through intimacy for which she yearned to feel fulfilled, and it did make her feel lonely. Similarly, Myrtle recalled how her "guys were my leisure activities" during the pandemic. Having two partners with whom she was intimate made Myrtle feel supported, but when that intimacy was taken away during lockdowns, she felt lonely. The physical touch that arose through intimacy was a "love language," as Sally put it, for the two of them that was taken away which made the pandemic lonelier.

Hopeless

Here, our story branches off (see timeline above). Up until now, participants' narratives were generally alike. Though faced with the same plot, with exposure to the same global events (lockdown, restrictions etc.), differences emerged in the stories of introverted and extraverted participants. What follows is a narrative telling of the experiences of each group.

Not surprisingly, *extroverts* struggled more with public health restrictions that constrained their connections with others. Their source of energy, happiness, and fulfillment came from their social connections, so government mandates challenged extroverts who struggled with staying home and being away from others. As Sally put it, there was a period during which she felt "hopeless." The struggle of not being around people or seeing friends and family made extroverted participants feel lonely and socially isolated. Billie lost all her regular social routines. She recalled "I have lots of condo ladies. We meet every Friday night for a potluck or play cards. So that was off. We didn't even do that. Never went out to eat for a whole year." Similarly, Elsa "couldn't meet anybody. And even after, when I met them, I couldn't recognize them because they had worn masks all the time. So, I found that a little disconcerting." Elsa missed a lot during COVID, but

> The thing I miss most perhaps in COVID, as far as relationships go: you never could invite someone in for a cup of tea. Or a little chat, I really miss. And I missed it because I didn't know people. I couldn't get to know them, but it was that action that act of inviting someone in, having a nice chat and having a cup of tea, being able to host this.

Living alone and having maintained her social connections through hosting, it was hard for participants like Elsa to adjust.

To cope, Vivien made an adjustment to her everyday routine:

> I got to the point I thought, you know, I have to do something socially to keep my mind active. And, like I said, I am pretty social, and so I kind of made a little promise to myself

> that I would do something to make some kind of contact every day, and it might have just been a text to somebody. It might have just been going up in grocery or a telephone call.

While calling a friend temporarily alleviated feelings of isolation for some participants, for others, it was not enough. Sally believed her constant contact with her neighbour Eunice saved her mental health: “I could not do without. My life is social interaction.” Seeing Eunice even briefly, gave Sally an excuse to step out into the hallway because “she was just craving to talk to somebody.” She kept Eunice in her social “bubble” and went on walks with her because **“**I'm a very extroverted person, I needed it. I needed something to get out.” Not having her regular social routines of wine tasting, trivia night, and her book club made her realize more than ever that **“**I'm an extrovert. I get my energy from being around people.” Though the pandemic did teach her to “get better about being on my own,” it still made her question “do I want to be on my own all the time? No, I love being around people.” Myrtle, by contrast, differed from other extroverts.

Myrtle was perhaps more of an *ambivert*, someone who had both extrovert and introvert qualities, but leaned more toward being an extrovert:

> I am a bit of a social creature. I'm an introverted extrovert. I also need my, I call it Myrtle time to sort of recharge. So, I always thought I was an extrovert, but my former boss did the, I don't know, some kind of psychology test is that if you recharge alone, that means you're an introvert. So, I don't know what I am. All I know is I like people, but I also like to be away from people, too.

Myrtle was more comfortable with solitude than the other extraverted participants, but still felt the effects of not being able to see her friends and family. As a social person, she relied on her friendships to keep her life full and invigorated. She revealed she did not have “any problems figuring out how to reach out to people when I want to talk to them,” but the lack of physical contact and having her regular social routines disrupted was very challenging. For all the extroverts, lack of social interaction was quite difficult for them and a period of new adjustment.

Unbothered

While extraverts struggled, introverts remained unbothered. Introverted participants did not see the pandemic as a social crisis the way extraverts did. They saw it more as the threat of disease. Nevertheless, choosing to be alone differed from being required to do so, so introverts did face similar challenges as extroverts with adapting and adjusting their routines. However, once they settled into their physical distancing lifestyles and made the changes to their usual routines, they were quite comfortable. Introverts enjoyed the presence of their own company; they enjoyed their solitude. The difference between solitude and social isolation and loneliness, is that solitude is "the state of being or living alone; seclusion; solitariness (of persons)" (Simpson & Weiner, 1991, p. 977). Solitude is beneficial and can be a form of self-care. Whereas social isolation and loneliness are generally seen as negative emotional states which most people seek to avoid; they indicate deficiencies in the number or quality of one's social relationships (2003, p. 2).

Eunice was unable to volunteer or see her friends regularly at the height of the pandemic, but she felt grateful for her apartment overlooking the river: "I just have to look at my surroundings and I feel good." When Eunice spoke to the changes in her routines and her experience with physical distancing and staying home, she said responded, "I like being alone"; "I didn't feel lonely"; "I really value my solitude"; and "I love my own company." Having divorced from her husband five years prior and having lived alone ever since, Eunice became quite comfortable with solitude. As she viewed "being retired and not having anybody living with me" as "a bonus," she perceived stay-at-home restrictions as an opportunity for self-reflection. Eunice did not feel lonely. According to her advice, "instead of wallowing in self-pity, go inside. Find out why you don't like to be alone."

Moira also found her peace with solitude during the pandemic. She explained “I don't generally get lonely. I'm pretty introverted and I like being alone a lot.” Moira experienced bouts of loneliness here and there because, on “some level, I started to miss social interaction . . . I sort of wanted to engage again, but another part of me didn’t want to” because her desire and “internal inclination to curl up with a book” always took priority over social interaction. She laughed as she mentioned she had been this way her whole life, and the thought of seeing other people never really crossed her mind; she was never “praying, I hope I see a face of somebody soon.” Social interactions had “never been very important, and they haven't been really. I always just had a few people close to me . . . And then most people take a lot of energy to be around. And I am like an introvert and invaded by social interaction and recover by being alone.” She was aware she was socially disconnected from people: “Disconnected? Yes, but in a good way. I liked that so that was okay because I wanted not to be with other people.” She “just didn’t want to be with other people.” In general, Moira found peace during the pandemic because:

> I was in a space where I really just wanted to get into bed, pull the covers up, and not have any obligations or, you know, talk to people or do anything just, you know, just, uh, withdraw. So, in that sense, [the pandemic] was great because it gave me the perfect excuse to do all that and just, um, not feel guilty about it because I could just say, well it’s a pandemic. I couldn’t do anything anyway.

It was clear the introverted participants took their imposed alone time as solitude and chose to cherish and enjoy it.

Though solitude was valued by my introverted participants and alone time was appreciated, there was still no denying that introverts still saw the value in social connection. Unlike extroverts, however, they did not need as much social connection. Lana was a perfect example. Living in the building next to Eunice, overlooking the same calming river, Lana started living alone just before the pandemic, after her husband passed away. When asked about the

importance of social connections, Lana laughed and said “I think they should be more important than I make them. Yeah, because I like to be alone. I don't mind being alone.” She added “I think I need to be more open to having more people connections . . . I haven't been to church for years. And I don't miss it, but I think it's important for me to connect with other people.” Reflecting on how difficult a lot of people found the pandemic and how aware she was of the challenges people faced with feeling lonely, Lana was just not able to relate. She just did not find the pandemic “too bad. I'm sort of an introvert, anyway. So, I don't need a lot of stimulation. My mind stimulates me enough, right? So yeah, I didn't find it too bad.”

For some introverts, the pandemic was barely a transition or adjustment. Fiona, a retired public health nurse, did not notice a difference in her home life. She shrugged and noted that “I’ve just always liked to live alone, so the pandemic wasn’t really a burden for me. It was just like, oh okay, I can’t necessarily do as much as I usually do in terms of getting together with people and stuff like that, but I didn’t get depressed or anything like that.” Fiona approached the pandemic with logic and rationality, and she applied the same approach to her social life. She mentioned “Because I’ve been accustomed to being alone it was nothing new” and “I didn’t feel isolated because I am used to being alone.” Social connections were just not a priority for her. Now that she was retired, all she wanted to do was be in her own company as, socially, she “wasn’t craving company.” Fiona was not “noticing an absence of social contact” and she was more than content with that.

Interestingly, but not surprisingly, introverted participants in this study were less likely to view the pandemic as a social threat. Cordelia described the pandemic as “actually not too bad, mainly because we have the Internet and we can talk to people and stuff, right? Yep. Not too bad at all, actually. I didn't mind it.” She saw loneliness as “sort of part of being alone in a house”

and not much to do with social connections. For her, being lonely came with living alone. Cordelia enjoyed her solitude, adding “I really like being alone”; “I really didn’t feel so lonely at all”; and “nothing really bothered me.” Myrtle, like other introverted participants, agreed that “I've never felt lonely in my life. The times that I feel alone are the times pretty much that I choose to be alone.” She was fine with her own company, and she preferred it that way. In Elsa’s words, “I think living alone, I always said I'm good friends with myself,” which perfectly illustrates the pandemic stories I collected from introverted participants.

All the introverts took the lockdowns and physical distancing as a time of “reflection,” as Eunice put it. Time to reflect on life, all their experiences, and truly enjoy their solitude. They assumed a “this too shall pass” mentality. As older adults, they had already been through hardships. Their resilience got them through the pandemic. As Elsa put it, “when you have already weathered a big storm in your life, the pandemic doesn’t seem so bad.” Though the introverts were more hopeful than extraverts because they did not need in-person social connections to help them cope with pandemic restrictions, it is important to note that social connections were still important to them, albeit not as critically important as extraverts viewed them, at least not in-person connections. It was still hard for the introverts to not be able to see their loved ones in person, and they missed seeing their family and friends. Nevertheless, they were at ease with connecting through technology (FaceTime, texts, phone calls, etc.). Needing lower amounts of social stimulation, the introverts remained “unbothered,” as Fiona described it, during the lockdowns and physical distancing.

Life During the Height of the Pandemic

Here our story slowly starts to come back together again. Though extraverts and introverts responded to the social restrictions differently, public health constraints played a role in participants' routines, moods, and mindsets, regardless of introversion and extraversion. Some embraced the time alone to reflect inward, spent time in solitude, and enjoyed their own company. Others found the public health restrictions too challenging and coped with their situation by "letting go" of routines, eating differently, and spending their time in unproductive ways.

Frustration

The public health restrictions of physical distancing, stay-at-home mandates, and quarantine, proved to be a challenge for some participants. Extraverted participants like Misty "absolutely hated the shutdowns" and all the "uncertainty" that came with them. Vivien was frustrated by the constant "unknown" and mentioned how she

> was just getting used to this concept. And everything kept changing. Like you just get used to, okay, this is what we can do for what we can't do. And then, boom!, it changed. And things like maybe you could do, then you couldn't do anymore. So that was, that was difficult.

Frustrated with the ongoing lockdowns, stay-at-home orders, and shifting messages from public health, Myrtle felt her rights were being violated:

> There was no, there was literally no freedom. We were not free to do what we wanted. We weren't free to get in our car and drive to the grocery store. We weren't free to go into the office if we wanted to because of the municipal and provincial and federal lockdowns. And it was scary. I've never lived at a time like that. Even when there was AIDS, I could still go out and walk around. I just had to be careful who you got naked with, right?

Similarly, Mary felt the restrictions prevented her from doing the things she liked best: “I missed going to restaurants. I missed, like, grocery shopping, and it was such a pain.” Constance expressed a similar sentiment: “a lot of that stuff that I would have done that I, you know, would have made me feel good, it was taken away.” To be sure, frustrations with the seemingly never-ending nature of the restrictions began to take their toll on participants.

On top of other challenges, including losing a job or being away from family, being home alone tested participants’ mettle. Most of the participants lived alone but doing so with nowhere to go made the pandemic particularly difficult to negotiate. For Mary, being by herself at home “was awful, as long as we had restrictions.” She spoke to her experience of coming home after visiting her daughter in the United States after her husband died:

> It was ridiculous. I stayed there for two weeks, came home, and then I had to go in quarantine for two weeks. And it was strict then. It was so strict. The government didn't care that I didn't have a balcony. I literally, I came home after two weeks there, and I sat in this apartment for two weeks, and I never left. I'm sure other people did. Like I'm sure other people would say, screw that. I'm going out, I don't care. I was so worried I was going to get caught. We were afraid, right? What the government would do if I went out? So, I did that twice. I went down to see her twice and both times, I had to quarantine for two weeks.

Mary was actually “more afraid of getting caught, getting fined, getting in trouble than I actually was of getting COVID,” and her fear of getting in trouble led her to stay at home more than other people, which resulted in her feeling extreme loneliness and social isolation. Zoe felt that living alone was a challenge in the first place, and then introducing “a pandemic and government mandates” added another layer to that challenge.

Social Consequences of Public Health Restrictions

For most participants, the world felt like it was in constant flux. As soon as participants would settle into a new routine, they were suddenly forced to change again to adapt to a new mandate or restriction. Each time, participants found different ways, through leisure and non-leisure, to spend their time alone. Leisure refers to an "uncoerced activity engaged in during free time, which people want to do, in either a satisfying or a fulfilling way (or both)" (Stebbins, 2009, p. 1). It is typically freely chosen and intrinsically motivated, thereby distinguishing it from "work" (Edginton et al., 1995). Non-leisure activities are not typically what people want to do (i.e., housework, work, chores, studying etc.) (Lin et al., 2011), and they can be boring and usually unstructured (Moore & Ohtsuka, 2000). Though these definitions fit the participants' narratives, it is important to keep in mind that leisure and non-leisure activities are different for everyone. For Eunice, organizing and cleaning out her crystal cupboard was her "favourite leisure" activity, while Violet found cleaning out her cupboard was non-leisure. Violet engaged in domestic work (i.e., non-leisure) during her time alone. She "started cleaning up cupboards and drawers, and all those things done that you never did before. And, you know, but as time went on, when things didn't get better, they got worse, but then [coping with the pandemic] started to get harder."

Others, such as Lana, sought out unproductive leisure, including watching too much TV. For Mary, instead of having her regular meet ups with her friends at the local pub, she was required to stay inside. She felt she was "going to lose my mind doing nothing. I mean, you can only watch so much Netflix even though I love watching TV." Mary's reaction was natural, albeit unrewarding.

Here it was evident that eudaimonic leisure (personal enrichment), and hedonic leisure (nothing more than fun or pleasure) (Fine & Corte, 2017) came into play. It was common for participants to discuss watching TV to cope with their situations (hedonic leisure), some participants almost always desired to do something else, something more social. At the height of restrictions, participants did what was easiest, but eventually sought out more meaningful experiences (i.e., eudaimonic leisure) as time went on.

Letting Everything Go

Once the initial fear of the pandemic settled and the unknown became more known (e.g., talk of a vaccine began, routines had been adjusted, epidemiologists learned more about coronavirus), participants settled into a "new normal." A new normal meant trying to create daily living routines in a pandemic world. Those older adults who lived alone were forced to adjust to pandemic living and developed new routines. For most participants, however, public health restrictions meant to mitigate the spread of infection brought different problems.

A decline in the wellbeing of some participants resulted from the interruption of regular routines. As public health restrictions were implemented (physical distancing, stay-at-home mandates, essential work only etc.), life "changed drastically in so many ways because routines definitely changed" (Sally). When asked about her routines, Myrtle chuckled and paused briefly before answering: "the routine was gone. There was no getting up and getting dressed and having a shower, breakfast, getting in the car, I'm going to work. So those routines were gone. So, it was learning new routines. And I have to say, I struggled with that." The familiar was gone. Participants struggled at the beginning because of the new routines they had to establish. Mary felt the pandemic also changed her life and interrupted her daily activities. She recalled "lining

up to get into grocery stores with my mask on talking and standing six feet away from people. So that, I hated."

For Moira, being home alone during the pandemic "took all my responsibilities and obligations away." Though she enjoyed her "alone time" as she was "quite the introvert" because she was home alone for so long, Moira felt she would not be held accountable for the appearance of her house, which intensified her hoarding problem. She recalled that "my hoarding problem became quite a bit worse and it's still a problem. I'm still having to deal with that problem. And it's even bigger now. So, yeah, everything kind of fell apart, really. I just didn't care." Her anxiety got worse because she no longer had a reason to leave the house (i.e., she no longer had her business because it shut down due to COVID and her husband had passed away) and being alone without anyone to talk to made matters worse. She felt staying at home by herself during the pandemic "exacerbated both my sanitizing OCD and my hoarding thing and that I felt like I really had to prepare, and I prepared too much."

Billie spoke to her change in routines, including differences in eating and sleeping. She mentioned that during the first lockdown,

> you don't sleep well and you're not eating well. You don't feel like cooking yourself anything. So, you don't. I found that at the first part where I just didn't feel like eating, so I didn't. I forced myself at some point to eat some toast. That's what I lived on for a while, just toast and peanut butter.

For some, a new normal was difficult to adapt to, after so many years of doing things a certain way. This difficulty in adapting reflected in the physical, mental, and overall wellbeing of some participants, especially during lockdowns.

Unmotivated and Unhealthy Vices

As routines shattered, poor habits started to form for some of the participants, which caused a decline in their health and wellbeing. As Moira put it, "I think I deteriorated quite a lot. I certainly deteriorated physically. I found it very difficult to get up to do things. Physically, I wasn't up to it, and I think mentally, emotionally, psychologically I kind of deteriorated." Similarly, Eunice mentioned a setback in her health. She recalled how she "just got fatter and drank more alcohol, smoked more cigarettes, smoked more pot." And for Jude, the stress of the pandemic and interruption to her daily routines caused her to seek unhealthy vices. Jude noted that she:

> Started drinking red wine. So now you can see the acceleration, so you've got the anxiety, you got the depression, you've got the loss of isolation, loss of identity, loss of friendships, loss of everything that I knew, and so I can addict. You reach to the bottom, and you take the codeine to kill the pain, and sort of finding out what's causing the pain. And alleviating the symptoms, which is what I was doing. So then, okay, well, that doesn't work. Well, know what am I going to do today? Oh, I don't know. What will I do? There's nowhere to go. What should I do? I think I'll go to the liquor store and buy a bottle of wine. So, I did.

Jude found it difficult to adjust to the pandemic. Like others, she felt her overall health and wellness deteriorated with the inability to manage. There was even a point where Jude thought "to hell with the world" as the weight of the loneliness and sadness became intolerable. Delphine felt the same with her drinking. She mentioned that she drank more than she would have liked to cope with the end of her usual routines. She sounded defeated as she mentioned that "it was really hard. I drank a lot and I put on a lot of weight." She spoke of how unhappy she became with her body. Her physical health took a turn for the worse because of her alcohol consumption.

Body Image Issues

Like Moira, Eunice, Jude, and Delphine, Constance spoke to the body image issues she faced as she "tended to gain more, so I gained about 20 pounds over the COVID." Her physical health was deteriorating:

> I wasn't exercising. I wasn't going out. I wasn't walking. I wasn't going to the gym. You couldn't go to the gym. I gave up my gym membership because that was one of the things I had. So, I did. I tended to gain more weight and I wasn't eating the normal healthy foods that I normally ate, and I watch too much TV and then I would end up staying up late because I needed some downtime, you know, and it was just a vicious cycle . . . For me, it was more important to actually see people visually. Oh yeah, that's the other thing that went by the wayside was my weight watchers' program. So that's another reason why I gained weight because I was going to weight watchers every week before the pandemic. And then all of a sudden, poof, I couldn't go anymore. And then they did this online thing. I just didn't work. Online weight watchers did not work for me. No, no. A lot of people did, but not me.

She noted that the discomfort she felt with her weight gain contributed to her feelings of loneliness and being socially isolated. She mentioned that "I felt afraid to leave the house. There was a fear of not wanting to go because I gained so much weight, And I didn't want people to see how big I was," which caused her to feel self-conscious, resulting in isolating herself from others. Constance, like the other three participants, struggled with her health and its decline during the pandemic, which set in motion a decline in mental and emotional health, as well.

Depression and Vices

The monotony of her new routines and the movement of life online did not sit well with Constance. She had a difficult time adjusting. She spoke to the new uniformity brought on by the pandemic and revealed:

> I was depressed in the sort of neurotic normal way. Most of us became that way. Depressed, right? I didn't feel like I couldn't live, or I mean, I never felt that. Yeah, routines and then just the monotony of get up, I go to the computer and go to work. You know, have my lunch, and go back to the computer and shut the computer down. I make

> supper and I watch TV and the same thing starts all over again, right? It's just the monotony of it all. And not being able to you know connect with people

Constance experienced depression because she lived alone during the pandemic: “it was very lonely and very depressing . . . I didn't realize I was depressed or down, but I just felt alone, and I never felt that way before.” Constance was “depressed and that was a way of . . . feeding my anxiety or feeding my depression.” For her, like other participants, it seemed as though depression came first and then vices (i.e., drinking, smoking, eating junk food) came after as a way to cope. Constance’s experience reveals how isolation can lead to loneliness. With difficulty adapting to new routines and struggling with overall health, some participants experienced a demanding transition in establishing new routines and trying to maintain an overall sense of wellbeing.

Using vices to cope was a common theme. When asked how living alone affected her during the beginning stages of the pandemic, Jude was

> asked to go on an antidepressant. Because I knew I couldn't cope. But the isolation, the cut off from everything that I loved. Everything that I knew, everything that made my heart sing: nature, being outside, friendships, camaraderie, intelligent conversations, all of that. The death of my cats, so I asked to go on an antidepressant to cope with it. I do not like antidepressants and I, it was a big thing for me to ask to do. But I knew I was thinking fast. I thought, is this all there is? Why am I, why do I have to stay in? I was afraid to go out of my front door?

Similarly, in Constance’s case, her isolation led to loneliness. Not getting together with friends and family meant feeling alone. Comparably, Misty felt the same with her experience of depression during the height of the pandemic. When asked about living alone during the pandemic, she said she felt

> Quite lonely. I felt cut off. You know, you see your family on video rather than being able to visit them. And I would say I've never been clinically diagnosed as depressed. But I would

> say I was depressed during COVID. Like I could cry at the drop of a hat. By myself, right? It was COVID and by myself.

She added, “I would sit here, and I just start crying at nighttime. Wow. I don't know what that's all about. And I just thought it must be COVID because you're feeling cut off from the world.” It seemed for some participants the feelings of depression induced by the pandemic arose first, then vices were used to cope and get through the feelings.

Disruption in Work and Relationships

For some participants, loss of work and employment was a major problem that arose during the pandemic. Moira a café owner, referred to the pandemic as the most “difficult time” of her life because people were no longer allowed to dine together inside. As a result, Moira had to close her business. She had to let go of all her staff when she shut her business down. Not only was she out of work and without a source of income, but she also accrued a great deal of debt and experienced tensions with her landlord. As well, Sally lost her “job during the pandemic,” which led her to reconsider what to do with her career at the age of 67. Sally went from

> Working full-time and making a damn good salary to not working at all and homeschooling and doing all that…I was going from working full-time and going to events and, you know, working on however many hours a week to get the job done to being a stay-at-home grandma.

Not only was her routine of going to work every morning and spending eight hours a day in the office taken away once the pandemic hit, but her identity as an employee shifted suddenly to stay-at-home grandma. Not surprisingly, these changes made for a difficult transition for her.

Loneliness

Though everyone in the Kitchener-Waterloo area was forced to abide by the same government mandates (physical distancing, quarantine, etc.), living alone and not being able to go where they pleased during the pandemic exacerbated the social isolation and loneliness epidemic for some participants. Lack of communication, invisibility of other people, and feeling "stuck inside" (Billie) were problems identified by participants. Delphine and Madison recounted with sadness how they both "missed Christmas" and "spent it alone." Physically being alone, not being around loved ones for holidays, and not seeing anyone for days at a time, exacerbated feelings of loneliness for some participants.

All extraverted participants expressed feelings of loneliness during the beginning and middle stages of the pandemic (in our timeline, up until the New Normal stage). They described the experience as "really tough" (Myrtle), "pretty hard" (Madison), "pretty lonely" (Billie), terrible . . . I did feel very lonely and isolated" (Mary); and "very isolating" (Delphine). As a result, when restrictions were lifted, Madison noted that:

> I think if you're living with people it's a lot easier to, you know, I don't want to say do the right thing because I didn't really do the wrong thing. I did everything I was supposed to do as per—I mean restaurants were open, so obviously you were allowed to go, you know. Places were open. Shops were open. You were allowed to go. But I think, like, I did it a lot quicker and more often than other people did just because I needed to.

Being forced to stay home alone was different than choosing to do so. The sense of freedom, autonomy, and control had been taken away during the pandemic. The simple thought of knowing they could not go see a friend, go to the mall, or go sit in a restaurant, became a daunting thought that made participants feel as though they were on "house arrest," as Zoe put it. Social isolation and loneliness even got to the point of anger for Zoe. At 80 years of age, Zoe did

not take well to the government mandates. She said the restrictions and staying home were hard on her mental health. Citing the importance of social connection in her life, Zoe felt the restrictions were not something she should have had to go through at her age. When asked about her experience living alone in the pandemic, she described being “shut up, shut down, and crushed, and segregated and alone.” Billie also noted that “it was hard starting to live by myself, and then you get, you get used to being able to see people, and then when that's gone, it's sort of puts a damper on things.” The change in routine and spending time alone, exacerbated loneliness and feelings of sadness.

Spending time alone and not seeing it as solitude hurt the extraverted participants. As Constance put it, “the lack of not being able to see people physically made me feel more lonely” and brought this impending sense of dread, thereby making her feel like “this is not going to end.” Similarly, Violet voiced her frustration about not being able to invite people into her home. She would “start feeling sad for myself.” She became more aware than ever that she lived alone. She had no one with whom to confide in or be present. Jude, similarly, “felt really lonely because I got nobody to share it with because usually my girlfriends and, you know, we would all come together at each other's places to, you know, shall we do afternoon tea or what looks or what will you so you couldn't do any of that.” Not seeing friends or family, and having the option taken away made it more challenging for participants.

Delphine also found herself impacted by a medical scenario that coincided with the pandemic. Her daughter was pregnant, which meant “I isolated myself all the time. I wouldn't go near them” to protect her daughter from unnecessary exposure. Not surprisingly, Delphine felt isolated and stressed for her daughter who was also isolated: “it was challenging because we couldn't see each other.” To keep her daughter safe and physically distanced from others,

Delphine would go to her cottage and “sit and cry” as she thought about how she could not be near her daughter and experience her daughter’s pregnancy together. She found herself thinking: “I couldn't go near my family. I couldn't go near friends. And I'd be up there, and I'd be going, is this the way the rest of my life is going to be?” She could not fathom the thought of not being there for her daughter or holding her newborn grandchild.

Feelings of loneliness even affected one introverted participant, Moira. Though the effect was not as severe as it was for the extraverted participants, it was more a realization and reflection period for her. As Moira put it, living alone during the pandemic made her realize that she also was susceptible to loneliness, as one day

> this wave of loneliness just came over me. And I had trouble even identifying what it was. I don't like it. What is that happening now? And I suddenly realized, oh, that's loneliness…it was it was strange feeling and I realized that I don't get lonely a lot.

Moira’s realization of loneliness shows how the pandemic exacerbated loneliness, even for those who had never felt it before. For the extraverts, it was a time of turmoil and hardship, as living alone and physically being alone, led to feelings of loneliness.

Grief

Though all participants spoke to the changes in their lives they had to make to adapt to pandemic living, a few participants were not primarily focused on the pandemic or the loneliness that it came with. Due to other major life events occurring at the same time, the pandemic was secondary for some. Life kept going regardless of the pandemic. Loss of a spouse, a cancer diagnosis, other illnesses, and childbirth, all still happened amidst the chaos of COVID-19.

Eunice regarded August 2020 as one of the worst months of her life when “during COVID, I was diagnosed with cancer, so, yeah, I had other things to worry about than COVID.”

She was alone in the hospital when they told her, and she could not have anyone by her side due to restrictions. Eunice recalled, “in the hospital, in the ER and I was talking with my sister, she was the first person I called—the only person I called, actually—and, um, I was crying, and she was crying, so I missed not having her there to hug.” Solemnly, she recounted:

> I went from a diagnosis at Cambridge Memorial Hospital August the 26th and I remember because it was the same day that my mom died so that date was significant and um within. I believe it was September, the end of September. I already had my surgery at Juravinski [hospital] booked I had my hysterectomy and then I was set up for lung testing after that, boom, boom, boom.

COVID took a backseat once the reality of her diagnosis set in. Not surprisingly, Eunice was even more socially isolated because she was now labelled *immunocompromised* and was unable to have her family and friends around her to help her cope and work through her grief.

Loss and the grieving that came with it distracted participants from the pandemic. Mary lost her husband during COVID after his choice to have a medically assisted death. She spoke about her husband with passion and pride, but also could not ignore the difficulty she faced. She recalled

> After my husband died in June. So, March, April, may, June, my husband was with me, but he was really sick. And I was going through medical problems with him. I also fell and broke my arm… I used to have to help him into the shower, to clean him up. And I had a cast on my arm.

To make matters worse, “we couldn’t have a funeral,” which made Mary’s grieving process much more difficult. She could not have her daughter or son next to her for comfort or support, nor could she turn to any in person therapy or support group. She felt she was alone in her grieving process and the support she needed was taken away from her because of the public health restrictions.

Moira, similarly, lost her husband just before the pandemic and had to work through her grief. She sobbed as she recounted that:

> Two months before the pandemic hit, my husband died and he had been very sick. For two years before that, I was grieving, but I was also very, very, very tired. Just exhausted. Really from everything. And then the pandemic hit. That's why I was in the state that I was.

For her, the loss of her husband and the healing she required only made living through the pandemic worse, as her grief exacerbated her OCD and hoarding tendencies. She felt she could not give up anything that belonged to her husband, nor was she able to hire or bring anyone into her home to help clean because of the restrictions.

Lana experienced both loss and grief at the same time. Through tears, she recalled:

> It started with my son in 2017. And he was 29. And that was a big one. And then we barely got over him passing when suddenly, and then my mother-in-law died . . . And then my dad died in 2018. And then my husband died in 2019 and then my mother died in 2020.

Lana recalled the first lockdown as one of the most challenging times of her life because she was grieving: "I was all of a sudden alone. No mom, no dad, no son, no husband, and daughter moved away because she couldn't deal with stuff." She spoke to the challenge of living alone and not being able to see anyone, and how triggered she felt when her mother was diagnosed with cancer. She was grieving the loss of her husband and son, which was then exacerbated by her mom's diagnosis of cancer:

> I had to take my mother for her first chemo treatment, and I had to drop her out the door and say, oh yeah, you couldn't go in. Couldn't go in! For her first chemo! And the line-up, because it was all distancing. She had to line up in the middle of winter, cold outside of KW hospital. There at the cancer center. Saint Mary's. No at Grand River. At the cancer. And she had to line up. I dropped her off. Outside the door there. And there she got out, 80 years old.

Harboring the guilt of watching her mom go through chemo alone while grieving her husband and son, things were made worse when her mother passed away during the first lockdown. Not only was she grieving the loss of multiple family members, but she also was unable to turn to her daughter for support due to physical distancing guidelines. For multiple participants, the reality was that the pandemic exacerbated their grief-stricken situations. Life kept going and heartbreak, loss and grieving all still happened, just on a more complex and isolating level. Through grief and sorrow these women shed light on the reality of the other major life events that occurred at the same time as COVID.

To Vax or Not to Vax

In addition to the extent of extroversion, *vaccination status* of participants played a role in their pandemic experience. First, participants who chose to be vaccinated against COVID were less lonely and more socially engaged. Once "we got vaccinated," said Billie, "then we would talk." Participants like Billie were more comfortable with physical social interaction once they were vaccinated. Moira felt less lonely and socially isolated once she received her vaccine. She told me, once "the vaccines started coming, I felt better and more comfortable." She could resume her relationships and gatherings with friends and family.

The vaccinated participants found peace in the protection the vaccines brought them and saw getting vaccinated as "the part they had to play," as Constance put it, to keep themselves and society safe. Cordelia received all her COVID vaccines and kept all of them "up to date." As a result, she felt "healthier." Misty said with pride, "I'm vaccinated. I'm fully vaccinated. And I'm waiting to have my last booster … I think that's all we can do, right?" Misty was a firm believer that "vaccinations and the masks, and washing our hands was our safety net" to stay protected and secure. Moira "trusted the science and scientists" and felt "good to be around people again"

once she received her vaccines, and knew they were vaccinated. Similarly, Constance "believed in vaccinations. And I got my vaccinations, and I followed all the protocol." Fiona was "in support of the strategies" and was "thankful the vaccine was fast tracked to development, which was great! That was a freaking miracle to see people again!" Like the other participants, she felt the vaccines kept her safe and healthy, and allowed her to resume in person social connections.

It was hard for the vaccinated participants to appreciate those who chose not to get vaccinated. As Elsa told me, with a tone of disapproval, "I really don't understand people who wouldn't get vaccinated. Just even for the protection of other people." Similarly, Delphine recounted how "it was very threatening to know that many people don't believe in immunizations. Many people don't believe in isolating and many people believe that God will protect them." Myrtle even made the decision after the vaccines were released to no longer stay in contact with some of her family who remained unvaccinated. She noted, "I don't see them in person as much. A lot of a good half of my family, I wouldn't say anti-vaxxers, but they're commitment to being careful is not really there. So, I don't hang out with them in person as much." The judgement was prevalent amongst the vaccinated participants, and this judgement was felt by all unvaccinated participants.

By contrast, *unvaccinated* participants said they were socially isolated, lonely, and judged by others during the time the first vaccine rolled out in December of 2020 up until the vaccine passports were no longer mandatory. Zoe had the strongest reaction out of all participants when asked about her social interactions during the pandemic. She responded through a heavy sob, "what can you do when you're not vaccinated? They don't want you anywhere." At 80 years old, Zoe lost most of her friends, lost touch with her family, and had only a few social connections left. She wanted her "non-vaccinated" side of the story to be told because she "just thought many

of the people that you may talk to might have gotten the vaccination and been able to continue with their friends and do their activities, and I thought you should know the other side as well." She recounted how all her social relationships "diminished and they grew sour. I was a devil to mention my beliefs." She lost her "bridge pals I've known for years"; she had been "made fun of, laughed at, verbally assaulted"; and at "80 years of age, I'm looking for friends," all because of her decision to remain unvaccinated. Zoe felt judged by both family and friends. She wept as she disclosed how she and her daughter

> had a big disagreement and with her sister today. I suppose it will blow over, but they are also like dogs tearing at my heels to, uh, shame me into believing what they believe. She can believe what she likes, but respect me enough and allow me to make my own decision.

Zoe felt no respect or support for her decision from anyone in her life.

Madison, like Zoe, was weary of the vaccine. She mentioned how people interrogated her about why she was questioning the government and science. She recalled that after the first vaccine was released, she was listening to

> Theresa Tam [the medical officer of health] begging everyone to do that, but I'm just sort of you know, vaccine weary. And I've always been very careful about what I put in my body, so I haven't had, you know, antibiotics in years. I try to take really good care of myself, and so all these vaccines I find very terrifying. As well, I just, you know, what's the long-term effects of the vaccines, too? We just don't know that yet, do we?

Madison felt judged when she expressed her concerns. The people around her questioned her and asked why she would even try to question the vaccine when it was all about "doing [her] part," as most people in her life said. Comparably, Jude had a socially isolating and lonely life starting in December of 2020 up until vaccine passports were no longer mandated, when she made the decision not to be vaccinated. She mentioned,

> I haven't had the vaccine. No, it's my choice. It's my body. I don't want it. I don't get the annual flu shot. I don't believe in them. I have a very strong immune system. I have been vaccinated for many, many diseases. I've traveled all around the world. I've been to jungles. I've had malaria. I've had all sorts of yellow fever vaccines, everything.

Jude felt judged and discouraged by everyone in her life. She felt

> Put down and everyone around me, my own family doctor, my trusted, all saying, Jude get it, get the vaccine. It's safe and effective. I said, but I don't want it. I said, I don't want it in my body. I don't want it. I have a brain. I don't want it.

More than feeling judged, Jude felt lonely. She was unable to see anyone. A lot of her friends and family did not want to talk to her because of her vaccination and masking beliefs, and she was excluded from a majority of her usual social interactions. Jude felt that both the vaccine and mask mandates were unnecessary, but her views kept her socially isolated. She mentioned how

> I went to a horticultural meeting just last week. Very excited to find out about pollinators of the bees and how to encourage them. But I wasn't allowed in at the local library because I wouldn't wear a mask. And so, I walked away from that. I was so incensed. I couldn't even argue with her. Why can't I come in and learn from a PhD doctorate person talking about pollinators and bees? And I'm wanting to better my garden and better the world. Why can't I come in because I won't wear a mask? And she wouldn't let me in. So, the stupidity that still is going on like that around."

Jude, like Zoe, was extremely socially isolated and lonely. Because she refused to get the vaccine, "I couldn't go anywhere. I couldn't do anything. I couldn't go to Toronto. I couldn't get on a bus, couldn't go in a café or anything unless you'd been forced to be jabbed," which made her life very challenging. The experiences unvaccinated participants went through due to their vaccine status contributed to their feelings of loneliness and social isolation.

COVID was a Hoax?

The decision to remain unvaccinated against COVID paralleled an underlying belief among participants who chose not to be vaccinated that an element of deception or "fake news" existed about the pandemic. For Zoe, the entire pandemic was a government conspiracy to control and dominate the public. Not only was she against the vaccine, but she was also firm in

her beliefs that Big Pharma and world leaders were trying to control the population. From her perspective,

> I think those people, you know Bill Gates and all those guys that want to de populate the world, well, they should show a good example by killing themselves. They want 50% of the world's population, uh, gone as quick as they can.

Jude also suspected the pandemic was an effort to exert government control:

> I think you should all be wearing your mask again. And not only should you have two injections of this poison, but you should also have booster one, two, and three before you can ever go. So, what they have done is condition people to do as you're told. And this is all about governmental control and the ultimate thing of what the World Economic Forum is all about, which is control and identity and digital currency.

Jude could "smell the rats, and I could work it out, but nobody else could see it. So, I knew I was on to something, and yet I was coerced." In her view,

> The mRNA was never tested for transmissibility. So, they rolled it out worldwide, and we were all hoodwinked into it. I know we're living with the fear of, you know, am I going to die all of a sudden death? Am I going to get an autoimmune disease? Am I going to get Bell's palsy? What's going to happen to be? And the whole global depopulation is what we're all in about right now.

Because of her beliefs, Jude was cut off from a lot of her family and friends:

> I have family members saying, well, it must be true, Jude. You're being a conspiracy theorist. This can't be right. You have to trust the CDC and the world health. So, I was an outcast because I hung on and hung on, not wanting to get the vaccine because I knew I smelled a rat. So, what did it do to me? It cut my life off completely. Thank goodness I had a brain and I had the ability to do my research and seek out other sources of truth other than the mainstream narrative, which is all governed by the media, and all governed by big pharma and politics. World Health [Organization]. World Economic Forum. Everything is all intertwined. This is now not a conspiracy theory. We know what's happening to us as a people of the world.

She felt dismissed, ridiculed, and labelled a conspiracy theorist. Having been a nurse for over 30 years, she felt no one cared about her:

> Everything that I tried to say, oh, well, don't you think that we should be doing this and what vitamin D and nobody talking about diet or vegetarian or it's not been thinking, no, no, no, no, no. Nobody wants to talk about it. I couldn't find any information anywhere. And the world had gone mad. It was as if my profession had just been hijacked because I know if I had been with nursing at that time in public health, I would have been saying

> no, look, you must strengthen your immune system because it's a virus going around, and you must do this, this fish and this and this, you must exercise, you must breathe deeply meditation, yoga, do all the things, blah, blah, blah, blah, strengthen your immune. Don't sit in at home. It's the worst thing you can do. And yet, the mainstream narrative was don't do anything. You stay at home. You don't do anything. You stay in, stay away from everybody. Stay away from grandma because you might infect her and kill her. And so, I started doing my research. And my research led me to the great Barrington declaration. Out of the UK and I'm sure you've heard of that, which said, you know, we should be really shutting down our ordinary everyday people with livelihoods and cafés and restaurants to run. Why are we doing this? And let's just protect the elderly. Anyway, the great Barrington declaration got shut down and nobody listened to it. And as much as I don't like Donald Trump, he has blundering blustery ways when it first came out all the pandemic scanned in it. He said, well, what about Ivermectin? What about hydroxychloroquine? And the Ministry of Health over there in the U.S., she was aghast, and he never mentioned those words again. So, I began to see a big pattern. And I began to see that they were all wanting us to just have the vaccine and shut up. Don't do anything. Be quiet. Don't do anything. Don't worry about the vitamin D, it doesn't do anything. Nobody wanted to do anything natural but didn't have any money in it. And of course, you know, they won. So, everybody, the whole world was put on vaccines to make the money for the big pharma.

Jude was adamant she was "not a conspiracy theorist or a tin hat." She simply felt her

> anger is many folds at the deception and how I have been tricked and forced and coerced to give up three years of my life. I'm not 40 anymore and not 50. I'm in my 70s, and these three years are just gone by, I've done absolutely nothing.

Jude spoke about the difficulty she experienced during the pandemic, especially being labelled a conspiracy theorist: "it has been horrible. I'm very angry." She felt the truth came out after three years, "three years of my life that I don't have, and then we'll never get back. The anger I feel is off the wall. The anger I feel against big pharma." Jude also felt that, as a Canadian, she was suffering because of "all the other bad people. Those Chinese eating all those bats. That's what this sort of caused all this," which led to the deception that is the COVID-19 pandemic.

Reflecting a somewhat different experience, Lana was a big believer in naturopathy and had always been sceptical of traditional Western medicine. When asked about the pandemic, she

mentioned she “got frustrated. I wasn't a believer in the whole pandemic thing. So, I found that frustrating.” Aside from the COVID vaccine, Lana was against all vaccines before the pandemic: “I didn't have my daughter vaccinated or anything. So, I am kind of anti-vax . . . I was told by homeopaths, naturopaths, that all my allergies were probably due to vaccines. So, I did kind of get that mentality over the years.” Once Lana made her decision to express to those around her that she did not believe in COVID or the vaccine, she became socially isolated right away as most of her friends and family “did not see me during the pandemic” because she was “not vaccinated.”

Lana expressed how she had “people that gave me a hard time and were you know hard on me that way. But I stood my ground on how I felt because of all my allergies. And I didn't push it, but it wasn't right.” She felt tormented when she expressed her beliefs and articulated how a lot of people guilted her into making her feel like she was not doing her part. She mentioned how her neighbour offered to drive her to the vaccination clinic and hold her hand to get her vaccine. She felt her neighbour was blaming her for not “doing my part, you know. All that, right? I'm not helping flatten the curve, right? Well, we all see now, it's absolutely bullshit.” Her neighbour and numerous other people in her life chose to “exile” her from social gatherings, group hangouts, and even one-on-one get-togethers, leaving her feeling banished and arbitrated.

For Zoe, Jude, and Lana, their experience during the pandemic had another layer of hardship to it. On top of already living alone, having disruptions in their routines, and being lonely, they felt they had to engage in battles with those around them every day because they were labelled conspiracy theorists. The exhaustion and defeat were apparent in all three of their voices when asked about their experience during the pandemic.

I Hate Facebook

On the opposing side, the vaccinated participants had difficulty engaging with people who believed COVID was a hoax because they did not share the same belief. For Sally,

> the biggest challenge I think overall was the difference in friends and people that thought COVID was a hoax so COVID was overreacting like that. The biggest thing and the political landscape with especially in the states and you know everything that was going on. I think that was some of my friends lost friends because of it and some of our friendships changed because of it because they perceive things differently in the whole Trump thing.

Sally mentioned she "had some discussions with friends of mine where we just stopped talking about politics because they were very much on the different page." Those friends "would talk about, you know, Fox News all the time. And just so right-wing, you know. Stuff with Trump." Sally spoke to the changes in some of her relationships with friends who thought COVID was a hoax, and how she mourned their friendship. Sally's conviction was that social media played a big role in making her friends "conspiracy theorists." "That's what I really hate about Facebook," she said. "Just so much misinformation." She felt her friends who did not believe in the vaccine, or the pandemic were simply "resistant to the whole political climate of being told what to do and not being able to do my, you know, go for a walk or do all these restrictions." So, with difficulty, Sally made the decision to no longer engage with people in her life who believed in this misinformation.

Like Sally, Myrtle did her best to avoid the political conversations with her friends who did not believe in the vaccine or COVID:

> You know the anti-vaxxers as well, you get COVID, if you have a vaccine or not. I just don't want to get into the conversations with people. It's like, you know, pro-choice, and it's tough. It's just, I can't get into the discussions because people believe what they believe or their fears that dictate what they're believing.

Myrtle felt frustrated with the entire nature of the pandemic and the

> Fear of not knowing what was going on because all the fake news, both that were coming out of the states and some places around the world. You just didn't know what to believe. You were just bombarded with people guessing about what was going on because that's all it was. Nobody really knew.

As far as interactions went, Constance had to interact with people who were against the vaccine and COVID daily. As a public health nurse for over 30 years, Constance struggled to stay neutral when she interacted with patients who not only refused the vaccine but did not believe that COVID was real. Constance saw

> a lot of it in my work where people died. And I couldn't convince the extremists that were non-believers of how bad this could be. How bad it can be. Because they were young and healthy. And I had one guy. When I was immunizing him, he was like, you know what? It's only old people and fat people that get this. And that's what he said to me.

Constance struggled to navigate these conversations with anti-vaxxers. The common theme for the vaccinated participants was to no longer engage with people who did not believe in COVID, and to cut them out of their lives.

I'm Looking for Friends

For some participants, the pandemic resulted in weaker social connections and exacerbated feelings of loneliness and social isolation. Whether it was due to participants' vaccination status, fear of getting COVID, the lockdowns, or being home alone, some participants struggled and had a big decline in their social connections. In Violet's words, "we didn't visit, and we didn't socialize."

When asked how her social interactions changed, Zoe began to sob. She said her social connections "diminished and they grew sour. I was a devil to mention my beliefs." As someone who did not believe in the vaccine or pandemic, Zoe reported she no longer had any friends or acquaintances, and she had "lost my bridge pals I've known for years" once they found out she

was not vaccinated. She recalled how her old friends “made fun of, laughed at, verbally assaulted” her. she told me “[she] can’t take it anymore.” “[I’ve] been strong all my life,” she said. “When you have been isolated from your friends, those close to you start to think that they’re right and you’re wrong, and it’s not true.” Experiencing isolation meant she felt as if she had “been punched in the head too many times.” And now “I look at myself at 80 years of age. I’m looking for friends.” The isolation left her feeling lonely and disheartened.

For Moira, it seemed as if every social relationship in her life from friends, family, acquaintances, and even familiar strangers, had soured and declined during the first two lockdowns. When asked about her social life, Moira said she had “lost contact with my friends.” When asked about her family, Moira responded:

> Well, I think they've lost a lot of respect for me. My family. And they can't understand this hoarding problem. They can't understand why I don't just have faith and open it. Things like that. So, I think they don't. I'm not sure they really respect me.

Moira spoke about how her family had distanced itself from her because of her hoarding problem, which got worse during the pandemic. Even Moira’s relationship with her landlord declined since the first lockdown: “my landlord at the café is really mad at me” because she struggled to make rent and keep the café clean.

Though most of her social connections declined, seemingly, the relationships with her neighbours soured the most. Moira’s hoarding problem spilled over to her front and back yard. She mentioned she tried

> To go and cut my grass every week. And so, they call the city, told the city I had rats in my house . . . If I didn't ever leave my house, maybe it came from them, but hey, I don't have rats because I have four cats. And so, I have no rodents in this house. Yeah. You know if you've got rodents, as you know, it's pretty hard to hide the signs. In the end, they accused me of attracting skunks and raccoons. For what reason? How would you attract them? Oh, I don't know. They just seem to think that, you know, my yard was such a disaster that all the wildlife in Cambridge were there.

Moira felt her neighbours treated her like the “neighbourhood Willard,” a reference to a 1971 movie about a boy who was obsessed with rats. Moira recalled that the turning point in her relationship with her neighbours was when they “called the police” on her for a “welfare check.” She suspected her neighbours “were trying to get the police to come in my arms and so, I'm glad I didn't answer the phone. And then they called the city.” Moira’s social connections with her neighbours now consist of tension and anger, a big transition from the previous friendly neighbourly connection they had before the pandemic started.

Like Moira, Lana had a major decline with her social connections. Lana was quite open with her decision not to be vaccinated and her disbelief with the pandemic, which caused quite a strain on her social relationships. She recalled that she did have “quite a few that did not respect me . . . and we still don't talk about it, especially my one friend.” As Lana “swings more right” politically, her social relationships with friends “got a little cold, got a little distant. Especially my one friend who I really enjoy.” Her close friend even sent her “a few not very nice texts . . . and emails” and chose “not come to my birthday party. And she would have. She was my neighbour for 35 years.” All because of Lana’s vaccination status. A few of Lana’s friends “did not see me during the pandemic” and cut her out because she “was not vaccinated,” which caused a great deal of tension in their relationships. Lana even got into a tiff with her next-door neighbour. As she recalled, “my neighbour gave me a bit of a hard time too . . . so, she's all about that, and she's got flu shots and all the boosters, and you know.” Lana remembered how she and her neighbour got into a disagreement where Lana had to tell her to “lay off once and said, ‘stop bugging me’” about getting the vaccine, which strained their relationship.

Misty also had a decline in her social interactions because of the pandemic. For Myrtle, since “you couldn’t go out and you couldn't socialize,” not being “able to see people or hug

people or touch people . . . it was that isolation, the physical isolation, I think, was hard on me." Myrtle's regular social interactions and routines were all gone after the pandemic hit. She recalled her "ladies' card group, a ladies' remotely group, right? We're all the same age. And that was all gone." Myrtle even spoke to the difficulty she had with both her romantic relationships. She recalled how hard dating was and "I have two men in my life. And I felt very disconnected from the physical part of those relationships." Being physically apart from both her partners was a challenge because

> not being around my guys was really hard because relationships work with, for me with seeing them and being with them and talking to them. And again, the nuance of when you're talking to somebody, how they're reacting or not reacting to what you're saying. So that was really hard. You know, that was a really tough eight or nine months until I finally just went, yeah, if I'm going to die, I'm not going to die. Without my guy. You know, I have to have some point to make a decision that I'm not going to, I'm not going to turn into a nun, so that I never get COVID.

Myrtle spoke about how even though society is more relaxed about COVID in present day, she still does not feel back to "normal." She mentioned that

> My family usually, you know, we play games and stuff. And in the two years of COVID, we never did that, and we don't seem to do it. And I just think it's perhaps, you know, like another chapter of our life, COVID hits, and things changed.

Although she felt stronger and ready to resume the social interactions she had prior to the pandemic, she admitted she was still "not comfortable" doing so. She mentioned that she

> Just started maybe, I don't know, a year ago or 8 months ago, just going out to the grocery stores again. You know what? And I've got all my vaccines. Every single booster that's available, and I'm like, I've got to get out and be around people and actually look people in the eye when I talk to them. So I have been going out, but it has affected going to bigger venues. Like, I didn't go to Oktoberfest this year, for the first time ever. I mean, they shut down Oktoberfest for two years. I'm a Concordia Club member, and live basically next door to it. So that was difficult, but I just didn't feel comfortable being in a venue with 3,000 people. I'm not there yet. And I hope I do get there again because I love the energy of a crowd. But I'm not there yet. And restaurants, I've been to maybe five since COVID, which is unusual for me.

When asked if Myrtle felt she would ever resume the social connections and engagements that she had prior to the pandemic, she responded by saying

> I would say that people have changed their priorities since COVID. So, whether their priorities are now just family, I'm not sure. I'm not sure, but I think some definitely, some social relationships have not died down, but certainly got to a lower level of importance.

Like Myrtle, Sally also struggled with her dating life and felt it declined during pandemic. She recalled that she "did date a guy through the pandemic that I saw face-to-face, but you know, it was challenging. But, you know, he wears a mask, I would wear a mask, and so I did date somebody for three or four months," but it was quite difficult. Sally disliked dating during the pandemic because she felt the connection just was not there. She mentioned how hard dating was even "online dating, you could kind of have connections with people by phone or, you know, video, I don't think I'm really in the video, but texting whatever, but you can never, you couldn't really meet anybody under those situations for quite a while." Sally felt her social connections in terms of dating decline and chose to put dating on pause for a few months before she could start seeing people in person again.

Constance had a comparable experience to Myrtle and Sally in terms of having her social connections decline. She spoke to her inability to connect with people and how after a while

> it started to get a little bit more isolating, and I couldn't really connect with people and then I couldn't go to the grocery store where you would see people couldn't go outside. So it really felt like it was an imposition. It was very isolating to be, you know, the only thing I think what I tended to do more is I watch TV. I've never watched TV my whole life that much. So, I couldn't connect with people. And, yeah, I just felt it lonely very lonely very depressing., I started to eat so some of the things that I did when I was on my own. And, you know, the days just seemed to go by longer. I was getting more and more down and depressed with the job that I was doing. And even though we had chats on teams and on Zoom calls, it wasn't the same.

Similar to Myrtle's ladies' club, Constance was no longer able to attend her book club. Through tears she recalled that

> My book club, I had a book club that we were doing, and I couldn't do that anymore. We couldn't get together. Some people that I would normally go for breakfast with on a regular basis couldn't do that anymore. So, I had to stay inside. And then having people over for dinner or for a luncheon or something like that, I couldn't do that anymore either. So, I really restricted my social activities with other people. And I felt that I could, yeah, and I'm a social person. I like to have people around. So, it really was difficult.

Constance also spoke about feeling like an outcast when

> several of my friends, we were getting together. And we were all going to, and this was like at one point when they had lifted the restrictions or something like that. And I came down with a cold. This is the cold. And they wouldn't let me go. They said, no, I couldn't go. And I was like, but I know it's not COVID because, you know, it's not. And so, I felt really like an outcast, you know, because of that. And I mean, I've been vaccinated by that point, and everything was fine. And I could go, but they just didn't want me. And I just felt really awful about it. I felt really, really bad. So, I did, and I mean, I understand that they didn't want to catch whatever I had, but it was over the top. And people tended to react like if people had a cold or sniffly eye or don't dare cough if you're out in public or sneeze because people are going to jump away from you, right?

Constance felt distanced from both her family and friends as she felt "that we didn't we didn't connect as much, we didn't emotionally connect." Lack of social interaction and connects made Constance feel lonelier than she had ever felt, and she felt a negative shift in her friendships because she was not able to see anyone.

Changes in communication also affected social connections negatively. For Jude, she felt her neighbours and friendly strangers she would see on her daily walks in her neighbourhood began to avoid her once the pandemic hit. She noticed that she "would look at them in the eyes and they wouldn't look at you. They would avert their eyes. So, the loss of communication skills of people not being friendly with one another was very profound, about first year and second year." Delphine felt the same as Jude. She felt the communication skills of people in her life negatively impacted her social connections because everyone was "disconnected . . . because none of us would get together." On a greater scale, Violet even lost touch her friends that she had made through volunteering because she was no longer communicating with them on a regular

basis. She recalled that she "had made a lot of friends and so . . . I lost touch with quite a few of them." Lack of communication, physical interactions, and fear of getting COVID all contributed to some of the participants having weaker social connections during the pandemic.

Connections Kept

Regardless of vaccination status or if the participants were an extrovert or introvert, each had ways to keep in touch with his or her friends and family. Similar strategies were used among participants to stay in touch with others around them. The most common strategies participants used to stay connected during the pandemic included the phone (texting, FaceTime, calls) and e-mails. During the pandemic "there was a lot more, um, phone calls and, um, and facetime" (Madison); "more emails, more texting, more phone calls" (Delphine); a lot more phone calls . . . different strategies just by using phone calls and FaceTime" (Sally); "text somebody send somebody an email" (Vivien); "I'm a huge texter . . . texting, phone calls . . . video calls" (Myrtle); "So, a strategy is face time . . . telephone calls and texting" (Jude); "I talked to friends on the phone and family of course" (Fiona). As Eunice put it, "my resilience strategy was facetiming my grandbabies."

Every participant agreed that technology kept them connected with others around them. For Billie, she recalled how she "kept in touch by email or by phone. Like, it's not like we didn't talk to each other. We did. We kept in contact, even though we didn't see each other," which helped alleviate some of her loneliness. For Madison and Mary, Zoom was one of their methods of technology that let them stay connected to multiple people at once. Madison recalled how she

> did a ton, a ton of zooming with people. With my book club, we zoomed. Or I would have Zoom visits with friends. We would have a glass of wine over Zoom, or I had a couple of friends we would play games on Zoom.

Mary had a similar memory. She remembered how

> one time having a Zoom with 15 people where we were playing the game. And she set this thing up. I didn't even know the people, but we were, I was on my iPad, and there's all these squares, you know, and we had fun. We had fun. We managed to get through it.

Other participants still saw people physically but stayed six feet apart. Violet recalled talking "to a neighbour across the fence" to keep some level of social interaction. To stay social engaged, Lana "walk[ed] along the river. And yeah, I'd see people and wave. And people with dogs are always friendly." Misty remembered staying connected with her boyfriend by staying together, yet apart. She creatively adapted to hanging out with her boyfriend:

> What my boyfriend and I would do, I'd drive to Lakeshore we'd park by the water that is a park that you could park there. And he'd sit in this car, I'd sit in mine, and have the window down and that's how we kind of got through it… We'd park and talk to each other through the window. You know, I have a coffee together, looking at the water and talking, but we didn't get out of the car and hug each other or anything like that.

Participants' memories of staying connected showed that, one way or another, they were able to find sometimes creative ways to keep in touch and stay socially connected.

I'm Closer to My Ex-Husband

Though some participants experienced a decline in their social connections, other participants found the pandemic made their social connections stronger. Madison felt the pandemic made the people in her life more aware that she lived alone, so she felt like she "talked more" with her family and friends. Mary felt the same way about her friends and family: "they were all worried about me. So I was, I was exhausted. I was out for lunch and dinner that summer all the time." Mary laughed as she mentioned how her friends and family were suddenly aware that she lived alone. During the first lockdown, they kept reaching out and asking to see her.

Billie also felt that her “family kept in contact with me with text, we FaceTimed . . . I don't think I was really too threatened with the COVID thing, to the effect like some people might, because my family kept in contact with me constantly.” Like Billie, Violet felt that during the height of the pandemic, her “family connections are still very, very strong for me” as she “ended up talking a little bit more on the phone” with her brothers and sisters.” Violet pointed out that she became closer to her friends and family because “everybody’s in, almost in the same boat as you. I think that helps” in terms of experiencing restrictions, physical distancing, and stay-at-home orders. Interestingly, Moira became “closer to my ex-husband, but in a healthy way, not the old relationship” as he was going through the same experience in terms of the pandemic.

Sally, a natural extrovert who went through a hard time of not seeing her friends and family, still felt that she became closer with them during the height of the pandemic. Sally felt her “life would not be the same without my friends” and her social connections were something she valued deeply. Sally spoke to the relationship with her son and how she “became closer with [him] oddly because obviously I was homeschooling and everything” and how much stronger their relationship became. In terms of friends, Sally found “out who was a true friend through the pandemic . . . I think you found out who was really there for you, who really showed up when you needed them.” Sally even felt that her acquaintances turned into friendly acquaintances, as her social ties strengthened. She felt everyone in her building was friendlier and talked more which “was almost like that was a positive thing because it would be people you'd see in, you know, you'd want to talk to people and think about what you're doing.” Sally mentioned she still talked to the people in her building more and even knew their names and built on the social connection she created with them at the start of the pandemic.

For Constance, the positive aspect of the pandemic was that she had “a good circle of friends outside of work and through work connections that I kept in touch with.” For her a theme of strengthening of social ties occurred as she felt her acquaintances transitioned into friends as

> Some people that were acquaintances became better friends, because you all of a sudden, oh, you haven't seen somebody for a long time, all of a sudden, you see them. And it's like, oh, we got to talk. There's so much, we have to catch up, right? And yeah, so that happened with people from my book club, which you know, all of a sudden, they became acquaintance because I haven't seen them for a while, but then all of a sudden, I always want to get together again.

For Constance, she always knew that as she “gets older, it's much more important to have those connections and see those people on a regular basis. It's harder sometimes to do that but you have to make the effort.” Having the pandemic strengthen her existing social connections validated the importance of those connections even more.

For other participants, it took the pandemic to realize “you don't know how much you missed something until it's gone,” as Myrtle put it in referencing her social connections. Like Myrtle, Sally appreciated how her social connections became “more important to me to recognize how much you have, what your friendships mean.” Sally also spoke to how the pandemic strengthened and made her friendships change for the better while simultaneously making her “realize who's important to that you've missed not being able to see.” Delphine mentioned how the pandemic

> Increased my awareness because when you don't have something and you want it so badly, you know, like you're going to make an effort to make sure that it stays that way. I mean, me and my friends, we make sure that we always get together now, right? Instead of in the past, it could have been a month, it could have been two months and we go, oh yeah, they're doing their thing. I'm doing my thing. Well, now let's do our things together.

In terms of appreciation and doing things together, Vivien felt her social connections were

> Another thing that I appreciate so much more because, like, I go to the Y, and I call that my Y family because you get to know everybody. You know what's going on,

> housewives with them, or who's going on a trip or that type of thing, and it's the same way as church now. And that the church, we'll go every Sunday, and I call them my church family. So yeah, those types of things, they mean a lot. Because that's part of my normal life, my normal routine. And just being with people, and you know, talking to them and finding out what's happening in their lives.

The topic of gaining perspective and realizing what's important in life was raised by participants. Fiona, like Myrtle, Sally, and Vivien, could not help but emphasize how the pandemic made her "realize the importance of maintaining those connections, you know, like friendships especially." She noted that she felt especially closer to her female friends as she believed "women especially value their female friends, that is such an important source of support you know it's your girlfriends that will get you through life." Sally also mirrored Fiona's sentiments in agreeing that "the loneliness was an issue, and I think having my neighbour, even my other girlfriends are like, thank God you guys have each other because you need some physical touch and stuff." Having friends, especially female friends were relationships that most participants appreciated more during the pandemic. Eunice mentioned how she "values my close friendships, those are what I nurture," and those relationships were what strengthened for some participants during the pandemic.

An Opportunity to Clean My Cupboard

Though most pandemic narratives seemed to touch on "doom and gloom," many stories revealed positive outcomes that arose out of the pandemic. For Eunice, she felt she was able to "slow down a lot" and truly "appreciate things more . . . and I learned what I can live without." She took the pandemic as an opportunity to learn "how to order online really well" and utilized her connective strategies by mentioning that she "had internet. I had my cellphone. I have Facebook. I have Instagram. I could FaceTime with my kids, so I made the best of it." Eunice

further thought the pandemic restored a sense of peace, not only within her, but in the world as well. She spoke with a sing-song voice:

> I think the world needed it at the time. The planes don't forget the planes didn't fly for a year or they slowed right down. Nobody was driving to work, so the air was saved. They said the first time, uh, Venice could see, you could see the water in Venice because there had been no tourists.

As the world learned new routines, so did Vivien. When asked about her pandemic experience, she perked up with excitement. She mentioned how "I did my church service because I went to church every Sunday." It was such a positive experience for her. Not only was she able to attend her church services through Zoom, but she did "yoga and meditation online with a lady that I used to take classes from in person." In terms of keeping life a little fuller, Violet was happy to "clean her cupboard" and Billie simultaneously "did a lot of cleaning my cupboards inside and out," which was a task they both felt they finally had an opportunity to do. Though Myrtle did not organize or clean as much, she felt just realizing the amount of people she had her life "was good." Vivien agreed; she thought connectedness was "another good thing that came out of it, too. I am much more aware and grateful of how fortunate we were. And what we actually have, and you know appreciate it more." Though the pandemic did have many negative aspects, the good that was shared was enough to keep some participants fulfilled, appreciative, and grateful.

A New Normal

By the end of the timeline, COVID became a "familiar fear" as society began to loosen up. Most participants became habituated to COVID and adapted to their new routines. Eunice described the narrative structure of the COVID-19 pandemic as "coming in like a hurricane and gradually go down to a tropical storm." For Delphine and many other participants, "as time went

by, I just felt more confident and comfortable." As they "became more familiar with the COVID-19, then [they were] more confident." For Madison, she even resumed going back to big events as

> Last summer I went to a wedding (laughs), and I think the restrictions had lifted, but we were totally, nobody thought anything about COVID once we got into that banquet hall and we were still dealing with COVID then, but we didn't care we were just all so happy to be out and at a big party and celebrating somebody's wedding.

Going to the wedding was the first step for Madison in resuming her life. She felt as if she was "back to normal now. I think that's how I feel. I feel it's pretty back to normal." Similarly, Lana felt "back to normal." She was "not afraid now. I always thought it's going to be like a cold or a flu, like anything else." Misty stated flatly, "I'm so over it. It's, like, I don't wear the masks when I go to LCBO."

For Sally, COVID became a familiar fear, just like "the flu." After she received her vaccine, she became "less concerned." After being vaccinated, Sally mentioned that in "all honesty, I didn't follow all the rules. There were times when it was just like 'Fuck it!' People come over and stuff." There was resistance as she felt that she became

> Less concerned about us trying to, I, at the beginning was very concerned and following all the rules and then it was kind of like "Fuck it!" After a while, it was just like, well, you know how much more can you do? And sometimes, it was just like, well, you can only live so long, you know? One of these four walls and stuff.

Constance mentioned that, after a certain point, she felt "fatigued. I've heard enough of this COVID. I don't want to do this anymore. I don't want to be swabbed anymore. I don't want to. I don't want to isolate anymore. I'm done. I'm done!" Misty also felt done with COVID as she mentioned that she did not "feel as threatened by it. Maybe that's the wrong way to feel. I'm open, I'm not being too, you know, sort of, what's that word? Not being as cautious about it." No longer being as cautious was the theme among most participants. For Vivien, the pandemic and

the fear of COVID "got better as time went on, yeah. We all adjusted, and things weren't quite as strict." Though Vivien feels adjusted, she also noted that

> I still, you know, in the back of my mind, like I still know that it's not over and maybe never will be over. We may just have to learn to live with it the best we can. So, I kind of mellowed a bit to that. I know it's serious. I know that, but I thought we just have to adjust, you know, our lifestyle to it the best way we can.

Myrtle agreed that COVID was "going to be with us forever. I think it's going to be like getting flu shots every year and I've sort of resolved that." She mentioned that

> I think I just honestly think we're going to always have to live with it and I'm okay with that, but I don't think I'll ever be back to normal if you want to call it that. Like, pre COVID. Yeah, because we have flu seasons and we have cold seasons. And, you know, the older we get, there's always going to be something, you know. It kind of reminds me of, I don't know how old you are Victoria, but in the '80s when AIDS hit, and everybody was afraid to hug people with AIDS, and then, you know, and then Princess Diana went into a hospital and said, 'I'm going to show you. It's okay to hug people who have AIDS,' you know. So, I think we're kind of getting past that point of being so afraid.

Myrtle's narrative included fear, but that fear dissipated as her experience of life in present day versus the start of the pandemic became quite different. She felt "now we know more . . . it's just a little bit more comfortable," suggesting that the fear in her narrative was the fear of the unknown. She was no longer "afraid to get COVID. I'm not afraid to go out and be with people." Myrtle recalled how different her life was at the start of the pandemic and how far she had come. She spoke to how "shocking how fearful and isolating it was at first. And I don't know if it got better just because the vaccines were better, or we just finally thought we got to just get on with life. I'm not sure or maybe it was a combination." Since "getting over the hump of the fear," Myrtle felt that her "life is probably high 70s, low 80% back to where it was pre COVID."

For Jude, not only had COVID become a familiar fear and something she became used to, but her mental health had strengthened since the start of the pandemic. Jude found herself "in a much better place." She returned to saying "hello and good morning to people when I'm

walking my dog. [It] is getting a little bit better, and we stay on the same pathway now" rather than crossing the street and no longer speaking to people. Jude described herself "in a perfect place" because "I'm off all the medications, stupid medication . . . but I'm not on anything whatsoever at all now and I am coping well because of strength that I have within me." Jude spoke to her resilience during the pandemic, which reminded her she was much stronger having lived through it.

Conclusion

Our story ends with participants "wrapping up the COVID chapter and moving on" (Eunice). After asking participants to re-visit feelings of nostalgia of life pre-pandemic and the initial horror of the start of the pandemic, the timeline split between stories of extraversion and introversion. Extraverts struggled with stay-at-home orders and saw the pandemic as a social threat, while introverts were comfortable in their own presence and saw the pandemic as threat of disease. Themes of grief, social isolation, loneliness, social connections, and leisure all carried different meanings, based on participant's vaccination status. Unvaccinated participants struggled more with judgement, rejection, and loss of social connections. All 18 participants used technology to stay connected, and now felt they were back to "normal life, once again" (Jude). What follows in the next chapter is participants' understanding and meaning of resilience, and the role leisure played to maintain that resilience.

CHAPTER 5: FINDINGS FROM AN ANALYSIS OF NARRATIVE

This chapters turns to an *analysis of narrative* whereby I collected stories as data and analyzed them using a more conventional qualitative approach (Polkinghorne, 1995). This conventional process resulted in of the identification of themes based on the narrative data collected (Polkinghorne, 1995). This chapter focuses on the meaning of resilience for participants, what resilience and coping strategies participants used to stay socially connected during the pandemic and delving into the role that leisure played as a resilience strategy in addressing the threats of social isolation and loneliness during the pandemic. Given that my research questions included focusing on the role of leisure and the meaning of resilience, the findings that follow focus on these questions.

The Meaning of Leisure

In terms of staying resilient and exercising resilience strategies, leisure represented the most common strategy utilized by participants. For all participants, leisure helped get them "through the pandemic, definitely," as Vivien put it. Through various leisure pursuits and activities, staying fulfilled and happy, participants were able to remain resilient by doing what the enjoyed.

For most participants, television was a big leisure activity in which they engaged. Participants "spent my time watching TV" (Zoe); "watched TV" (Billie); "I watched TV too and movies" (Elsa); and "a lot of Netflix" (Cordelia). For Eunice, watching TV during the height of the pandemic was the most fun she had in a long time. She squealed with excitement that she loves "TV! I watched every series from top to bottom! I watched new series!" Mary, like Eunice, "watched more TV, and I still do that. I stay up later than I ever did. And I sleep in later than I ever did." For Mary, it was "leisure. I love watching movies." Misty fell in love with numerous TV shows and was excited to watch them. She discovered "Grey's Anatomy. I never watched it

before. So, I loved it. I finished watching it. It was my friend." Myrtle shared similar sentiments and felt that TV was her friend. When she felt low or had a day where she "just decided to check out and not do anything but watch Netflix," she watched TV as her solution.

Quality time outside was another leisure activity in which most participants engaged. As Vivien said, being outside

> Got me out of the house. I don't think if I had been quarantined or whatever it was you know proper terminology. I can't stay inside all day, every day. I'm an outdoors person. Always have been, and I need to be open. It's fresh air and exercise . . . it is a bit of a social thing, too.

Elsa completely agreed with Vivien in terms of the social connection. As Elsa was "a gardener and I love gardening, so I did that . . . I'm a person that I like flowers. I raise ferns." She spent a lot of time sorting "out the garden and that was my big thing. I was outside, working in the garden." Gardening for her allowed her to engage in favorite leisure pursuit, both socially and in solitude. If she was feeling she wanted to talk to people or be seen, she would garden the front of her house, but if she wanted to stay in solitude, she would garden her backyard. By being outside in the front, she made new friends and stronger social connections as it was

> Amazing how many people come by when you're out gardening. Yes, that was the way I got to know a few people. You know, they're all interested in this old lady out there, or whatever, you know. They were so glad to see the place cleaned up that really, I got to know my neighbors quite well that way, through the gardening.

As Elsa put it, she "wouldn't have known anybody if I hadn't started with the gardening." Myrtle, like Elsa, spent a lot of time outside working "on designs for my deck, sort of renovated my deck, so put in a whole new kitchen outdoor kitchen and you know built in banquets." Jude also worked outside "gardening and raking" as it was important for her "to be in nature. I must be outside, and I must do something with my brain to prevent atrophy." Jude was grateful that she could "sit on my deck in beautiful sunshine, you know, surrounded with nature and the

birds." For leisure, Jude would "sit on my deck and in my garden. I would read on my deck and do some sunbathing," which helped her enjoy herself. Constance felt the same as Jude. To enjoy herself, she would "do some gardening and be outside and in the sunshine and just to relax" and strengthen her mental health.

On the subject of mental health, Lana mentioned that

> The mental health, the feeling I get from fresh air on my body and face, is really good. I agree, I love the fresh air. You know, some people I know don't get out of their units for days. And I can't do that. I'm shocked by that. I am shocked. If I don't get out every day, it doesn't matter how cold it is, I don't do well. I don't do well with the stuffiness of just being inside. So, I have to go out every day.

The feeling of needing to go out every day to enjoy the fresh air, but also strengthen mental health was something Moira believed, as well. For Moira, going outside everyday "did alleviate, you know, the feeling of depression. It was more releasing the depression" that her leisure activity provided for her. For Delphine, when she was outside, she was "at peace with nature. You know, when you hear the birds and you know, you hear the kids jumping on trampolines and stuff like that, and it just makes your heart happy." To keep her heart happy, she spent a lot of time "outside in the garden, you know, gardening all the time. Just trying to keep myself busy because if you don't, I mean, I know mental health wise, it would be horrible to do nothing." Keeping herself busy and seeing familiar strangers brought her a sense of calm in the storm that was the pandemic,

Puzzles were a big leisure pursuit for participants that enhanced joy, focus, and intention. Madison "did a lot of puzzles," Myrtle did "puzzles, puzzles, and puzzles," and Billie "did puzzles and puzzles. Lots of puzzles." In fact, for Billie, "the only leisure thing I did was puzzles." Doing puzzles kept Billie from feeling lonely and socially isolated by keeping her

mind “on something else rather than thinking of what is happening around you.” The “puzzles helped me a lot” in getting through the pandemic.

Sally also “did jigsaw puzzles, I did a lot of that” which “helped me get through it.” Sally felt her jigsaw puzzles kept her mind active and sharp and gave her a sense of purpose and enjoyment. For Misty, puzzles kept her “focused . . . it keeps your brain going” and gave her something to look forward to during the lockdowns. Puzzles for these participants served as a reliable leisure activity during the pandemic.

Another leisure activity in which a few of the participants engaged was drinking alcohol. Drinking had a social element for some participants, but not all. Some used drinking to cope with the loneliness and depression (negative outcomes), while others drank for pleasure (positive outcome). For Mary, during the height of the pandemic, she felt bored, so she began to “drink more” and enjoyed the perks of her mini bar. Her drink of choice was white wine, and she enjoyed having a few glasses a day while watching TV. She mentioned that “during the pandemic, I feel like the height of it. I was drinking a lot more.” Misty mirrored Mary’s sentiments and said with a laugh that she “probably drank more wine than I care to admit” during the pandemic. Sally, like Mary and Misty, enjoyed her wine during the pandemic and considered it her “favourite” leisure activity. She recalled how she and her neighbour, Eunice, who “lives two doors down from me and really she helped me get through it because we did do a lot of daytime drinking.” Eunice also recalled how Sally and she would go out because “the bars open at noon (laughs) then we’d day drink” and indulge in wine. Fiona also indulged in wine, but over Zoom. She recalled how she “belonged to a wine tasting group. This was through the university Women’s Club, and we would meet over Zoom,” which she enjoyed and described as her

favourite leisure activity. For Mary, Misty, Sally, Eunice, and Fiona, their relationship with wine during the height of the pandemic gave them a sense of pleasure and joy.

Another pleasure filled leisure activity that some participants spoke to was sex. For Sally, "sex was leisure" and something she enjoyed very much. During the second lockdown, she had "a friends with benefits with this guy for three or four months. I did have that, casual." Sally recalled how having sex made her feel less lonely, especially during the lockdowns. She explained how she missed dating and sex during the first lockdown, which prompted her to go on dating apps and have a "friend with benefits" to stay in the same "bubble" during the second lockdown. Sex made her feel empowered and fulfilled, and it was one of her favourite leisure activities. Myrtle was on the same page as Sally, and recalled how her "guys, were my leisure activities" during the pandemic. At the start of the pandemic, she was weary about getting together with others, so abstained from having sex to stay safe. Once living through COVID became familiar, by the second lockdown, she kept both her sexual partners in her "bubble" and resumed her intimate relationships with them. Sex was her "fun," and it was something she "really enjoyed doing." Having two partners with whom she was intimate made Myrtle feel less lonely and more content. Though they did not disclose too much about their sex lives, perhaps because it tends to be a private topic, it was evident that both Sally and Myrtle viewed sex as their leisure and something they enjoyed quite a lot.

There were other leisure activities participants engaged in that were individual to them through the pandemic. For Eunice, it was all about consumption and collecting. She touched on a spiritual dimension, and "spent a fortune on crystals and that's what made me happy." For her "crystals are my happy place" as "every piece is different, and I'm always looking for messages from divine. You know, both of my parents have passed, and I do believe that they do guide me

and sometimes I'll pick a crystal that has angel wings in it or has hearts and that just gives me that little mmm!" Eunice loved purchasing a new crystal, placing it in her collection and then sorting them: "I've got a shelf for my crystals." Alongside purchasing crystals, Eunice loved "doing tarot cards" during the height of the pandemic. She felt receiving messages from her cards were also her "leisure, which is good (laughs) you're doing what you want." Eunice's time spent at home with her crystals and tarot cards were her favourite forms of leisure.

For Mary, a big part of the first lockdown was all about sewing masks from scratch, she considered to be her "leisure for the first part." She recalled taking

> Shirts of my husband's and used them. And I got a pattern online. And my brother-in-law was so excited because I was making three layers of fabric and, you know, I got hair elastics because you couldn't get elastics from the fabric store because they were closed. I went to Shopper Drug Mart and so that was fun, sewing those masks. That's what I did.

For Mary, making masks was a good way to spend her time as she felt like she "could not read," which is something she usually did for leisure. Reading for her felt "exhausting" during the pandemic for "some reason." She was unsure why she did not read, but all she knew was that she was being pulled to sew, which was her favorite leisure activity. By contrast, Fiona read quite a bit during the pandemic as she belonged "to a book group . . . and were meeting over Zoom." She enjoyed reading a new book and discussing it with her book group as she felt that was a leisure activity that kept her fulfilled alone and gave her social connections through talking with the group. Technology enabled leisure for Fiona, and reading was a social activity for her that kept her part of membership in a club.

Like Fiona, Violet read quite a bit. During the pandemic Violet "read my favorite books over twice. I've never done that before. I've heard my neighbors saying that they've read a book twice, and I always thought it was weird, but I did. I just read some of my favorite books over

again." Though Constance, like Fiona and Violet, read, her favorite leisure activity was pottery. She recalled how she "got a lot of pottery done" which she adored more than any other leisure activity she had ever done. She already knew how to do pottery, but she felt lockdown gave her an opportunity to do more of it, which brought her an immense amount of joy.

Though leisure and leisure activities are different for every individual, perhaps the most common leisure activity that every participant engaged in during the pandemic was walking. Walking was one of the few sanctioned activities in which people could participate at the height of the pandemic. Participants spoke to how much they "walked a lot, I got out and walking a lot . . . I did a ton of walking!" (Madison); "I walked all the time" (Lana); "I walked" (Eunice); "I started walking" (Misty); "I kept going for walks" (Fiona); and "I walked for an hour and hour and a half every day" (Violet). Walking was the leisure activity that every participant had in common as it kept them socially connected, got them outside the house, and helped with their mental health.

Walking served as a common form of physical activity, which in turn strengthened mental health for some participants. For Madison, walking helped "keep my sanity" as she spent "most days walking" to keep her mental health strong. Jude walked for the same reason, and she spent her time "walking, going out into nature reserves . . . I also began because of my mental health. I needed stimulus." She felt she had "to walk, so I would walk. I would walk alone each day and then I would come back. At least I'd got my exercise in. And I would talk on the phone to friends." As Jude's mental health took a toll during the height of the pandemic, she felt walking saved her and was the leisure activity she enjoyed and needed the most. Violet similarly felt that the thing that "helped me was walking, I walked every day outside." Cordelia also agreed that walking helped clear her head and forget the world around her and "walked a fair

bit." She felt on days she was particularly overwhelmed with COVID and the news, walking "an awful lot" helped ease her mind.

Some participants chose to walk to keep socially connected and physically active. Fiona recalled how "a couple of friends we would meet up for walks." She recalls that she didn't get together with friends" as she was afraid of COVID, but she did make an exception to see friends and "go for a walk." She felt safe doing so as long as they "stayed physically distanced." Sally agreed that "walking really helped that was a huge thing being able to walk and walking with friends" and helped her stay socially connected when she felt very lonely. To alleviate her loneliness, Myrtle would "walk with a friend" and "go for walks . . . my sister and I would just walk the floors just to, you know try, and just get some perspective, or we would walk over the Concordia club and walk around the parking lot." Perspective serves as a dimension of resilience which shows the connection between leisure and resilience. Walking as a leisure activity enabled Myrtle like other participants to demonstrate their resilience.

Vivien also felt she needed to gain some perspective. She began to walk as her social isolation had her feeling quite low. She recalled that

> Walking was a big thing that I did. Because it got me outside. And then it got, you know, you would see a lot of the same people when you were walking. So even if you just waved at each other, like how are you today type of thing? So, it was you were still being social at a distance.

Constance agreed that seeing people on her walks kept her socially connected. As "walking was probably the only thing that I really could do that was out there and connecting with people, walking is a huge thing." Constance recalled how she would go "out for walks longer walks and trying to connect with friends and people that I could go for a walk with. So, I did start to do that, walking helped a lot, walking helped quite a bit." For Constance and every other

participant, walking was the leisure activity that everyone enjoyed and helped with physical and mental health during the pandemic.

Adaptive Leisure

Though leisure activities proved to be a resilience strategy throughout the pandemic, participants did engage in "lonely leisure," as Jude called it. Some participants felt that, even though they engaged in leisure which helped them get through the pandemic, it would not have necessarily been their leisure of choice. Because of shutdowns, physical distancing, and government mandates, they had to engage in leisure activities "alone" (Jude), as their group leisure activities were no longer possible.

When asked about her leisure, Jude said

> My leisure? If you were to ask me what my leisure is, my leisure is going to acquisition and dancing, and having fun, and enjoying my retirement years that I've worked so hard for. That's my leisure. My leisure is not sitting alone on my deck every single day and not speaking to anybody.

Though Jude did feel sitting on her deck and being outside was her leisure during the pandemic, it was not her first choice, nor was a leisure activity in which she would normally participate. Frustrated, Jude said

> I think leisure, if you're working for prime, your leisure is on the weekends. It's lovely. Oh, you sit on your deck. You have a glass of wine. Your friends, that is leisure. But when your leisure is seven days a week, 24 hours a day, and you're on your own, you're living in your own house, and you can't go out anywhere, you can't have interaction with anybody. That doesn't cut it anymore. It is now no longer fun to sit on your deck with whatever chocolate cake you want or pieces of chocolate that you know you shouldn't be eating or whatever fatty foods. In fact, I would go out and I would order, or I would get some donuts just for the hell of it.

Jude felt that she "didn't need a loneliness leisure, what my leisure was . . . and that is my leisure because when you live alone and you're elderly, your family are all less than there or you're on

your own or you don't have any relatives. Your community and your leisure are your friends, and the people you interact with. So having lockdowns, that took everything away from me." In a sense, her leisure was almost a fallback option as Jude felt her true leisure activities were taken away from her and she had to resort to engaging in leisure activities that were not her first choice. She felt she had

> No leisure, no fun, no religion. You take away people's religion, as a personal thing, and then you force them to get a poison in their body that they don't want. You know, so, yeah, it was, it was, it was hard to, you know, you can only read a book for so long and then you need to talk with people, and you need to interact with people and have fun.

Jude tried to adapt by going "on the Internet. I tried to learn the Zumba on the Internet, do the dance classes, but it was the people that I missed, it was the, it was interaction, social interaction, I was missing, so, I was desperate."

Moira echoed both Jude and Madison and felt that although she engaged in leisure during the pandemic and it contributed to her resilience, she felt that because she was alone and could not go out, her "lonely leisure" activities "made me feel good in the moment and maybe for a few hours afterward, but once I was back inside and back on my bed, I didn't really make a lot of difference." She felt she couldn't do her usual leisure activities because she had too much access to them by being home so often, and it took the joy out of them. She recalled how she "didn't do any art. I had all my art supplies here didn't do any art. But I didn't feel like there were thoughts in my head, and I'd write about, and I'd think of all sorts of things I want to write about." Moira chose not to write (something she usually enjoyed doing) because she felt her thoughts were too lonely and isolated for the paper.

Leisure Served a Purpose

"Lonely leisure" aside, leisure almost always served a purpose for participants. Leisure played a big role in the resilience. For Eunice, "resilience is leisure and vice versa." Mary underscored how leisure got her "through the pandemic" by keeping her "happy." For Madison, leisure played "a huge piece of my pandemic story" in terms of helping her stay "grounded." For Eunice, leisure was all about "doing something for a reason. If you need to stop thinking, or if you have to stretch your arms . . . it's good to do something you enjoy . . . organizing my crystals is both a pastime and a workout, ha-ha." All 18 participants agreed that leisure served as a resilience strategyby giving them purpose. In particular, it helped them: (1) stay distracted, (2) stay connected, and/or (3) stay active. I explore each of these themes next.

Staying Distracted

Staying distracted was the first purpose leisure served for participants. Staying distracted and "busy" helped participants "keep [their] mind off the craziness that was the pandemic," as Cordelia explained. From taking a break from reality to letting their minds wander away from "the news, Theresa Tam, and whatever else of the day" (Jude), participants drew on leisure as a means to keep their attention occupied elsewhere. It led Madison to refer to the activities in which she participated as "busy leisure." Ultimately, she felt her leisure during the pandemic became "about keeping busy" because "you can't get out and you can't socialize," so she resorted to "re-doing [her] living room," an activity that allowed her to shift her focus. Madison saw leisure during the pandemic as an effort to "find all these things to do that just keep your mind busy and away from the negativity of the world." She, like others, engaged in leisure to stay distracted and "focused on something other than the pandemic."

Spending time outside was one of the most common ways participants engaged in leisure to distract themselves. Delphine tried to keep herself "busy because if you don't, I mean, I know mental health wise it would be horrible to do nothing, so I sat outside to ground myself." Vivien felt that being outside got her "out of the house. I don't think if I could have been quarantined or whatever it was you know proper terminology. I can't stay inside all day, every day. I'm an outdoors person. I need to stop thinking and just smell some flowers." Unlike the casual leisure activities many participants described, Myrtle's leisure was more project-based. She spent a lot of time outside working "on designs for [her] deck, sort of renovated [her] deck, so put in a whole new kitchen outdoor kitchen and you know built in banquets, it was nice to just focus on that." Whether their leisure focused on an outdoor project or "nothing at all and sitting on the deck and sunbathing," as Jude described her own preference, engaging in leisure outside almost always served as a distraction for participants.

Cleaning, organizing, and puzzles played the same role. It may seem contradictory, but Violet and Billie were happy to clean their cupboards, a task they both felt kept them "busy like a bee" (Violet). Similarly, Eunice organized and cleaned out her crystal cupboard, an activity she described as her "favourite leisure" activity. She viewed it as a chance to focus on "good energy and the healing powers of the crystals." After cleaning, Billie would resort to puzzles, as it was "one of the only leisure things [she] did" during the pandemic. Puzzles kept her from feeling lonely by keeping her mind "on something else rather than thinking of what is happening around you." Moreover, they kept her "occupied at doing something else rather than thinking of what you can't do." Sally also "did jigsaw puzzles, [she] did a lot of that" which "helped [her] get through the pandemic." Sally felt her jigsaw puzzles kept her mind active and sharp and gave her

a sense of purpose and enjoyment. In Misty's words, puzzles kept her "focused . . . it keeps your brain going" and gave her something to look forward to during the lockdowns.

For other participants, TV served as their biggest distraction. Misty fell in love with numerous TV shows and was excited to watch them. She discovered "Grey's Anatomy. [she] had never watched it before. So, [she] loved it. [She] finished watching it. It was [her] friend." Myrtle shared similar sentiments and felt that TV kept her mind off of "the lockdown scaries." When she felt low or had a day where she "just decided to check out and not do anything but watch Netflix," she watched TV as her solution. Mary also "watched TV, but not the news. That was too much. It was all about comedies and whatever you didn't have to think about." TV kept participants distracted and "freed the brain from thinking," as Mary put it.

It is important to note that maladaptive coping strategies also kept participants distracted. Eunice spent a lot of her time during lockdown "smoking weed" and "drinking." Though she "just got fatter and drank more alcohol, smoked more cigarettes, smoked more pot," she felt these leisure activities that were not "necessarily good" for her, but helped her "spend [her] days laughing. You're a lot happier when you've got some booze and smokes in you." Though the long-term effects of her maladaptive coping strategies were not ideal, as over the course of the year Eunice did "gain a lot of weight and [she] coughed more," during the short-term period of lockdowns, these maladaptive coping strategies served a purpose of keeping her distracted and getting her through "lockdown and stay-at-home orders." Sally and Delphine felt they "drank more than usual" (Delphine). They thought alcohol was "bad, of course, but in that moment of feeling lonesome, it was nice to not think about is this going to be life forever" (Sally). Though participants were aware of the negative long-term effects of their maladaptive strategies, they recognized "I'm pushing 70. I'm not an alcoholic. I'm in a global pandemic. What the fuck? I'm

having a drink!" Sally exclaimed. In that moment of fear and uncertainty, staying distracted outweighed long-term negative effects for them.

Staying Connected

The second purpose leisure served for participants was *staying connected*. The efforts participants made to stay connected showed how much they valued social connection. As Vivien spoke about her "church service every Sunday on Zoom where [she] spoke to all her friends." For her, that was what "leisure is all about. Talking to people." To keep in touch with her friends and talk to her neighbours, Vivien sat outside her house and viewed it as a "social thing" to "chit chat with anyone from a distance." Likewise, Elsa spent time in her front yard gardening, which enabled her to connect with her neighbours who passed by. For her, it was "I got to know my neighbors quite well that way, through the gardening." Elsa admitted she "wouldn't have known anybody if I hadn't started with the gardening." Constance, Cordelia, Myrtle and Fiona also felt that being outside kept them social. Myrtle underscored the importance of "being outside [during the pandemic]" because "you saw another face, and that was great." It clearly helped with social connectivity.

For some participants, they stay connected by having sex. More specifically, engaging in sexual contact with others enabled an intimacy that was otherwise missing during the pandemic. Sally recalled how having sex made her feel less lonely and more "in touch with another person," especially during the lockdowns. Sally had a "friend with benefits" who stayed in her "bubble" during the second lockdown. They enjoyed each other's "company, and it was a good way to have company around." Myrtle recalled how her "guys were [her] leisure activities" during the pandemic. She kept both her sexual partners in her "bubble." Sex human touch and intimacy, which enabled those who engaged in it to remain "close to another person" (Sally).

Drinking alcohol also served as a leisure activity that helped keep participants connected. Delphine mentioned how she would have "social distance wine dates" with her friends during the "height of the pandemic. You bring a glass of wine, sit over there and chat." A glass of wine brought her friends "together and provided some laughs." Sally also recalled how she and her neighbour, Eunice, who "lives two doors down from me and really she helped me get through it because we did do a lot of daytime drinking." Fiona also indulged in wine, but over Zoom with her friends. She recalled how she "belonged to a wine tasting group. This was through the university Women's Club, and we would meet over Zoom," which she enjoyed and described as her favourite leisure activity. Drinking served as not only a form of "fun" (Sally), but also a way to bring friends "together, during a tough time," (Eunice).

Staying Active

The third purposes that leisure served was *staying active*. The most common form of leisure that helped participants stay "active and moving" (Constance) was walking. Seventeen out of 18 participants walked to not only "clear [their] head," as Fiona put it, but to "stay physically healthy and energetic" (Violet). Participants spoke of how much they "walked a lot. I got out and walked a lot . . . I did a ton of walking!" (Madison); "I walked all the time" (Lana); "I walked" (Eunice); "I started walking" (Misty); "I kept going for walks" (Fiona); "Oh, I walked lots" (Myrtle); "Walking, everyday!" (Cordelia); and "I walked for an hour and hour and a half every day" (Violet).

Walking provided participants with numerous benefits, including relaxation, mobility, and staying social (Adamson and Parker 2006). Staying active through leisure helped them "unwind" (Violet), "move their limbs" (Elsa), and "see other people. Walking not only kept me healthy, but I saw a face or two, which was nice" (Lana). As Constance mentioned, she "had to

make time for walking. It was my daily thing" to stay active and "keep healthy." Keeping active through walking was important for 17 participants because the "feeling you get from fresh air on my body and face, is really good. You move your body and burn some calories. It's nice," said Lana.

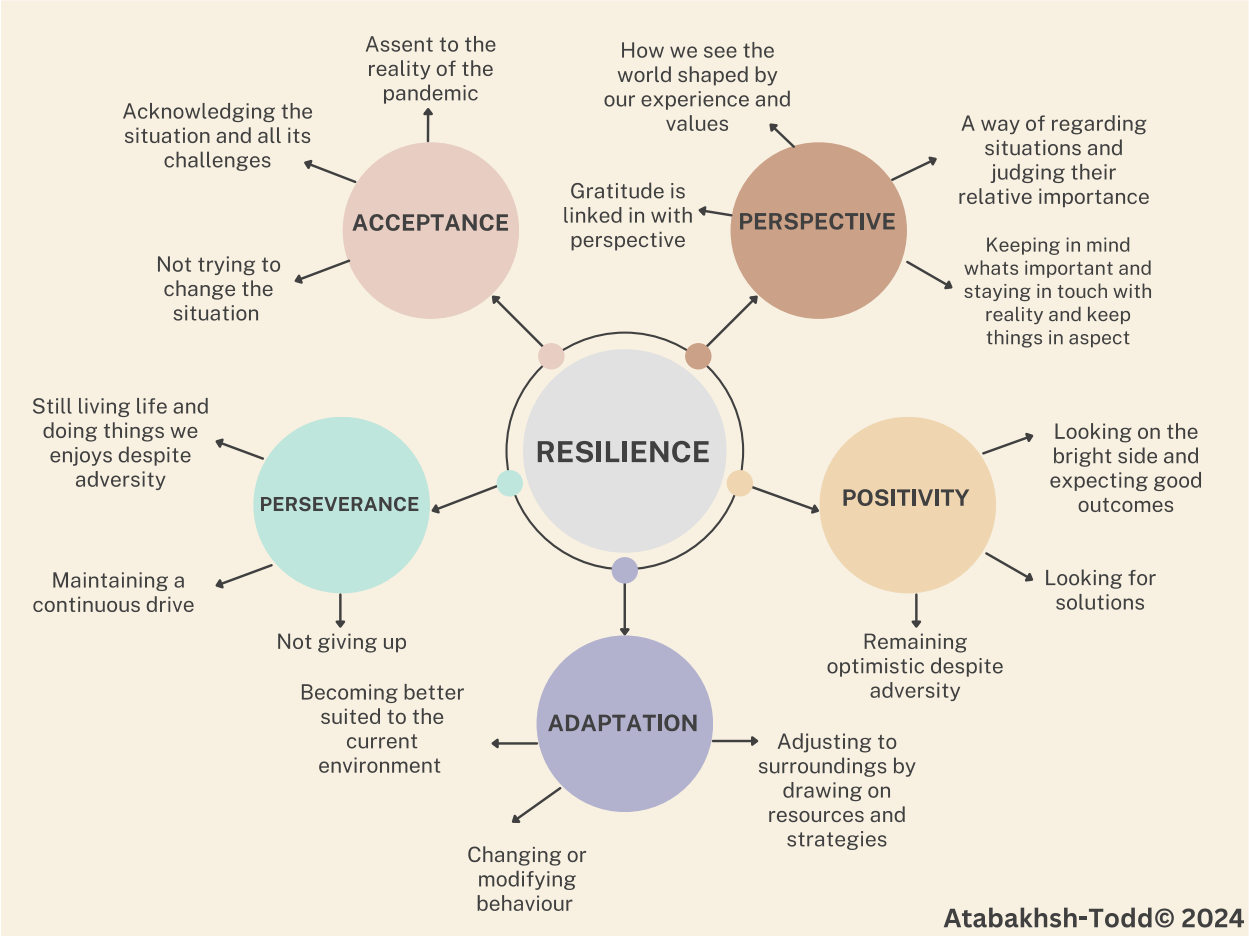
Other than walking, participants stayed active by doing online workout classes. When asked about her leisure pursuits during the pandemic, Vivien described staying active as "important" to her, and so she maintained her "fitness" by doing "yoga and meditation online with a lady that I used to take classes from in person." The online workout classes enabled Vivien stay "flexible" and helped her "sore back, the classes were great to keep my back from getting worse." Mary also spoke about the "pump it up classes" she did when it was "raining out" and she was unable "to go for a walk." She did the classes "at least once a week to just get [her] blood pumping" and her "heart healthy." Constance did a "few online classes here and there, just if [she] wasn't in the mood to walk. [She] needed to stay moving somehow." Staying physically active through leisure was a big theme that arose through participant stories and showed the importance of "moving the body," as Eunice commented.

The Three Purposes of Leisure

Though the purpose of leisure can vary from person to person, participant stories identified leisure as activities that kept them distracted, socially connected, and physically active. Staying distracted through leisure served as a form of escapism (temporarily diverting attention away from the pandemic), relaxation, and "mindlessness," something that doesn't create stress," as Cordelia put it. Staying connected through leisure was all about connecting with others, building, and maintaining meaningful relationships, and actively taking steps to alleviate

loneliness and social isolation. And finally, staying active through leisure encompassed strengthening physical and mental health, as well as getting in "exercise or physical activity to stay healthy," as Fiona described it. All three themes identified through participant stories revealed the meaning participants associated with leisure during the pandemic.

The Meaning of Resilience



Resilience was an important part of all stories, as it provided all 18 participants with the "strength that was needed" (Zoe) to overcome the difficulties the pandemic presented. Participants displayed resilience in navigating unprecedented challenges brought on by the

pandemic and coping with their circumstances in ways that "[kept] living life as best as possible" (Cordelia). All 18 participants viewed themselves as resilient during the pandemic. Indeed, their experiences led them to recognize themselves as resilient individuals: "Hell, yes, I was resilient in the pandemic! I was resilient *before* the pandemic, and I will stay resilient until the end of my days" (Jude, original emphasis).

For Fiona, resilience was about

> Being flexible in the sense of not being attached to outcomes. We all have attachment to outcomes, and we want things to go a certain way, but, like, if you live long enough, you realize that things are not going to go your way. How you approach disappointment is all up to you in the sense that you can be resentful and angry and what have you, and that's fine, but that's not adaptive.

When examining the narratives that I presented in the previous chapter, resilience was undoubtedly a major theme. In many ways, resilience became the "moral of their stories." What follows is a conventional qualitative analysis of what resilience meant to participants, and the dimensions of resilience that emerged in their pandemic stories.

Generally speaking, the idea of "bouncing back" resonated across all conversations. Zoe, for example, felt being resilient meant that "you can come back happy and normal from having a punch in the head" and to "revive from a bad situation and carry on and be happy and do my life." For participants, this bounding back stemmed from certain traits that were revealed in their behaviour during the pandemic. Almost universally, participants described resilience as something that "comes from the inside and helps you come back."

Madison spoke of a "low point" she and others felt during the height of the pandemic, and how she exercised her resilience by "pull yourself out of it really quickly and carry on." The emphasis, here, was on individual agency. Similarly, for Elsa, resilience meant that "if something comes along, and you can't change it, then you adapt to it. You just make changes in your

thoughts, and then in your life." These descriptions contain a variety of important dimensions—or traits—that participants referenced in talking about what resilience meant to them: (1) positivity; (2) adaption; (3) perspective; (4) perseverance; and (5) acceptance. I will explore these dimensions next:

Positivity

Positivity emerged as a common theme when discussing resilience. Staying optimistic and seeing the "light at the end of the tunnel . . . and the fact that everything has a silver lining" as Eunice put it, was a dimension that contributed to many participants' resilience. As Myrtle put it, "resilience is a positive move forward" and all about "staying positive." Lana, like Myrtle, felt that "being positive, seeing that there's an end in sight, that it's just a short-term thing, using whatever resources you have at hand to help you get through it" is what being resilient is all about. Similarly, Sally described resilience as being about "waking up every morning and being positive." Sally viewed resilience as being "grateful for what I have and not being brought down by the fact, yeah, it's snowing, it's like, shit, you know, or whatever. So being grateful and positive for what you have in your life and being resilient because you can be healthy, too." Moira agreed that staying positive made her resilient. Moira would "say to myself that, you know, three hours for the really small problems, three days for the bigger ones, three weeks, and I guess three years," which enabled her to recognize the pandemic would eventually come to an end.

For Constance, to be resilient meant

> That you have a lot of resources or ability to sort of get yourself out of situations that are not so bad, not so good, right? So, learning how to, you know, come out of a bad situation or depression or anxiety. Figuring out, you know, what it is that's causing that. And maybe sometimes you can't figure it out, but at least you can figure out what can I do to move out of, move away from this. That things would be ok.

Madison like Constance knew things would eventually be okay. She recalled how she "never had any serious lows" and if she did, she knew it "was only momentary" because "everything would be ok." Violet as well, was all about having a good attitude and mindset. Violet mentioned that as soon as the pandemic hit, she had to "be resilient, and I think we all have to look on the bright side of things and see what we can do and don't worry about the things that you can't do." Since Violet had a "good attitude," she did not pass blame or get angry. She mentioned that she did not "blame China or get mad and do all these weird things that people do . . . there is a silver lining to everything" but instead just focused on the "bright side" and "stayed positive" like other participants, to remain resilient.

Adaptation

Adaptation was another dimension of resilience that participants mentioned. Resilience for Vivien was about adapting, and during the pandemic, she began "adapting the best way I could" to "pandemic life." Fiona adapted by "knowing when I need to take a break so I can come back stronger… I don't usually step back but I started adapting to pandemic life." To Myrtle, being "resilient is finding solutions for things that you want to do. To me, it's not being resilient if you're finding solutions to doing things you don't want to do. I'm a problem solver. I can figure out how to get things done that I need to be done." Fiona was also a problem solver. She tended to "problem solve and adapt" by creating "new routines that public health allowed." Instead of going out with her friends, to get away, she would "go to the cottage alone and that's how I would adapt." Her adaptation through problem solving helped "keep me resilient."

Vivien began "adjusting and adapting to the pandemic the best way I could." By talking to her friends and family through "video calls versus in person," Vivien adapted to the public health

restrictions and moved her social life from in person to online. Cordelia, like other participants, just felt like she had to "make the best out of whatever's happening in your life because things to happen." She felt the pandemic was just another stage of life and that it was "temporary." To honour this temporary stage of life, she "adapted to pandemic living" by "staying inside more" and "doing things at home." Adapting to new routines, new leisure activities, and new ways of staying socially connected, contributed to resilience for many participants.

Perspective

Perhaps one of the most common dimensions of resilience that arose in my discussion with participants was perspective. Keeping in mind what is important, maintaining a certain attitude and outlook, and mixing in gratitude with perspective, was a dimension that kept participants resilient. It seemed that as one ages, the more perspective one gains. As Jude mentioned, she "must be resilient because, you know, at this age, you've been through ups and downs and, separations and all sorts of things in life, and upsets." Perspective played a big role for the older adult participants in this research.

For Billie, her pandemic approach was "instead of sitting in here feeling sorry or worrying about it so much, I just thought, well, if I don't go out, I'm not going to get it, so I don't think I worried a lot." Billie's attitude was the source of her resilience as she did not like "to dwell on things, you know. Well, there's always tomorrow, the next day." For Lana, resilience meant putting "faith in God. That he has a purpose in my life. And that I've went through all these things for a reason, and I just feel like there's still hope for me, and I don't want to drown in life because I could." Lana's strategies for staying resilient, included practicing "prayer and just gratitude, to keep in mind what is important." Violet also kept the pandemic in perspective by

> Thinking about good things and not think about poor me, because there were so many other people that had to go to work like nurses that were fearful every day, and then had to come home to their family, not knowing whether they were giving them the virus or not. And then here I am. Staying in a beautiful house. And able to go for a walk and not have to worry about infecting anybody. So, I just had to keep thinking about how lucky I was.

According to participants, resilience required recognition of understanding when enough is enough, mentally, physically, and emotionally. For Jude, resilience meant:

> That even though I'm slapped in the face, or I'm pushed to the floor, or my house burns down or my dog gets hit by a car, outside, that I have the strength and fortitude to get up from my knees and stand up and face the world and go and, you know, cry my eyes out, whatever it is I have to do in the grief, but work through it, and eat the food and get back to walking and build another house or build another whatever it is I've got to build. And try, it would never be the same, but at least I would have got up from the floor from when the first, you know, whatever it was that hit me. And I think to be a resilient is to be wiser, a little bit more cautious. And a little bit more grateful for what you have got. And very thankful that you are where you are in life and there is so many of the people much worse often you.

Jude referred to the pandemic as a "kick up the backside" that allowed her "to see how strong you are, and then you remember what matters." The pandemic served as her "kick," which led Jude to exercise her resilience strategies. She mentioned that

> I did also with my resilience was to learn about cognitive behavior therapy and mindfulness-based stress reduction therapy. So, I have done both the courses and knowing how to do the "stop thinking" and "stop negative thinking" and drawing on your resilience and the "what if factory," what is okay. So, the pandemic is on your back, you're a single lady. You've got your dog. You've got your health, and this is the world's gone bloody crazy. What are you going to do? So, are you going to lie down? Well, I'll just lie down and let it all swing over me and that's it. I've given up. Or are you going to say, no. There must be something else and there must be something else. I've been through so much in life.

By putting into perspective how far she had come in her life, Jude remembered how "resilient I am." As most participants maintained a "this too shall pass" mentality as Eunice put it, it showed that, perspective played a big role in keeping many participants resilient.

Perseverance

Exercising resilience through the pandemic was a common among all participants in this study. Though resilience arose a different time in their timeline, they all considered themselves resilient. Their perseverance to keep going despite the challenges the pandemic presented contributed to this resilience. Madison believed she had a great coping strategy of socializing that kept her resilient, a strategy she persisted with, despite constraints associated with public health restrictions: "I've come through [the pandemic] just fine. I kept myself, you know, busy. I kept myself socializing, and I had lots of great friends to rely on." She mentioned that she was able "to be pretty resilient and get back to normal and not let it slow me down." This concerted effort to intentionally keep the pandemic from "slowing themselves down," showed participants' perseverance. For Madison, her perseverance let her "come back from it every day and keep moving and try to keep busy and keep happy and keep in touch." When she would "go through these little bouts of sadness . . . then my resiliency (laughs), would come forward, to make it through the shitty days." Madison drew on her leisure, which she used to pick "myself up and phone someone, get out for a walk I mean you could just really wallow in it, and I guess a lot of people did and aren't able to do that, but it just kind of drove me to keep connected." Even when challenged by the seemingly overwhelming constraints of the pandemic, participants made the extra effort to stay ahead of adversity and showcased their perseverance and determination to get through.

Jude's perseverance was a big dimension of her resilience, as it got her through the pandemic by using the "strength to get up and use my wits and use my ability to seek for help and say, listen, I'm really down. I need some, I need some help." Even when it seemed hopeless, Jude persisted. In her words, she "kept going." Sometimes "these are the cards that are dealt,

[and so] you have to play them," commented Misty. Billie thought "just get up, get up and do something. Don't lay here and feel sorry for yourself. You got to do something else. You're going to be in a worse state." Moving forward with a strong mindset—persisting—was the foundation for Billie's resilience.

For Vivien, there was no doubt she "had bad days," but she "really tried to do the best I could in that type of a situation." Vivien knew she was resilient even prior to the pandemic because if she had a "down day, well, then I tried to just pull myself back up the next day," as if to "keep in mind what was important." Perseverance was an important dimension of resilience for the participants as it demonstrated their ability them to keep going, despite the adversity they faced. It showed they would not give up, even though some days were harder than others (i.e., stay-at-home orders and lockdowns).

Acceptance

Finally, participants cited acceptance as an important dimension of their resilience. Some participants felt the pandemic reminded them of the resilience they possessed. Once Fiona recognized the pandemic was no longer in her control, she took a back seat and said to herself "shit happens!" To her, resilience is, in and of itself, knowing that the pandemic was not in her control and accepting "what was to come." For Eunice, her entire mentality of the pandemic was "it's going to take more than COVID to take me out." She felt that she "could stay in here and cry for 3 days if I want to, but you know my eyes would get puffy, and I would have no lashes (laughs). I'm like, oh my god nobody sees me anyways. So, yeah, resilience is acceptance." Resilience for Eunice was "knowing that you have no control over [the situation] and be resourceful." With this attitude, Eunice went "under the table and found a hairdresser that would

work during COVID, and I found a chick that would come to my house that would do lashes." After accepting her situation, Eunice used her resources and strategies to control what should and let go of what she could not.

For Billie, resilience was all about not dwelling on the situation. To remain resilient, Billie kept herself "busy, so I didn't think. I didn't dwell on it so much. I did a lot of cleaning, like I said. I kept busy, and if you keep yourself healthy, then that's all you can do." Keeping busy was a coping strategy for her and a way to accept "the situation of the pandemic." Billie refused to "dwell on saying, oh my, the pandemic! What am I going to do?" Cordelia's acceptance, similarly, was a great source of her resilience. She considered herself a strong and resilient person who "thrives on change." Cordelia also chose not to dwell on her circumstances as she was firm that "you can actually cope with a lot of things, right? Bounce back and just make the best of whatever's happening in your life. Because things do happen." Vivien remained resilient by accepting the pandemic "for what it was." All she could do was "accept it" and "live life." Fiona knew she "was resilient before the pandemic." Being resilient to Fiona was all about thinking "okay, this is the situation, and this is what it is." She, along with the others mentioned above, practiced acceptance to remain resilient during the pandemic.

The combination of positivity, adaption, perspective, perseverance, and acceptance made participants resilient. Accordingly, participants regarded themselves as "resilient," even if they did not always act accordingly, because of their understanding that resilience "comes from within, I am resilient so it's always there" as Zoe mentioned. Through internal protective factors, participants remained positive, adapted, kept perspective, persevered, and accepted their situation to remain resilient during the pandemic.

Conclusion

In summary, participants revealed much about leisure and resilience in their pandemic stories. Leisure often served at least one of three purposes for them: it helped participants stay distracted, stay connected, and stay active. In doing so, leisure was utilized as a coping strategy that assisted participants in getting through the worst of the pandemic. Participants demonstrated their resilience in their stories, which they described as traits embodied in their pandemic behaviour. Specifically, they saw resilience as something made up of positivity, acceptance, adaption, perspective, and perseverance. These findings and the others found in this, and the preceding chapter warrant discussion in relation to the existing literature. Accordingly, I take on this task in the chapter that follows. The next chapter, therefore, provides me with an opportunity to reflect on the meaning and significance of my research findings and to situate them within broader scholarly conversations in my field(s).

CHAPTER SIX: DISCUSSION

The purpose of this chapter is to interpret the findings of this research project in relation to the existing literature on COVID-19, social isolation, loneliness, older adults, leisure, and resilience. In doing so, I aim to point out where my dissertation provides evidence to support existing research, as well where it introduces new ideas and/or fills certain gaps in the literature. Moreover, I will consider the theoretical and practical implications of my results. Though participants in this study had their own unique experiences of living alone during the pandemic, a common narrative structure tied their stories together. What follows in this chapter is a discussion of my findings related to the timeline participants experienced in living through the pandemic; the diverging experiences of extraverts and introverts; how participants' vaccination status influenced loneliness and social isolation; the role of leisure in coping; and the meaning of resilience. These discussions fit within the purpose and research questions that guided this project.

As a reminder, the purpose of this dissertation was to understand the role(s) of leisure as a resilience strategy to combat social isolation and loneliness among older adults who lived alone in Kitchener-Waterloo during the COVID-19 pandemic. Connected to this purpose, I aimed to answer the following research questions: (1) how did public health restrictions affect older adults during the pandemic; (2) what did resilience mean to older adults and what resilience strategies did they use to stay socially connected during the pandemic; and (3) what role did leisure play, if any, as a resilience strategy in addressing the threats of social isolation and loneliness during COVID-19? The discussion that follows offers insight into these questions.

The Narrative Performativity of Life Pre-Pandemic

In recounting their lives before the pandemic, every participant spoke overwhelmingly positively about their pre-pandemic lived experiences. These reflections triggered feelings of nostalgia (see more below). Each participant told me stories about their past lives to seemingly position what their lives were like in relation to their negative present (i.e., the time of the pandemic). They spoke about their involvement in clubs, community events, seeing friends and family regularly, going into the office for work, and travelling—all things that were minimized or completely taken away after the pandemic arose. Even the participants who were widowed—some within a year of the start of the pandemic—did not speak to the sorrows of widowhood, but rather recounted fond memories of their lives with their husbands. They all underscored the fulfilment they felt with their lives and their feelings of happiness pre-pandemic. Not surprisingly, all participants referenced a life before, characterized by greater stability and certainty.

Narratively, how participants recalled and/or retold their experiences depended, in part, on me, their audience, and their purpose for sharing their experiences:

> When testifying in court or supplying evidence to a police officer, people usually try to be as accurate as possible. However, when relating an anecdote to friends, people often focus on entertaining their audience rather than on accuracy. In this case, they may make the story more interesting by omitting certain details and exaggerating and embellishing others. The act of retelling is a creative, constructive process, and the final product depends on the perspective the reteller adopts (Dudukovic, Marsh & Tversky, 2004, p. 1)

In serving as participants' sole (initial) audience (as interviewer), I undoubtedly affected the way participants explained their pre-pandemic lives (Tversky & Marsh, 2000). As the researcher, I aimed to understand how participants experienced the pandemic as older adults who lived alone.

It is highly conceivable, and frankly human, that participants followed through in helping me understand their experiences by embellishing their stories to highlight how wonderful their lives were before the pandemic and how challenging their lives became during the pandemic.

Through this narrative performativity, they demonstrated their "capacity to execute an action, to carry something out actually and thoroughly, as well as to do according to prescribed ritual" (Berns, 2009, p. 1). In this sense, the older adults in this study were not merely recounting events, but actively engaging in action insofar as they were curating their own stories, which included selecting, interpreting, and presenting events in a particular way. Even so, they were not simply superficially describing their experiences, but rather delving into details and nuances of life before and after the pandemic by utilizing vivid descriptions, emotions, and reflections that aimed to convey the depth of their experiences. They did so, however, within the prescribed norms and expectations surrounding how stories are told and shared within a research setting. In other words, they likely felt compelled to conform to these expectations, while also drawing upon cultural and social norms related to storytelling. Embellishment and persuasion are accepted as fundamental features of narrative (Glover, 2003) and predictably,

> when talking about their lives, people lie sometimes, forget a lot, exaggerate, become confused, and get things wrong. Yet they are revealing truths. These truths don't reveal the past "as it actually was," aspiring to a standard of objectivity. They give us instead the truth of our experiences (Personal Narratives Group, 1989, p. 261, original emphasis).

Understanding that participants perhaps engaged in embellishment, Glover (2003), mentions that narratives are not necessarily about a capital T truth, but rather about speaking truth to experience. In other words, even if participants were embellishing, the point of collecting their stories was to understand how they felt and why they were embellishing. In this case, they

were doing so to underscore how significantly their lives were altered from better to worse, guided by feelings of nostalgia.

Nostalgia refers to a longing for stability and continuity during a time of transformation (Davis, 1979). Because the pandemic created an abrupt social change, in large part due to public health restrictions, (i.e., physical distancing, and disruptions in routines), feelings of nostalgia characterized participant narratives when recalling their lives before the pandemic. Intense social change, such as the pandemic, is accompanied by "the feelings of surprise and strangeness it induces in us, and this, too, is a form of discontinuity with which we must somehow cope" (Davis, 1979, p. 2). The nostalgic stories that participants recounted about life pre-pandemic captured more socializing, different forms of relationships (in person rather than online), and pre-pandemic leisure activities (i.e., in person social gathering). Some participants spoke of how often they travelled, how they worked a job and went into the office, how they spent time in person with their family and friends, and how they had consistent routines and schedules. For some participants, their nostalgia stemmed from their pre-pandemic leisure activities, including socializing with friends at restaurants, going to organized group activities (book clubs, swimming clubs, wine clubs etc.), to community centres, and simply having no restriction in doing what they enjoyed with other people face-to-face.

Emerging research supports the effectiveness of nostalgia as a coping strategy (Sedikides et al., 2008). Nostalgia is typically elicited by negative moods and loneliness and is mostly self-relevant as nostalgic narratives tend to reflect on and recall the positives of life (Sedikides et al., 2008). This fits into the stories of the participants in this study. When they re-counted their positive stories about life pre-pandemic, their voices resonated with a sense of warmth, clarity,

and optimism. Their positive emotional memories mediated the relationship between their resilience and their experience of positive emotions in the face of a difficult event, sadness, and stress (Philippe et al., 2009). By contrast, when they compared life pre-pandemic with their experiences during the pandemic, they painted a gloomy picture in which they were alone in a dark and cold house, with no contact with anyone—almost as if a rain cloud were right above them the whole time and the world was grey with no sunlight.

When engaging in nostalgic memories, people see themselves as protagonists, which in turn increases their self-esteem, boosts mood, fosters social connectedness, alleviates existential doom, and provides a sense of a more meaningful life (Sedikides et al., 2008; Feldman, 2022). Whether intentional or not, every participant seemed to recall a nostalgic time about life before the pandemic in what seemed to be an effective coping strategy. Coping is defined as the "thoughts and behaviors mobilized to manage internal and external stressful situations (Folkman & Moskowitz, 2004). It is a term used distinctively for conscious and voluntary mobilization of acts . . . which aim to reduce or tolerate stress (Venner, 1988)" (Algorani & Gupta, 2023, p. 1). Engaging in nostalgia served as a coping strategy for some participants as their thoughts and behaviours went back to a time when they felt safe and content, so they could manager their current stress of the pandemic.

Though nostalgia has its merits as a coping strategy, it can be misleading. As Millburn (2019, p. 3) pointed out, nostalgia only recalls "half-truths." Individuals who are nostalgic usually recall the positives about a certain point in their lives, without acknowledging the negative parts. In the context of this study, not one participant seemingly recounted a "bad" or "negative" story about their lives pre-pandemic. Instead, they focused on the good and expressed

how much they missed life before COVID. Nostalgia served as a narrative device for participants to perform and enhance positive stories about their past and to position it in relation to their negative present (the time of the pandemic). With this knowledge, I move forward with an exploration of life at the beginning of the pandemic.

The Horror of COVID-19

Back in March 2020, views of the film *Contagion* surged while people were stuck home because of public health restrictions (Scrivner et al., 2021). Though almost a decade old, the film became one of the most watched movies of 2020, likely because viewers could relate to its content and sought to make sense of the similarities and differences between the fictional narrative and their own real-life pandemic experience. Like the movie, fear and panic emerged as people responded to a novel virus that threatened their safety, wellbeing, and lives. Not surprisingly, then, the global chaos that occurred in *Contagion* mirrored, in some (but clearly not all) respects, the chaos that unfolded during the COVID-19 pandemic.

Horror, etymologically, stems from the Latin word *horrere*, which means to tremble or shudder (or, of hair, to stand on end). As Reyes (2016, p. 1) explained, "horror is normally used in fiction to refer to texts or narratives that aim to generate fear, shock, or disgust (or a combination of these), alongside associated emotional states such as dread or suspense." The horror of Covid-19 was embodied by the fear of spread of disease, concerns about never seeing loved ones again, difficulty accessing healthcare, exacerbation of economic recessions, disruption in "normal" life, and the overall fear of the unknown (Compton & Schulz-Hansen, 2023). From the literature, it is evident that these responses were collective, as the pandemic caused a change in people's personal, social, and economic lives. The pandemic brought forth

fears of financial uncertainty, social isolation, testing positive for COVID, and routine disruptions (Wyler et al., 1971; Heanoy et al., 2021). These fears created a strong demand for individuals to adjust to this sudden/new transition, thereby affecting participants' wellbeing negatively (Fitzpatrick & Harris, 2020; Tull et al., 2020; Shigemura et al., 2019).

Many of my participants referred to their pandemic experience as "horror." Olssion et al. (2007) noted that human fears arise socially, rather than through direct experience with an aversive incident, which reflected the experience of participants in this project insofar as their fear of the virus and the pandemic was driven significantly by the media and news sources. By and large, participants feared the unknown (Nummenma, 2021). The novel virus meant they had no sense of what would happen or its consequences. What participants did know at the time was that older adults were evidently the most susceptible to the virus, so they were the more likely to get sick. This realization translated into even greater fear.

The Beginning: A Fifth Domain of Fear

The beginning of the pandemic coincided with the beginning of the horror theme I described above. During this stage of the pandemic, participants learned older adults were most susceptible to the virus and at greatest risk of dying from this novel disease. Accordingly, participants' fear was not surprisingly higher than those who belonged to other age groups (Alsharawy et al., 2021). Even so, their fear did reflect the general sentiments people felt at the time. Based on their research during COVID-19, Schimmenti, Billieux, and Starcevic, (2020) identified four domains of pandemic fear: (1) fear of oneself or one's family members contracting the virus, (2) fear of economic instability and being unemployed, (3) fear of

avoidance behaviours toward gaining knowledge about the pandemic, and (4) fear of making decisions on showing or not showing actions (e.g., whether to visit other family members or not).

These domains capture the fear participants in this study felt during the pandemic. First, fear of oneself or one's family contracting the virus was voiced by all participants when they reflected on the start of the pandemic. Most participants expressed feelings of loneliness because they had to stay away from others to avoid getting sick themselves or spreading illness to their loved ones. Because older adults were most vulnerable to the virus, their fear was especially heightened. The fear of contracting the disease or getting others sick led to social isolation and loneliness (discussed below).

Second, fear of economic instability and unemployment was not as common for all participants as most participants were already retired. However, for those still working, COVID led to unstable income and reduced opportunities to secure a job. Among my participants, some closed their businesses, while others went from working full-time to not working at all. These changes were unexpected at this stage in their lives, thereby touching their lives significantly.

Third, participants avoided gaining knowledge about the pandemic, particularly toward the latter stage of COVID-19. Some participants felt a deep sense of pandemic fatigue and wanted to move on with their lives. Others avoided talking about the news altogether because perspectives differed so dramatically, especially politically. The misinformation, the differences of opinion, and the fear-driven narratives resulted in participants engaging in avoidance behaviours (i.e., no longer watching the news, reading the newspaper, or listening to the radio) to protect their mental health.

Finally, every participant in this research project grappled with the fear of deciding whether to reveal their actions or keep them concealed. They experienced a constant back-and-forth struggle regarding whether they should engage in face-to-face interactions with friends and family. They expressed emotional turmoil as they confronted this ethical dilemma. Each participant seemingly engaged in a virtuous battle, fighting with the emotionally and mentally draining task of determining the right course of action.

Alsharawy et al. (2021) found women experienced greater stress and fear of COVID-19, a finding consistent with the general literature that observed gender differences in behaviour during the pandemic. Though my research does not offer direct comparisons between men and women, Hosen et al. (2021) suggested men reacted to the pandemic differently from women insofar as they were more likely to display reckless behaviour toward government restrictions. Men were also less likely to wear masks and physically distance themselves and women, by contrast, tended to comply with government restrictions (Hosen et al., 2021). This behaviour was consistent with the participants in this study as their motivation to do so came from their awareness of the virus and its health consequences (i.e., experiencing illness, spreading illness, death), which generated fear of infection (Hosen et al., 2021). As Mary put it best, "I follow the rules because I'm a good girl, I do what I'm told."

Further, fear surfaced from the understanding that women, especially older women, were typically respected and seen as the head carers of their families, which led them to worry about not only themselves, but also their loved ones (Hosen et al., 2021). Many participants expressed feeling a certain type of responsibility for their family as they took their matriarchal role seriously. This underlying sense of "worry" came through all participants stories as they were less concerned about themselves and more concerned about those they loved. It was apparent

through their stories that they were respected as heads of their families. In some cases, their kids or other loved ones would encourage them to stay at home, physically distance, and essentially, as Eunice's son said, "take this shit seriously."

While my research did offer illustrations of Schimmenti, Billieux and Starcevic's (2020) domains of fear, it also introduced an additional fear: *fear of one another*. Participants' fear of others and others' fear of them was identified as a major theme in my participant interviews. For example, when going for a stroll in their neighborhoods, participants reported walking a distance apart, as if everyone they encountered was infected. Often, walkers would cross the street to avoid one another when happening upon others. Moreover, they would often avoid looking at one other. In short, the public health restriction associated with physical distancing made people behave as if everyone with whom they came into contact was automatically a carrier of the virus, thereby making everyone a suspected threat to participants and their loved ones. These behaviours created a universal narrative based on "vulnerability-to-harm," whereby being physically close to another human, presented a threat (Nardone and Portelli, 2005).

As these encounters demonstrated, participants engaged with each other in public space with what Goffman (1963) referred to as civil inattention, a normalized display of disinterestedness without dislike. Civil inattention gives "to another enough visual notice to demonstrate that one appreciates that the other is present . . . while at the next moment withdrawing one's attention" (Goffman, 1963, p. 84). Participants used their public space (neighbourhoods) to make their intentions to avoid social interaction and stay physically away from others clear, to remain unknown and avoid all meaningful interaction (Goffman, 1963, p. 112). Participants were co-present, meaning they were physically proximate (i.e., proximity), but socially distant (i.e., they would ignore others while aware of their presence). With the

pandemic, it seems that some people engaged in uncivil attention—they displayed self-interest with seeming contempt. Here, I refer to and contrast Glover's (2022) work in which he spoke to the longing for connection, familiarity, and security that drove people to interact with familiar strangers in their neighbourhoods. The familiar strangers in neighbourhoods provided a sense of familiarity, created geographic settings as "comfort zones" (Blokland & Nast, 2014, p. 1147), and contributed to a sense of security (Felder, 2020), and a thickening of thin neighbourhood ties (Glover et al., 2022).

Glover et al., referred to interactions, such as:

> When neighbors stop to talk with each other from across the street, they invite meaningful social interaction and create an opening to build a relationship, even if only superficially. They no longer see themselves as familiar strangers participating in random encounters. By noticing, acknowledging, and engaging with neighbors (i.e., neighboring), "feelings of solidarity, increases in emotional energy, creation of symbols, and feelings of morality all stem from [the] interaction" (Campos-Castillo & Hitlin, 2013, p. 170). Welcoming a neighborly interaction, even if only for a brief, but authentic, moment establishes a bond of mutual obligation, which opens the relationship up to future engagement and potential favors (Rosenblum, 2016) (Glover et al., 2022, p. 5).

Findings from this study differ from Glover et al.'s (2022). At the beginning stages of the pandemic and before the introduction of the vaccine, most participants in my research (as cited above) did not stop to talk to each other, but rather avoided each other on the street and seemed to be afraid of familiar strangers. It was the opposite of a "comfort zone" (Blokland & Nast, 2014, p. 1147) for them, as seeing or interacting with people was quite frightening, perhaps because my participants were older adults and at greater risk of infection and death. It was not until after second lockdown when vaccines were available that some neighbours would stop and talk to each other. Prior to the vaccines, however, participants did not connect or talk to neighbours or familiar strangers.

Doom seemed to represent the underlying feeling of participants at the beginning of the pandemic. Many older adults, including those in this study, worried about never seeing their friends, children, and grandchildren again. They witnessed their friends die alone, some without their spouses or family present (because of restrictions), and with no celebration of life afterward. The sentiment that "things will never be the same again" as Billie said, could not have been any truer than with older adults during the pandemic. Presumably, this sense of doom led older adults to either isolate further or seek out resilience strategies to make things better.

Location: Living Alone, Social isolation, and Loneliness

An important inclusion criterion for participants in this study was that they lived alone in either a house or an apartment before the pandemic and during it. From their stories, I gathered that their homes were their sanctuaries, safe spaces, and havens. In the literature, it has been found that when people are confronted with difficult scenarios, their homes are often described as a haven or refuge (Mallet, 2004). Home, for participants, was depicted as a space where they could retreat and relax (Moore, 1984). Throughout the literature, home relates to house, family, haven, self, and gender (Mallet, 2004). Though I recognize home does not mean the same thing to everyone (i.e., victims of domestic abuse, people living in poverty etc.), in this case, the private realm of the home was understood for participants as a space that offered security (Dovey, 1985) and rejuvenation (Allan & Crow, 1989). Home, for all participants, was a "warm and cozy place," as Eunice put it, where they could "lay their heads" (Mallet, 2004, p. 4). Based on the data I collected, I think it is fair to describe their homes as reflections of what participants enjoyed and who they were as people.

Time spent in their homes underscored the differences in being alone, living alone, being social isolated, and feeling lonely. To clarify, living alone meant "when you shut your front door, you are solely responsible for what happens within the walls of your home" (Hannah, 2020, p. 1); social isolation refers to the objective absence of social relationships upon which an individual can draw for meaningful support (Smith & Christakis, 2008); and loneliness is the subjective (i.e., perceived) absence of such relationships (Victor, Bowling & Scambler, 2009). Living alone, social isolation, and loneliness are separate constructs with overlapping qualities (Victor et al., 2000). Participants' stories of their pre-pandemic lives indicated no participant thought of him or herself as lonely while living alone before the pandemic.

Studies of the effects of living alone on older women have created inconsistent and sometimes contradictory results (Aday et al., 2006). While some researchers note negative effects on older women's health and wellbeing while living alone (socially isolation, depression, loneliness), others disagree and find no noteworthy differences in the rates of decline in wellbeing among women living alone and those living with a spouse (Michael et al., 2001). Regardless, women who live alone can be any combination of lonely and socially isolated (or neither). Andersson's (1986) quadruple typology shows individuals can be neither lonely nor isolated, isolated but not lonely, lonely but not isolated, and both lonely and isolated (1986). Although living alone can make a person socially isolated or feel lonely, it does not mean it will. Accordingly, even though people were asked to isolate at home during the pandemic, it did not mean they were socially isolated. Social isolation means a lack of meaningful relationships upon which a person can draw when needed. In this sense, isolation may be regarded as a restriction imposed on participants, whereas social isolation may be the objective presence of meaningful connections in one's life, whether they are physically present or not.

The literature suggests those who lived alone during the pandemic spent most of their time on their own due to unwanted withdrawal from society (Chernova et al., 2021). The lack of social contact caused (or reinforced) feelings of loneliness, social isolation, and mental health problems (Brooks et al., 2020). Participants felt these outcomes differently. Extraverts felt lonely due to unwanted withdrawal from society, while introverts expressed a lack of loneliness because they were comfortable in their own presence. For the participants in this study, social isolation was *not* a reality for any of them pre-pandemic but arose during the pandemic because of physical distancing and stay-at-home measures that led to social isolation and feelings of loneliness for some.

Women Who Live Alone

The participants in this study all identified as older adult women, had strong identities, and were confident in who they were. Some were mothers, some were grandmothers, some were employees, some were retirees, and all were resilient and independent women. Some let their natural salt and pepper hair grow long so they could "put it in a ponytail," as Jude mentioned, while others enjoyed the "monthly box dye or highlights from the salon," as Eunice put it. Being an older adult woman meant a greater acceptance of self, more wisdom, more experience, and greater resilience. Participants expressed an understanding and gratitude for the privilege of reaching older adulthood.

During the beginning and middle stages of the pandemic, "limiting mobility, restricting people to isolate at home (sometimes by themselves), and keeping them from seeing their family and friends in person [had] damaging health consequences, for meaningful social ties and the support they provide" (Holt-Lunstad et al., 2015; Glover, 2021, p. 4). As social interactions and

meaningful social ties were reduced for some women in this study, either feelings of loneliness or social isolation (or both) were heightened. The current literature posits that stronger increases in loneliness were associated with more COVID-19 related worries, lack of social connections (Lee et al., 2020), and female gender (Ausín et al., 2021). As Rodney (2021), Lee (2020) and Goveas (2021) found, older women faced more disruptions in social connections during the pandemic and expressed more feelings of loneliness and social isolation.

Older women tend to report frequent and greater perceived social isolation, as they rely greatly on their social connections (Baumeister et al., 2010). For many of the participants, because of this reliance on social connections, they were negatively affected by being less socially connected (Shukla et al., 2020). Some of them felt a loss of community around them as they were not seeing people as often; some had worsened mental health as their routines of seeing friends and family was disrupted; and some felt lonely due to a decrease in social connections. As demonstrated in my research, routines, adjustment, and energy were diminished during the pandemic which mirrors the grand narrative in the literature that women were negatively impacted by social isolation during the pandemic (Baumeister et a., 2020).

It is unfair to generalize and suggest all older women felt lonely or were more susceptible to being socially isolated during the pandemic. The causes of loneliness were multifaceted and therefore hard to isolate (Lim, Eres & Vasan, 2020). And every individual was equally at risk (Cacioppo et al., 2015; Holt-Lunstad and Smith, 2016). What made each participant in my study feel lonely was unique to them. For one participant, the lack of dating made her feel lonely. For others, it was not seeing their children, not volunteering, or not being able to attend a club to which they belonged. The lack of face-to-face interactions affected participants. Interestingly,

Goveas et al. (2021) found that older women expressed increased feelings of loneliness during COVID-19 as a result of exposure to multiple life stressors (particularly death of a spouse) during the past year and social connection disturbances. These findings mirror the experiences reported by my research participants. In this study, however, participants also introduced struggles with dating during the pandemic (not being able to physically meet up and be intimate) and differences of opinion on the vaccine (is COVID a hoax? Is the vaccine safe?).

Positive Solitude

Being alone is not necessarily a bad thing; it can be quite liberating, recharging, and central to wellbeing. Though all participants in this research lived alone during the pandemic, *not all of them felt lonely*. From no longer being able to volunteer, to social clubs shutting down, to transitioning to working from home, to being unable to engage with friends and family in person, all participants seemingly experienced social isolation. However, not all participants expressed feelings of loneliness when they were alone. They were just in *solitude*. I refer to this time alone as *positive solitude* because there were benefits to the experience (Koch, 1994). This concept of being alone, but not lonely raises an important distinction between loneliness and solitude. In Long and Averill's (2003, p. 2) words:

> we distinguish "solitude" from "loneliness" and restrict discussion to the former. This restriction is in keeping with the way many people conceive of solitude, emphasizing benefits of time alone. In contrast to solitude, loneliness is generally seen as a negative emotional state which most people seek to avoid; it indicates deficiencies in the number or extent of one's social relationships.

Introverted participants in this study enjoyed being alone and did not feel lonely in their own company. They valued their *solitude*. Solitude means that individuals, even when alone, engage in an internal dialogue that involves an interaction between the individual and his or her own

thoughts and feelings which are shaped by social influences, interactions, and experiences with others (Long & Averill, 2003). Eunice, for example, reflected during her solitude and felt that if "you're not comfortable being alone, I would . . . go inward and find out why you don't want to be alone . . . why don't you like talking to yourself?"

When spending time in their cozy homes surrounded by peace and quiet, some participants viewed their solitude during the stay-at-home orders as a positive experience. Spending lockdowns wrapped in fuzzy blankets, snuggled with their dog or cat, sipping on chamomile tea, or curled up on the couch watching Netflix, were some of the ways the introverts spent their time in solitude. In this regard, the mental experience of solitude was just as important as social connections for these participants. They were free from expectations, roles, and responsibilities as it was just" me, myself, and I." Solitude can "minimize such intrusive self-consciousness by reducing the immediate demands of experiencing ourselves as the object of another person's thoughts and actions" (Long & Averill, 2003, p. 2).

If people need social connection, social support, affiliation, and attachment, why do some seek to spend time in solitude whereas others do not? For some participants, mostly the extraverts, being around people was essential for their wellbeing and emotional state. Being alone for too long was not for them. Instead, they got "energy from being around people" (Sally), and that was important to them. By contrast, other participants enjoyed their solitude and needed it to "recharge." The difference ultimately reflected participants' affinity toward introversion or extraversion.

A Disruption in Routines and Letting Go

After the initial fear of the pandemic died down and participants settled into a "new normal" of staying home and avoiding physical contact, participants began to "let go." At this point in the pandemic, participants relinquished their normal routines and their behaviour changed. They surrendered their sleep routines, consumed more unhealthy foods, became more sedentary, and remained less social. These behaviour changes were not surprising, given the disruption that characterized the pandemic. Consistent with the literature, pandemics "are associated with a score of . . . psychosocial stressors, including health threats to oneself and loved ones. There may be severe disruptions of routines, separation from family and friends, shortages of food and medicine, wage loss, social isolation due to quarantine or other social distancing programs, and school closure" (Taylor, 2019, p. 5). Given such disruption, participant behaviour in this study was relatively predictable.

Sweatpants for the fourth day in a row, sitting on the couch all day, and a bag of ketchup chips for dinner was not unusual for some participants during the height of the pandemic. The reason they engaged in these behaviours was because the significance of their behaviours simply did *not matter to them*. There were seemingly no consequences to not making their beds. No guests were coming over, so no one would notice. It did not matter if they put on extra weight by consuming unhealthy foods and alcohol because they were not going to see anyone in-person whom they wanted to impress and so they did not need to worry about being judged. And it did not matter if they stayed up until 2 am and slept in until noon because they had no obligation to be up the next day, for anyone or anything. Interestingly, according to participants, it was *not* liberating to have no routine, watch TV endlessly, or have poor sleep hygiene. They had too

much freedom and too few consequences, which made for a vicious cycle that resulted from letting go.

Stories of participant experiences mirrored the existing literature. The findings in this study parallel Michael, Colditz, Coakley, and Kawachi (2000) who surveyed older adult women and measured health behaviours (smoking, alcohol consumption, exercise, and body mass index), social network characteristics (sociability, membership in groups), and self-reported physical functioning. The results found that a woman's social network and support positively correlated with physical health (Michael et al., 2000). My findings suggest that, during the height of pandemic restrictions, women separated from their social networks experienced negative health outcomes. These findings are consistent with the literature which indicates prolonged social isolation can adversely affect both physical and mental health by disrupting sleep patterns, healthy nutritional patterns, promoting obesity, and physical activity (Cacippo & Hawkley, 2003; Hammig, 2019; Christakis & Fowler, 2007).

Interestingly, narrative analysis is instructive here insofar as participants' stories reveal participants' behaviour evolved over the course of the pandemic from an initial reliance on maladaptive coping behaviours to adaptive coping behaviours. Once guidelines were modified, vaccine passports introduced, and people could gather again, participants began "to feel alive" again.

Social relationships strengthen an individual's feelings of self-worth and mastery (Antonucci, 2001) and "assist in the attainment of health-related goals (VonDras & Madey, 2004) or serve as agents of social control to promote healthy lifestyles and discourage unhealthy behaviors" (Tucker, Klein, & Elliott, 2004; Cherry et al., 2013, p. 2). Given the importance of

social relationships, the fact that they were scarce or taken away completely during the pandemic meant that psychological disorders such as depression (Rogers et al., 2020) did arise among some participants. As Seifert and Hassler (2020) found, older adult women who reported greater loneliness during the pandemic were those who lived alone, had little to no social contact, and experienced changes to daily routines. These findings are consistent with the participant pool in this study as participants all lived alone, all experienced limited physical social contact, and a huge disruption in their daily routines, which for some of them, caused them to "let go" of their healthy habits.

Bereavement

Perhaps one of the most difficult topics that arose for some participants during the interview process was the topic of bereavement. Though the world was focused on the pandemic, people still died, and people still grieved. Pietrbassa and Simpson (2020, p. 1) described death and dying during the pandemic powerfully when they mentioned

> we are forced to deal with death in ways unrelated to human civilization: from the thought of not being able to be with the deceased in his/her last moments of life, to the sense of guilt for the idea of having inadvertently infected the person, to the distress of not being able to properly honor him/her with a funeral ceremony, fundamental to the process of mourning – these are all factors that amplify the pain of death, increase the rates of depression, the consumption of alcohol, drugs and risky behaviors and, in the more extreme cases of suicide.

Not only did people die alone during the pandemic (Macleod et al., 2021), but people grieved alone as well, including participants in this study.

For participants such as Lana, they could not support loved ones in-person, which led to challenging personal circumstances that weighed heavily on their emotions. Lana was restricted to dropping off her mother alone at chemotherapy appointments and was not allowed to

accompany her. For her, it was not just about others being there for her, but it was also about her being there for others, especially her mom. When providing this support was taken away from her, it created unsettling feelings. She felt she was not being a "good daughter" and experienced significant guilt and sadness. Consistent with MacLeod et al. (2021), the reality was highlighted in this research as well: people got sick alone, went to medical appointments alone, and unfortunately, died alone. A lot of people had to go through during the pandemic grieving alone. Both bereavement literature and pandemic literature have also reported that experiencing bereavement was related to higher levels of loneliness during the COVID-19 lockdown (Seifert & Hassler, 2020; MacLeod et al., 2021), which was evident in my participants, too.

Character Development: Extraverts and Introverts

Participants' stories diverged for extraverts and introverts. These labels were often assigned by the participants themselves. Extraverts get their energy from involvement in events, get excited around other people, and understand problems better when they can talk out loud about them and communicate with others (Martin, 1997). Introverts, by contrast, get their energy from dealing with ideas, pictures, and memories inside their head, enjoy doing things alone, and taking the time to reflect and re-energize in solitude (Martin, 1997). The extraversion-introversion element is "central to leading trait theories of human personality in psychology" (Wei 2020, p. 1). Existing literature shows that individuals' personality traits (e.g., extraversion and introversion) are associated with how they assess situations like the pandemic in terms of mental health (Nikčević et al., 2020), utilize coping responses (Volk et al., 2020), and impact the strength of adaptation processes (Bliese et al., 2017), which was evident in this research project, too. A current "lack of knowledge on the role of personality traits as predictors of both individual

differences and changes over time in people's appraisals of the COVID-19 pandemic" (Zacher & Rudolph, 2021, p. 1) exists. For this study, the personality trait of extraversion and introversion seemingly had implications for adaptation processes, coping, and resilience strategies.

Extraverts

Extraverts deeply craved being in the physical presence of their loved ones. As a result, they initially struggled with the government mandates (stay-at-home order, in particular), as they desired face-to-face contact with others (Chernova et al., 2021). Personality traits like extraversion are likely to have an influence on coping and resilience strategies in terms of adaptability (i.e., social connections being taken away due to government mandates) and makes them more likely to engage in active coping strategies that involve seeking distraction from stressors and taking action (Panaitescu, 2018). Extraversion is usually associated with active and social ways of dealing with stressful situations (Costa, 1996), which was evident in this study as the extraverted participants expressed that they relied heavily on face-to-face social connections and leaving the house to recharge and gain energy. Whenever they experienced a hard time, they would take action (cope) by meeting up with a friend or going to a bar with friends to talk it out and be in the physical company of others. During the start of the pandemic, however, they could not do so, and that meant they had to shift their coping and resilience strategies.

Extroverts' sociability and outgoing nature seemed to facilitate resilience by enabling them to engage with their strong social networks and meaningful connections and draw upon those sources of support during this challenging time. The extraverted participants viewed the public health restrictions (i.e., physical distancing and stay-at-home orders) as more threatening to their subjective wellbeing (Folk et al., 2020). Physical distancing was particularly hard on

extraverts in this study as it hindered them from satisfying their social engagement needs (Woodcock et al., 2013), thereby making the pandemic much more challenging for them.

The literature recognizes extraverted adults experienced a harder time during the pandemic (Wijngaards, de Zilwa & Burger, 2020; Zacher & Rudolph, 2021). As social connectedness is especially important for the wellbeing of extraverts (Lee, Dean & Jung, 2008), the unwanted social isolation that the extraverts experienced caused "social pain" (Lauresen & Hartl, 2013), which led to feelings of loneliness, sadness, and depression. Extraverts in this study used words that mirrored this language of "social pain," including "lonely," "disconcerting," "sad," "segregated," "alone," and "stuck." These descriptors emerged because participants were physically unable to see people and engage in their regular social routines.

The findings in this study are consistent with themes found much of the literature, though there are studies that offer different results. In a Spanish study, Morales-Vives et al. (2020) found that being extroverted was associated with an *improved* ability of adaptation to government-imposed lockdowns during COVID-19. They found extraverts adapted *better* to lockdown because of a positive relationship between extraversion and resilience, which helped extraverts adapt to the challenges the lockdown presented (Morales-Vives et al., 2020). Resilience associated with extraversion, moreover, resulted in less mental health distress and loneliness during the pandemic (Haddadi & Besharat, 2010; Jakobsen et al., 2020). These findings contrast with my results. Though the extraverts exercised resilience in this study, they clearly adapted worse than the introverts, at least initially, to lockdowns and stay-at-home orders. I note that some of the studies I have cited focus on the full length of the pandemic as opposed to the height of it, which could explain why they thought extraverts, in the long run, did better.

It is fair to say that over the course of the pandemic, especially "after the second lockdown when we knew what to expect," as Mary put it, extraverts and introverts ultimately both adapted well. Extraverts Sally, Mary, Constance, and Misty all alluded to stay-at-home orders being a bit easier once the second lockdown hit—easier in the sense that they knew "how to pass the time, [whereas] the first time it was like, god, when is this going to end?" (Sally). By the second lockdown it seemed that extraverts (although still experiencing bouts of loneliness), eventually adapted to "the new pandemic life," as Constance put it. This new pandemic life included going for more walks, video-calling loved ones, gathering with people in "bubbles," and having hope. Hope was fueled by the promise of the vaccine, which signaled an eventual end to the pandemic. In the end, the conspiracy theorists had the most difficult time because they lost their social connections and experienced social isolation even after stay-at-home orders were lifted.

Introverts

Eight of the participants felt their introversion helped alleviate most of their feelings of loneliness and sadness. Though they felt the pandemic was hard on them in terms of face-to-face social connections (not being able to see their family and friends), they thought their introverted nature served as a form of protection from feeling lonely. They all felt that, as introverts, they were "good friends with themselves," as Elsa put it, and were comfortable in their own company. With the pandemic being an obvious time of stress, introverts in this study seemingly focused on the internal world of their own thoughts and perceptions and remained comfortable in their own presence (Myers & Myers, 1980).

The introverts in this study still needed human contact and connection in their lives, just not often as the extroverts. Introverts do require social connection, just minimally (Afshar et al., 2015). Humans are wired to desire and seek face-to-face contact, which has a positive long-term impact on health (Pinker, 2014). Though some participants, like Moira, claimed they "didn't need to see another face," the reduction in in-person connection isolated participants and worsened their mental health, especially during the beginning and middle stages of the pandemic. Even Moira, who felt she could survive with only a "phone call once in a while," offered insights from her story that suggested she needed face-to-face relations in her life. I suspect because extraverts have an easier time reaching out to others for social connection and support (Milek et al., 2018), that leaves introverts like Moira at risk for social isolation. Perhaps if she had more face-to-face interactions, maybe she would not have been so inclined to "withdraw" or have found it so "difficult to get up to do things."

Ultimately, introverts struggled much less with the lockdowns, stay-at-home orders, and physical distancing guidelines. Though they were saddened by their lack of face-to-face social connections, unlike the extraverts, they felt satisfied with online social connections. People were accessible to them through virtual means. In this sense, the pandemic was not perceived as a burden. Online connections were enough. Harbaugh (2010) discussed how introverts enjoy online platforms as they find it easier to express themselves online. Introverts sometimes prefer online interactions (i.e., video calls) because they a need to monitor the amount of social interaction to which they subject themselves, and online (unlike face-to-face interactions) is where they can limit these social interactions (Harbaugh, 2010; Baxter, 2010).

Our culture focuses on togetherness, so introversion can sometimes be viewed as a character flaw that limits one's ability to participate and perform productively in a competitive society (Dossey, 2016). This research project, however, suggests introversion was an asset in coping with restrictions during the pandemic. Even so, some introverts reached a point where their solitude had negative impacts. Some participants (and people in general) likely hid behind labelling themselves as introverted to mask their socially anxiety, agoraphobia, or depression. Burruss and Kaenzig (1999) highlighted problems associated with introversion, including having no friends, spending all of one's time alone, and behaving in unhealthy ways (sleeps much more or less, physical distress, withdrawal, etc.). Moira experienced these problems in full.

When Moira and I first started talking about the pandemic, she was calm and lighthearted. She laughed and said she was unaffected by the lockdowns as she "loved being alone." She described herself as "an introvert." But as we talked more, her tone changed. She mentioned she was sleeping a lot more and had lost a great deal of weight. Eventually, she told me she had lost her husband just before the pandemic, had to shut her business down (a café) because it was unable to stay open, and because she was unable to leave the house due to her intense fear of getting sick, her hoarding problem worsened, so much so that her neighbours called the city on her. Her problems had less to do with introversion than with mental health issues. In labeling herself an introvert, Moira seemingly aimed, perhaps unconsciously, to avoid the deeper issues of what was going on in her life. Staying at home and being alone without the physical connection of anyone else was detrimental to Moira's health as she had no responsibility or obligation to see anyone or do anything. Moira appeared to be depressed.

Though introversion can serve as a protective factor against loneliness, it can also contribute to social isolation and loneliness. While introversion can "facilitate emotional self-regulation, such habits can also function as a double-edged sword in perpetuating internalization (Bowker & Rubin, 2009), rumination (Cohen & Ferrari, 2010), and worry (Philippi & Koenigs, 2014), key cognitive underpinnings of loneliness, depression, and anxiety" (Beck, 2008; Wei, 2020, p. 5). It appears a few of the introverts in this study became too comfortable with being alone. Being alone for too long can temporarily or permanently sever social ties, which can become harmful if you are used to being alone and are unable to reconnect (Marano, 2008). For some participants, it seemed as if solitude had slowly morphed into loneliness (Marano, 2008), and they were not consciously aware of it.

Through my conversation with Moira, I worked out that this unidentifiable feeling she expressed was likely loneliness. Her introversion, though protection from loneliness, contributed to her social isolation. Holt-Lunstad (2022) makes the case that social isolation is detrimental to health. We tend to focus on the detrimental effects of loneliness because perceptions matter, but isolation, even if people do not feel lonely, can impact their health negatively (Holt-Lunstad, 2022), as evident in Moira's case. She did not feel lonely, *per se*, but her social isolation was harmful to her health, without her even realizing it.

Resolution or Complication? Vaccinated vs. Unvaccinated

The topic of the vaccine emerged in every conversation I had with participants. For those participants who rejected the vaccine, COVID-19 was a dark and trying time for them. A handful of participants were not only unvaccinated against COVID-19, but they did not believe in the vaccine, nor all the so-called "hype" about the pandemic. They felt shunned, socially

disconnected, socially isolated, and stigmatized because of their views. Stigma involves an unwarranted or groundless negative attribution to a group of people (Kampf, 2021). Many people across the world experienced stigma because they refused to get vaccinated against COVID-19 (Troiano, G. & Nardi, 2021). Their decision not to do so conflicted with vaccine promotional efforts by public health authorities. To encourage vaccination, many governments had policies against unvaccinated individuals that included moralistic rhetoric (Jørgensen, Bor & Petersen, 2021). "Framing" was applied to the vaccine to "govern the subjective meaning we assign to social events" (Goffman, 1974, p. 10-11), namely the pandemic and the need to get the vaccine. Vaccine uptake was framed to the public as something every member of society should do, and needed to do, to play their part (Korn et al., 2020). Framing in this context was about the public attitudes and meaning (Druckman, 2011) the vaccine held (i.e., the unvaccinated did not play their part so they should be viewed as outcasts). As framing can also be a "weapon" (Weiss, 1989), the social stigma that was framed affected the unvaccinated.

What unvaccinated participants in this study experienced, however, amounted to more than just stigma. They were subjected to *moral condemnation* (Kampf, 2021). That is, unvaccinated participants felt they were morally condemned by the vaccinated population for violating a "social contract," whereby everyone in society was expected to vaccinate themselves as their civic duty (Druckman, 2011; Korn et al., 2020). Those who did not fulfill this duty were treated as social outcasts, which meant their social relationships "diminished and grew sour." Zoe, for example, talked about losing her "bridge pals" whom she had known for years. She spoke of being "made fun of, laughed at, and verbally assaulted." The response left her friendless. Unvaccinated participants felt the vaccinated population held them morally responsible for the rise in hospitalizations, stress on resources, and the unnecessary prolongation

of the pandemic. Not only were they accused of harming themselves through selfish behaviour, but they were deemed irresponsible for harming those around them (Kampf, 2021). This treatment led participants to feel unfairly discriminated against (Henkell et al., 2022) and peer pressured (Rosenfeld & Tomiyama, 2022) into getting the vaccine.

Moralization refers to "the process through which preferences are converted into values" (Rozin, 1999, p. 218), and condemnation is defined as a "key element of moralized conviction and, in part, distinguishes those convictions from conventional preferences, people experience outrage when their moralized principles are breached" (Bor et al., 2023, p. 2; Fiske & Tetlock, 1997). The act of condemnation reprimands people through "stigmatization that signals to the target and other audience members that the punisher lowered their valuation of the target and is therefore less likely to act prosocially towards them in the future" (Sznycer et al., 2016, 3). Unvaccinated participants in this study felt targeted by moral condemnation as those who refused the vaccine did not wear a mask and did not adhere to public health restrictions (Johnson et al., 2020).

Unvaccinated participants expressed a sense of alienation regarding the moral condemnation they experienced and a sense of loss because their relationships with family and friends dissolved. They shared stories of being banned from social groups and labelled "conspiracy theorists" because of their choice to not get vaccinated and their controversial views on the vaccine. The social impact of these choices on participants moved me emotionally because their responses reflected the hurt, they felt in losing friendships and fracturing kinships, which impacted upon their wellbeing. More than half of the unvaccinated participants cried when they told me their stories. Not a soft cry. A cry of emotional pain. A cry that made me, as a

listener, feel a lump in my throat and hold back tears myself. Zoe bawled uncontrollably and needed to take numerous breaks from telling her story. She would pause for a breath, sniffle, and choke back tears as she recalled losing the respect of both of her daughters because of her choice not to get the vaccine. The people Zoe and others thought they could trust and with whom they believed they could be vulnerable seemingly turned on them and made them feel "shut down" and "crushed."

To be sure, a significant social divide in society arose based on vaccination status (Bhattacharya, Banerjee & Rao, 2020). Some participants felt the unvaccinated were treated unfairly (e.g., proof of vaccine was required to go to a restaurant or gym), while others thought it was irresponsible of people not to be vaccinated to protect others (Jung & Son, 2023). Regardless of subjective thoughts and feelings, vaccination status contributed significantly to the loneliness and social isolation unvaccinated participants experienced.

Though the vaccine played a critical role in reducing the spread of COVID-19 (Dyer, 2021), widespread vaccine usage led to the loosening of public health restrictions, which seemingly decreased the conditions for social isolation and loneliness to prevail (Williams et al., 2020). Vaccinated participants all breathed a sigh of relief when they received their first dose of the vaccine. They felt less lonely because they could resume in person social connections. Vaccination allowed them to be more socially engaged. To be sure, the literature provides evidence that the COVID-19 vaccination improved mental health (Koltai et al., 2021) caused by the risk of infection or depression from social isolation (Lee, 2022). Similarly, Lee (2022) found receiving the vaccine led to a reduction in stress and depression among individuals. These findings were reflected in my own research.

However, even though vaccination led to more social interaction and therefore alleviated loneliness, it was not necessarily easy to resume the same social routines in which participants engaged pre-pandemic. Participants said they still felt nervous to go out because it had been so long since they had last done so. Fear of getting sick remained. Eventually, despite their anxiety, participants made the decision to act and followed through by meeting up with friends and/or family in-person. For those who engaged in social interaction, spending time with others, face-to-face, was perceived as fulfilling, but it did make some realize they no longer had any desire to travel or attend big gatherings. Most participants had no trouble renewing their relationships, but it did take some time for them to get fully comfortable with others as the fear factor of other people as carriers of COVID was hard to fully extinguish (Hatun et al., 2020).

The COVID-19 vaccine reduced the risk of illness, which led to a reduction in public health efforts at physical distancing and increased social connection among the populace. As Lee (2022, p. 3) surmised: "enforced social distance and other public health measures during the COVID-19 pandemic intended to prevent the spread of the coronavirus pose unintended challenge to be socially isolated for people. However, vaccine can provide social connection which can improve mental health." Vaccination decreased loneliness and social isolation, a finding consistent, by and large, with the results in this study.

Conspiracy Theories and Conspiracy Thinking

Those who made the choice to refuse the COVID-19 vaccine were thrust into a situation in which they felt they had to consider with whom they could share their vaccination status to avoid feeling shunned or being "othered" (as the unvaccinated population). For other participants, the pandemic was about unearthing the "truth." These participants felt lied to by

public health authorities and government officials and sought to expose perceived conspiracies to make clear the vaccine was unnecessary. To them, the pandemic was blown out of proportion. And for other participants, the pandemic was about taking it one day at a time and not "making a big fuss." Their mentality was that they had already been through so many experiences in their lives, as older adults, that the pandemic was just another experience. It would pass.

Unvaccinated participants in this study all shared a common understanding that the narrative promoted by the prime minister and public health officials was dishonest, and the vaccine was unnecessary. For them, this understanding was amplified by social media and the internet. However, conspiracies tend to remain within the echo chamber of existing communities rather than spreading broadly through social media channels (DeWitt et al., 2018). The internet plays a pivotal role in fostering polarized online communities (Bessi et al, 2015), to be sure, but this polarization complicates rational and civil communication between groups, thereby leading to increasingly negative sentiments within and between communities (Zollo et al, 2015). Consistent with the homophily principle, it was clear that conspiracy thinkers found similar others—conspiracy thinkers. Like-minded people tend to interact with one another in social groups, which can lead to the formation of online communities that discuss matters in which they all believe and with which they agree (Khanam et al., 2020). Finding liked minded thinkers caused misinformation to be spread by unregulated sources. Social media posts and conspiracy-oriented internet sites caused fear, confusion, and anger among individuals (Van Bavel et al., 2020) by fueling belief in COVID-19 conspiracies (Romer & Jamieson, 2020) and peddling misinformation (Allington et al., 2020). The pandemic was the perfect time for all these conspiracy theories, as these "theories" tend to proliferate during periods of uncertainty (Gu et

al., 2021; Kuzelewska & Tomaszuk, 2022). Unvaccinated participants could easily be labelled conspiracy theorists because of their conspiratorial views.

A conspiracy theory refers to "a proposed explanation of events that cites as a primary causal factor a small group of persons (the conspirators) acting in secret for their benefit, against the common good" (Uscinski et al., 2016. p. 2). A few participants in this study subscribed to the conspiracy theory that the vaccine was a global plot to control the population. Vaccine hesitancy or "anti-vax" was highly supported by the spread of misinformation through social media during the pandemic (Alterri et al., 2021):

> the COVID-19 pandemic was time of significant rise of believers in the anti-vaccination theory. For example, since the COVID-19 pandemic has been announced, the number of followers of profiles related to anti-vaccination movement (Australian Government, 2020) on Instagram grew by 1 million, which gave the total number of 7.3 million followers. The same happened on Facebook, where the number of followers of anti-vaccine groups and fan pages grew by nearly one million followers, which led to the total amount of 29 million followers and YouTube—growth by 5.8 million to the total number of 21.3 million followers (Center for Countering Digital Hate, 2020; Kuzelewska & Tomaszuk, 2022, p. 7).

Some participants, such as Jude, did not view themselves as "anti-vaxxers," yet held "anti-science" beliefs and a distrust of other vaccines and medicine in general. Individuals are more likely to accept information confirming what they already believe and reject information contradicting it (Flynn et al., 2017). Moreover, their "theory" gains leverage through its enmeshment with pre-existing conspiracies (Sobo & Draziewicz, 2021). This effect is known as motivated reasoning, whereby people acquire new information that remains consistent with their pre-existing attitudes and social identities (Kunda, 1990).

The central difference between the vaccinated and unvaccinated participants was that the latter were more inclined to *conspiracy thinking* (Uscinski et al., 2016). Conspiracy thinking is the predisposition to construe relevant events as the product of malicious conspiracies (Cassese

et al., 2020), which has been found to condition the tolerance of conspiratorial information (Uscinski et al., 2016). This kind of thinking was voiced by some of my participants. The conspiracy minded participants seemingly went looking for conspiracies because they *were presumably interested in such theories and, I suspect, predisposed to consuming any alternative to the official narrative* (Chen et al., 2021). Some of the unvaccinated participants spoke of receiving their information about the vaccine on Facebook, podcasts, and through groups to which other fellow unvaccinated peers belonged. As they became informed about the conspiracies, they began actively seeking out this content online (Bessi et al., 2015) and welcomed reinforcing conspiratorial information (Enders, et al., 2023). This behaviour reflected a much different approach from non-conspiracy-minded participants.

The environment of being isolated at home, I suspect, exacerbated conspiracy thinking. In a time of fear, people have an epistemic need to know the truth and an existential need to feel safe. If they feel like they do not know the truth and/or feel unsafe, conspiracy theories become alluring (Douglas et al., 2017). The participants who fell under the category of "conspiracy minded" spent their time alone at home during lockdown or quarantine and seemingly fell into a blackhole of different theories and conspiracies that exposed "what was really happening," as Jude put it. Feeling like they were unsafe and being lied to, they spent their time "searching for answers to the threats about which they have read or about which they have seen reports on television" (Freckelton, 2020, p. 2). Fear, anxiety, and paranoia were heightened during the pandemic, which led to irrational responses (Freckelton, 2020). This emotional and psychological state was evident through interviews with "conspiracy minded" participants, as they cried more, went on long tangents, kept insisting (to either themselves or me) that they "weren't crazy." Conspiracy theories can spread (Uscinski & Enders, 2020) and consume

vulnerable people, including older adults living alone during a pandemic (Freckelton, 2020). The conspiracy theorists then become obsessed with misinformation insofar as exposure to conspiracies slowly converts into belief and action (Collins, 2020).

Being labelled a "conspiracy theorist" by others was arguably an effort to dismiss anti-vax perspectives and opinions as illegitimate. Generally speaking, though, people refused the vaccine for a variety of reasons, including for individual (e.g., religious beliefs, personal health beliefs, fear of side effects, bodily autonomy), interpersonal (e.g., bad side effects), and structural (e.g., feeling forced by the government, mistrust of science, skepticism of how fast the vaccine rolled out) reasons (Brody et al., 2023). In this study, the four unvaccinated participants did so for structural and individual reasons.

At 80 years of age, Zoe did not welcome the government mandates, nor did she respond well to someone telling her "what to do." She resented the government for "forcing" her to get the vaccine because, in her view, the government wanted "50% of the world's population gone as quick as they can." Like many other unvaccinated individuals, Zoe refused the vaccine because she was a believer that the government was profiting financially from its systemic distribution (Offit, 2015; Brody et al., 2023). Meanwhile, Madison refused the vaccine because she was uncertain about its "long-term effects" and did not believe the "clinical trials were accurate," similar to others who were vaccine hesitant (Sallam et al., 2021).

Madison's perspective was driven by her belief that the "data is faked, and harmful side effects of vaccines are hidden from the public to ensure that pharmaceutical industries and governments are able to make money" (Jolley & Douglas, 2019, p. 459). Jude, however, refused the vaccine due to personal reasons. She believed in bodily autonomy, so she felt it was "my

choice. It's my body. I don't want it," (Brody et al., 2023). Similarly, Lana refused the vaccine for personal reasons, albeit because she believed vaccines caused more harm than good (Offit, 2015; Santos, 2019). She was told "by homeopaths, naturopaths that all my allergies were probably due to vaccines," which reflected her belief in an assortment of speculative "vaccine-injuries" (Santos, 2019). In short, these four participants engaged in conspiracy thinking, which ultimately had consequences for their ability to connect with others.

Unvaccinated participants in this study experienced social pain and suffering because of their decisions. They felt judged, shamed, and exiled by others. More than physically isolated by public health restrictions, their choices left them socially isolated because of their radical beliefs. A viral survey conducted by One Poll (2021) found that 1 out of 7 respondents lost a friendship over vaccination status during the pandemic. All told, the social consequences of choosing not to vaccinate were severe.

Losing friendships because of conspiracy thinking was particularly tragic for participants in this study because of their advanced age. Any time taken away from traveling to see their loved ones or spending time with their friends meant they had less time to connect meaningfully with people about whom they cared in the relatively little time they had left in life. For this reason, unvaccinated participants were particularly upset about the introduction and enforcement of vaccination passports. Because of these restrictions, the data suggest unvaccinated participants were, not surprisingly, more socially isolated than those who were vaccinated (Ukai & Tabuchi, 2023).

Tend and Befriend During COVID

Friendship arose as a strong theme in this study. Some participants relied heavily on their friendships, while others saw their friendships weaken or disappear completely. During times of crisis (i.e., a global pandemic), women tend to become closer with their friends due to exchanges of social support (Doherty, 2021). Women also place higher value on their friendships than men do (Cross & Madison, 1997), evidently because friendship is more about intimacy, self-disclosure, and emotional support (Reis, 1998).

Literature surrounding friendship shows that humans need a sense of social belonging and emotional support from others (Baumeister & Leary, 1995; Juvonen et al., 2021), especially friendships. And for good reason: a large body of literature speaks to the positive benefits of friendship, which include social support, increased life satisfaction, and stronger wellbeing (Amati et al., 2018). Friendships, unlike family relations, are voluntary, though, so they require mutual effort to continue or else they can wither (Wiseman, 1986). Not surprisingly, then, the lack of face-to-face connecting and imposition of physical distancing did not help matters. Even so, participants in this study did their best to maintain their friendships as a strategy for resilience during the pandemic.

When women face challenging situations such as a global pandemic, they often engage in a gendered practice referred to as "tend and befriend" (Taylor, 2011), a concept that fits the findings in this study. "Befriending" involves the creation and maintenance of social networks, while "tending" refers to the social support made available to friends when needed (Taylor, 2011). Klein and Corwin (2002, p. 444) explained that "tending and befriending promotes safety and diminishes distress by creating and maintaining social networks." Though it typically

involves women relying on other women, women in this study also relied on their male friendships, including "friends with benefits" and relationships with neighbours. Friends with benefits blend friendship with physical intimacy outside of a committed romantic relationship (Owen & Fincham, 2010), making them another type of leisure friendship about which Iwasaki and Mannell's (2000) model of leisure coping fails to identify.

Seventeen of eighteen participants in this study communicated that they relied on their friends for support and social connections during the pandemic. This finding is not surprising, given that Tamres, Janicki and Helgeson (2002) found women are more likely to seek and rely on social support to cope with stress than are men. Moira, one of my research participants, was an interesting exception, however. Moira had a social network available to her (i.e., her sisters and one of her baristas), but she did not regard it as meaningful enough on which to rely. She felt judged by her social network because of her hoarding problem and refused to let anyone into her home. This decision exacerbated her social isolation during the pandemic. Moira was clearly socially isolated insofar as she had no one upon whom she could rely for support. Others may have been physically isolated, but people remained in their lives. Though she became socially isolated because of her own behaviour, Moira was firm in her belief that she did not yearn for social connection. She revealed how she "didn't feel lonely at all . . . I like being with myself, I didn't feel I ever needed to see another face." Though she mentioned she "didn't get lonely, except for one time" because or her lack of meaningful and unreliable social supports, Moira remained socially isolated until the second lockdown when she "finally went to visit my old café to clean it up with my barista." She went months without seeing or talking to anyone and had all her "cat litter and groceries delivered" to "avoid talking to people" and keep people from entering her house. Consistent with the mental health literature, Moira exhibited classic hoarding

behaviours. Those with hoarding disorders are very self-critical and harbour a great deal of shame because of their inflated sense of responsivity over their possessions (Chou et al., 2018). Because of this shame and guilt, hoarders are more likely to be lonely or socially isolated (Burgess, 2018). Coupled with her OCD and fear of COVID, I think it is fair to determine that Moira drove herself into a state of social isolation because of extensive mental health challenges, not necessarily because of unreliable social supports. People with hoarding tendencies are typically worried about people's comments or judgements (Chou et al., 2018), so these tendencies were likely the root cause of her social isolation during the pandemic.

Apart from Moira, social support was a coping mechanism for most participants, especially extraverts. Even participants who fell into the category of conspiracy thinkers still had people who were like minded upon whom they could rely for support (mostly found through anti-vax Facebook groups). As the existing literature shows, social connections and support reduce depression, anxiety, and loneliness during stressful events or periods of life (Fleming et al., 1982), a finding that proved to be true with the participants in this study. The stress of the pandemic was mitigated by having friends as social support, which benefited the overall health and wellbeing of participants.

Female friends were a support (Taylor, 2011) for many participants. As Fiona said, "women especially value their female friends. That is such an important source of support. It's your girlfriends that will get you through life." She, among others, was confident her girlfriends would always pick up her phone calls, answer her texts, go for walks with her, and would "always be there." Participants valued their female friendships, and many felt they received much support and social connection throughout the pandemic. In this sense, participants viewed

their female friends as very important to their wellbeing (Jacobs, 2014). Sometimes these connections amounted to a simple phone call or text, but whatever the gesture, it was perceived as placing a value on the importance of human connection. Participants spent a lot of time walking, hanging out, and talking with their friends to alleviate their feelings of loneliness and sadness, especially those participants who were single (all divorced). They found themselves relying more on the female friends for connection, support, and friendship (Taylor, 2011).

Evidence suggests friendship contributes meaningfully to wellbeing in later life through companionship (Larson & Bradney, 1988), support during stressful transitions, and adaption to changing circumstances (Stevens, 2001). As the pandemic brought forth changing circumstances, neighbours found innovative ways to stay connected, including communicating across balconies and driveways (Glover, 2022). Participants spoke about talking to their nextdoor neighbours and friends at a safe distance from their yards, even during the height of the pandemic. Many found themselves relying more on their friends and neighbours who lived close by because of public health restrictions on their mobility.

Older adult women rely on their friendships to support them through transitions related to retirement (Jerrome 1981) and widowhood (Stevens 1995) by providing welcome companionship. The pleasure derived from these friendships result from shared activities and social rituals. They have a positive effect on an older individual's wellbeing during periods of stress (Larson & Bradney 1988). Each participant had experienced a transition pre-pandemic related to older adulthood (e.g., retirement, widowhood, divorce) and relied on their friends who were going through the same thing to help get them through the pandemic. Here the homophily principle remains relevant insofar as “people's personal networks tend to be homogeneous with

regard to many sociodemographic, behavioral, and intrapersonal characteristics (McPherson et al., 2001). It is no surprise, then, that participants spent time with people who were going through the same things as themselves (McPherson et al., 2001).

Findings in this dissertation suggest friendships held a deep meaning for participants. The maintenance of a meaningful support network was recognized as an important resource for the emotional wellbeing of these older adult women who lived alone (Aday et al., 2006). Friendship brings "comfort and happiness in the late years of life" (Blieszner and Adams, 2001, p. 53) because "you talk about ordinary little things in your life because you know each other," as Elsa put it. Participants welcomed familiarity and comfort when spending time with their friends, including online. Doing so helped maintain social networks and decreased the risk of decline in mental health for older adults, presumably (Michael et al., 2001). Participants even took different measures to maintain their friendships during the pandemic. Most obviously, they transitioned from in-person to online connection. They also found ways to circumvent or work within public health restrictions to meet-up with friends and spend time together. Regardless of the way they maintained their friendships, almost all the participants felt their friends helped them through the pandemic.

Leisure friendships contributed to participants efforts to cope with the challenges of the pandemic. Kleiber, Hutchinson, and Williams (2002, p. 222) wrote about leisure's "potential to provide people with feelings of social support and a decreased sense of loneliness and isolation." To be sure, extraverted participants relied on their friends for emotional and informational support, thereby making the support they received an interpersonal external resource and protective factor (Ron, 2020). During a stressful and negative life event like a global pandemic,

extraverted participants drew upon their leisure friendships to gain social support, which acted as a buffer (Iwasaki & Mannell, 2000) against the negative impact of physical distancing and stay-at-home orders. For example, Sally leaned on her friendship with Eunice for a "great deal of support" to help her alleviate the stress and loneliness of the pandemic. They went for walks together, talked about their feelings, and drank wine. The literature refers to this friendship as a leisure companionship, whereby two or more people engage in leisure activities together in a friendly way, which is tied to the social support associated with leisure friendships (Iwasaki & Mannell, 2000). Having friends with whom participants had a strong sense of leisure companionship and enabled them to engage in joint leisure activities, especially walking and drinking, lowered participant's stress (Iso-Ahola & Park, 1996) and gave them a sense of positive social support (Glover & Parry, 2008). Like other studies, this project shows that social support helps strengthen psychological wellbeing during stressful times (Norris, 1992).

Data suggested participants in this study were heavily involved in both the giving and receiving of social support (Taylor, 2011). Not surprisingly, Chernova et al., (2021) found the pandemic increased women's need for social support—the perspective that one is loved, cared for, respected, and valued by others, and part of a social network of mutual support (Wills, 1991)—to reduce COVID-19-related psychological distress. The pandemic made 17 participants realize how "much I love my friends," as Sally explained it.

Coping

Coping was a strong theme in this research. Lazarus and Folkman (1984, p. 141) defined coping as "constantly changing cognitive and behavioral efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the

person." Resilience and coping go hand in hand as "resilience influences how an event is appraised, whereas coping refers to the strategies employed following the appraisal of a stressful encounter" (Fletcher & Sarkar, 2013, p. 5). Further, resilience is ''the process of coping with stressors, adversity, change or opportunity in a manner that results in the identification, fortification, and enrichment of resilient qualities or protective factors'' (Richardson, 2002, p. 308). Individuals respond to stress with coping (Frydenberg, 2004), though coping behaviour can vary among individuals. No matter the strategies used, coping is an individual's response to mitigate the damaging effects of stress (Schouten and Wiepkema, 1991). Whether participants knew they were coping or not, they all described coping strategies in which they engaged during the pandemic to alleviate the negative effects of lockdown, stay-at-home orders, and unwanted loss of social connections.

Depression

For the extraverts, there was nothing positive about solitude. No number of fuzzy blankets, tea, or Netflix could put a positive spin on being alone. No friends around. No family present. Stay home alone. Risk getting COVID or giving it to someone you love by going out. Long days. Longer nights. When will it end? Who knows? During such a challenging period, it was no surprise that depression skyrocketed during the pandemic (Kupcova et al., 2023). Nevertheless, Palgi et al. (2020) found that old age, as an actual risk for COVID-19 complications, was negatively related with depression and anxiety. Moreover, older adults (65+) who were at greater risk for COVID-19 complications, showed greater resilience to mental health challenges (i.e., anxiety and depression) related to the pandemic (Palgi et al., 2020). This resilience can be attributed to older adults usually exhibiting "lower reactivity to stress,

exercising more effective emotional regulation, having greater experience with being alone and with life-threatening medical situations, and thus were perhaps less sensitive" (Palgi et al., 2020, p. 3; Losada-Baltar et al., 2020).

Though they were not at as much risk for depression as other groups, some older adults still did suffer with depressive symptoms through the pandemic. Depression caused by social isolation, an inability to seek support from loved ones, an inability to engage in their communities, feelings of loneliness, fear of infection, suffering and death for oneself and for loved ones, grief after bereavement and financial worries have all been linked to pandemic induced depression that older adults faced (WHO, 2023). As the pandemic increased the risk of depression, regardless of resilience, depression "affect[ed] the individual's ability to solve problems, set and achieve goals, and function effectively, at work and in relationships, making recovery from the crisis even more difficult" (Pietrabissa & Simpson, 2020, p. 3). With compelling evidence that depression has been exacerbated among older adults due to the pandemic (Gaggero, Fernandez-Perez & Jimenez-Rubio, 2022), it was probable that some participants in this study suffered from depressive symptoms brought on or exacerbated by the pandemic.

To be sure, feelings of depression during the height of the pandemic, especially during lockdowns, were expressed by participants. Some spoke about their feelings of depression during lockdown, which made them cry uncontrollably, go on antidepressants, and experience trouble sleeping. The lack of connectedness they felt, the disruption in routine, the disturbance in sleep, the feelings of loneliness, and the general fear of the unknown all contributed to these feelings of depression. In particular, isolation provoked by physical distancing (being physically alone and

isolated from loved ones), lockdowns, and quarantines played a big role in depressive symptoms of participants (Kujawa et al., 2020). The pandemic exacerbated an already existing loneliness epidemic amongst older adults, coupled with physical and social isolation (Hwang et al., 2020).

Stress induced depression was also prevalent amongst participants. Stress brought forth by life disruption, concern about health, transitioning to remote work and online in general, financial stress, and job insecurity triggered depressive feelings (Kujawa et al., 2020). Stressful experiences associated with the pandemic, including social isolation, interpersonal strain, and uncontrollable stressors (lockdown) negatively affected participants during lockdowns (Kujawa et al., 2020; Hawkley & Cacioppo, 2010). For some, their biggest source of stress was unemployment and financial strain from job loss. Both are consistently linked with increased rates of depression (Frasquilho et al., 2016). The isolation and stress brought forth depressive symptoms for numerous participants.

Three participants acknowledged feeling depressed *before* the pandemic because of a recent loss of a spouse. Though they were dealing with grief induced depression, the pandemic exacerbated the severity because they were unable to host a celebration of life, physically get together with their families, or access face-to-face social support. Many individuals experienced grief, complicated grief (intense and prolonged grieving), and mourning due to loss of loves ones, which led to depression (Arora & Bhatia, 2023). Grief is often characterised as intense yearning for the loss, involving cognitive, behavioral, spiritual, and physical responses (Arora & Bhatia, 2023; Zhai & Du, 2020), whereas the process of mourning is an imperative protective factor against grief (Nakajima, 2018).

Grief induced depression was more prevalent during the pandemic due to lack of resources, uncertainty about the future, lack of routine, and absence of mourning ceremonies (i.e., funerals), and social supports and connections to help with coping (Arora & Bhatia, 2023). For example, the emotional exhaustion Moira felt from having to care for and cope with the eventual loss of her spouse before the pandemic only increased after the pandemic began. Like her, other participants were already in a state of depression due to grief. The pandemic for them, only made matters worse and more of a challenge, as they felt stuck in processing their losses, had difficulty moving on (Kokou-Kpolou et al., 2020), and felt socially isolated from the support they needed to help alleviate their grief induced depression.

Maladaptive Coping

Many participants engaged in potentially harmful behaviours during the pandemic because such activities represented the only form of control they had. Their situation seemed nihilistic. In many ways, they faced an existential moment when they grappled with the absurdity of their life circumstance. To cope with the nihilistic situation, some participants engaged in excessive alcohol intake, smoking, and reduced physical activity, activities characteristic of the socially isolated and lonely older adult population (Ong et al., 2016). Participants used these maladaptive strategies to cope with their situations during the pandemic that provided temporary relief, but adverse long-term outcomes (Sampogna et al., 2021). Maladaptive coping is a response employed by individuals when they face overwhelming stress, trauma, or adversity. Rather than seek constructive solutions or support, they may disengage from problem-solving efforts and withdraw emotionally, which can exacerbate feelings of isolation and distress (Cheng & Ebrahimi, 2021).

Moreover, the pandemic's impact on mental health and isolation resulted in an increased use of unhealthy vices as maladaptive coping mechanisms among some participants. Instead of alleviating depressive symptoms, these behaviours sometimes caused or worsened them (Jeffers et al., 2022). This outcome was also documented by Goveas et al. (2021) who found older women resorted to unhealthy vices (i.e., alcohol) because of disrupted social connections, loneliness, and depression. Participants in my research turned to alcohol, cannabis, or fast food, common vices cited as ways older women sometimes cope with loneliness and depression (Hanna et al., 2023).

Though these activities are often judged on moral grounds, those who engaged in maladaptive coping strategies did so to distract themselves from their thoughts about the pandemic and allow for respite. As Folkman and Moskowitz (2004, p. 752) explained,

> Distancing, which is a form of coping in which the person recognizes a problem but deliberately makes efforts to put it out of his or her mind, and escape-avoidance, which is more of an escapist flight that can include behaviors such as drinking, are both avoidant forms of coping that are usually grouped together under "emotion-focused coping." Distancing, however, is often adaptive when nothing can be done, such as when waiting for the outcome of a test.

Vices were an effective coping resource for brief mood improvement and temporary escape (Iwasaki, Mannell, et al., 2005). Though their passive coping responses can be construed as unhealthy and only offered temporary respite, they nevertheless provided temporary escape that some participants needed to simply forget about their pandemic circumstances. This approach is not uncharacteristic. Ungar (2011, p. 8) used the principle of "atypicality to argue that resilience will manifest in ways that we may not want to promote but that are necessary," which includes behaviours such as drinking, eating junk food, and smoking pot. These activities addressed participants' immediate concerns temporarily, but other factors (i.e., gaining weight, feeling

sluggish) helped them recognize they needed to change their behaviour to be more productive and therefore, more resilient.

Maladaptive coping strategies may be perceived as inappropriate because of the moral judgement applied to them, which can lead those who engage in such coping behaviours to be stigmatized. Stigma leads to marginalization, ostracism, and discrimination toward those who abuse alcohol and drugs (State of Wisconsin, 2003). Some of the participants in this study engaged in what society believed to be unconventional and perhaps even inappropriate coping strategies that they nevertheless felt contributed to their resilience. Socially contentious leisure and coping strategies are typically deemed to be non-normative because of stigma caused by the subversion of normative values, whereby stigmatized individuals tend to be demeaned, ostracized, and discriminated against (Vanwesenbeeck, 2017).

Hidden resilience is relevant to maladaptive coping. It refers to the manifestation of atypical coping strategies that go against conventional conceptualizations of socially appropriate behaviour but allow individuals to endure adversity (Malindi & Theron, 2010). For Eunice, her hidden resilience was drinking during lockdown. She was worried about the stigma associated with drinking alone and felt she had to keep it from her daughter to avoid her daughter worrying about her and assuming she was dependent on alcohol to cope. Though I suspect Eunice's drinking alone during a time of stress was a maladaptive coping strategy, it also doubled as hidden resilience as drinking kept her "happy. The hair of the dog will keep you tough and able to take on the day."

It is important to note that the frequency and amount of drinking was not disclosed by participants in this study, so I cannot comment on whether the drinking behaviour of participants

was problematic or connected in any way to alcoholism. However, when individuals engage in avoidance behaviours such as drinking (especially excessively), their resilience weakens (Teasdale et al., 2012). While participants who drank to cope were adamant that they were resilient, their coping appeared to be maladaptive, which ought to have been a potential cause for concern.

Leisure

One of the major themes of this entire dissertation is the role that leisure played for participants during the pandemic. Leisure is a psychological entity overwhelmingly defined by people's perceptions of freedom (Iwasaki & Mannell, 2000). Staying at home during lockdowns with bars, gyms, and gathering places closed, the elements of freedom and choice were limited and required adaption. Being required to transition from social leisure pursuits that took place outside the home to leisure pursuits done alone (mostly) at home proved challenging for some participants, albeit mostly during the first stages of COVID. Every participant felt that leisure was part of their pandemic story and felt that it played an important role of "getting through the worst of it," as Constance explained.

Iwasaki and Mannell (2000) identified three leisure-based coping strategies that individuals adopt to combat stress. These include (1) leisure palliative coping or engaging in leisure pursuits that grant participants temporary relief from stress and allow participants to regroup and gain perspective; (2) leisure mood enhancement or engaging in leisure activities to improve one's mood; and (3) leisure companionship or engaging in leisure activities with friends or significant others. My findings suggest that leisure helped participants (1) stay distracted, (2) stay connected, and/or (3) stay active. Two of Iwasaki and Mannell's strategies fit with my

findings. Temporary relief is similar to staying distracted, and leisure companionship complements staying connected. My findings differ, however, insofar as my participants did not speak to mood enhancement. I discuss the three leisure themes that arose from my findings in relation to the literature next.

Staying Distracted

For some participants, leisure served as a distraction from the pandemic and government mandates. In reviewing the relevant literature, Kleiber et al. (2002) suggested that leisure distracts, thereby helping protect individuals from the stressors of a negative life event. Some participants felt that keeping their minds distracted through leisure helped them escape or help create a positive diversion from the stress of the pandemic, thereby allowing them to rejuvenate and regroup to face the challenges of the pandemic (Iwasaki & Mannell, 2000; Iwaski et al., 2005). The more participants stayed "distracted by doing leisure" (Eunice), the greater happiness and less emotional distress they seemingly experienced (Sharp & Mannell, 1996). By gardening, cleaning out their cupboards, watching TV, and re-arranging crystals, participants engaged in leisure to keep their minds busy and distract themselves from the distressing thoughts that were triggered by the pandemic and its stressful events (stay-at-home orders, physical distancing etc.).

Some participants engaged in leisure activities deemed of less quality than their usual activities, but felt they were important to their wellbeing by helping them "stay busy" (Yang & Hsee, 2019), which is similar to "staying distracted." Busy leisure is the idea of keeping idle-hands busy (Mannell & Kleiber, 1997), which can signify competence to oneself, productivity, and satisfaction (Mochon et al., 2012). Participants such as Cordelia kept doing things she "enjoyed to keep [her] mind off the pandemic." She did not want to "do nothing and overthink" her pandemic experience, as staying idle can be challenging as it can result in boredom

(Eastwood et al., 2012), anxiety (Taylor, 1994), a decrease in self-esteem (Yang & Hsee, 2019), and depression (Goldsmith et al., 1997). Elsa felt the same as she engaged in gardening to "really focus on planting . . . to get lost in tending to my garden and only focusing on that . . . it gave me a sense of pride." Like others, using leisure to distract herself not only kept her mind off the pandemic, but also gave her a stronger sense of self-esteem and overall wellbeing (Yang & Hsee, 2019).

Wellbeing through Leisure can stem from hedonic (i.e., focus on pleasure and comfort) and/or eudaimonic (i.e., focus on personal growth) (Huta, 2007) activities. The former, however, seemed more common among participants than the latter. Though some participants read, most of my participants did not endeavour to learn a new skill, develop a new talent, or be their best self. This seemed to be because they were at a point in life (i.e., older adulthood, retirement) when they were more interested in pursuing leisure for "fun . . . not to learn, I've done enough of that my whole life," as Lana put it. Leisure during the pandemic was especially about "bringing some joy into life," as Cordelia put it, so "relaxing" was important to them. "I'm at the age where I want to relax and purely enjoy what I do," Eunice mentioned.

Participants seemingly sought out the hedonic leisure activities as a distraction because they wanted to experience joy at a time when pandemic took away many of their everyday pleasures. Moving toward hedonic forms of leisure was a counterbalance to their otherwise monotonous lives, so they searched for pleasure (physical or emotional), enjoyment, and comfort (Huta & Ryan, 2010). Hedonic leisure was common for all participants as it fostered positive affect, carefreeness, and vitality, and reduced negative affect, depression, and stress (Henderson et al., 2013). For example, spending time outside just "sitting and taking in the fresh air" (Lana)

helped participants relax and enhance their life satisfaction (Korpela & Kinnunen, 2011). In seeking immediate enjoyment and avoiding pain (social isolation, loneliness, stress, grief etc.) (Chen et al., 2015), hedonic forms of leisure helped participants achieve happiness (Giuntoli et al., 2021). Participants were all hedonically motivated to seek comfort and pleasure in something that helped them relax and de-stress, especially in a difficult time like the pandemic.

In line with hedonic activities, participants viewed passive activities as meaningful. Passive leisure activities are restful and static activities which do not involve physical exertion during free time (Joudrey & Wallace, 2009). The most common forms of passive leisure activities in this study were watching TV, drinking, and puzzles. Participants engaged in passive leisure activities to stay distracted and keep their mind and thoughts "away from the world," as Billie put it. Passive leisure activities served as a form of respite from the demands of daily life, (Sonnentag & Fritz, 2007), as well as a distraction from a stressful event (i.e., the pandemic) (Kleiber et al., 2010). The threat of the pandemic brought forth negative emotions, which caused participants to engage in leisure activities, particularly passive ones), that distracted them and created distance from the stress (Kleiber et al., 2010). Sally engaged in puzzles to "keep my mind off the bullshit," which speaks to how passive leisure activities helped divert participant's attention from their negative feelings (Houston, 1987). Consistent with the literature, findings from this study also echo the role that passive leisure plays in strengthening wellbeing (Ku et al., 2016).

Maladaptive coping strategies also played a role in keeping participants distracted. Leisure researchers report the value of leisure as a coping resource (Iwasaki & Schneider, 2003), and the maladaptive strategies some participants used as leisure helped them get through "the

dark days" of the pandemic, as Eunice described them. The COVID-19 literature suggests that during lockdowns and physical distance orders, using substances like cannabis and alcohol were common coping strategies (Mental Health Canada, 2020; Bartel et al., 2020). Though I suspect during lockdown participants had too much leisure time which resulted in deviant behaviours (Barnett, 2005) (i.e., drinking and smoking), it was something participants needed to do "in the moment . . . A glass of wine just helped" to make "lockdown go by" (Sally). Having too much unstructured free time can be risky for some people, as it can lead to boredom or destructive activities, such as drinking (Mannell & Kleiber, 1997). For participants who engaged in drinking during lockdown, it seemed to be a result of too much free time (Iso-Ahola & Crowley, 1991), but also to stay distracted (Houston, 1987).

Though maladaptive coping strategies can "feel good in the moment" (Eunice), participants were aware of the adverse consequences maladaptive coping strategies can have in the long-term (Folkman & Lazarus, 1988). They just "didn't really give a fuck about [their] drinking during lockdown," Eunice explained. Sally and Eunice especially chose to evade the stress situation of the pandemic through maladaptive behaviours (Folkman & Lazarus, 1988) like drinking and "smoking lots of weed" (Eunice) to forget about the "shitty state of the world" (Sally).

These findings suggest we need to think about coping and leisure more deeply and move away from simplistic thinking about "good" and "bad" coping to address more complex questions about how, when, and for whom different types of coping and leisure activities are adaptive and successful (Wadsworth, 2015). Furthermore, it is important to realize that

maladaptive coping strategies served a purpose for some participants by keeping them distracted, which helped them adapt to lockdowns in a suboptimal environment (Wadsworth, 2015).

Staying Connected

This study identified leisure as an activity that helped participants stay connected. Consistent with existing literature, leisure was described by participants as a coping style that provided a sense of belonging and connection (Loy, Kleiber & Dattilo, 2003). As mentioned above, participants engaged in hedonic leisure, not only because they wanted to experience joy at a time when pandemic took away many of their everyday pleasures, but also so they could "stay connected to [their] loved ones" (Delphine). Older adults who are regularly involved in social activities tend to be satisfied with their lives (Adams et al., 2011). Social activities (i.e., talking to friends) help improve dispositional optimism, life satisfaction, and subjective wellbeing for older adults (Ryu & Heo, 2018). Findings in this study showed that hedonic leisure activities kept participants socially connected, positive, and happier (Ku et al., 2016).

Leisure enhances social support, and people tend to be satisfied when they are engaged in leisure pursuits, thereby making leisure an effective strategy in alleviating stress and loneliness (Coleman & Iso-Ahola, 1993). Leisure social support refers to support received from family members and friends who engage in leisure activities together (Chang, 2020). It can lower stress (Coleman & Iso-Ahola, 1993), provide a feeling of fulfilment (Sasidaran et al., 2006), and strengthen personal vigour among older adults (Chang, 2020) because those who receive it access support from their leisure companions to solve their problems (Chang, 2015). Participants looked to leisure activities like "FaceTiming my daughter just to chat" to allow them "to see a comforting face" (Lana). In short, leisure enabled participants to stay connected. Leisure social support was not as available in its face-to-face form during the pandemic, so social options

tended to shift online, which "helped . . . the screen was so helpful. It wasn't in person, but it was a face" (Fiona).

Walking and Gardening to Stay Connected

Walking was an important way participant saw friends, family, and neighbours, and felt comfortable "hanging out, but distanced" (Constance). At the beginning of the pandemic, participants felt familiar strangers—those individuals who are "recognized from regular activities, but with whom one does not interact or communicate" (Jackson et al., 2017, p. 9)—and neighbours were both physically and socially distant. Neighbours fit on a spectrum of weak or invisible ties. Avoiding one another while walking in the neighbourhood, thus, led to civil inattention (Goffman, 1963). Walkers remained co-present insofar as they occupied the same physical space (i.e., sidewalks), but they also remained aloof and fearful. Participants recounted the alienation they felt when others they encountered on their walks would visibly attempt to avoid them to remain physically distanced. Moreover, most participants felt disconnected from those they encountered because few would even look at them while passing by.

Once the initial fear of COVID died down and the vaccine was available, however, walking became more about meaningful social interactions, physically seeing other people, and staying active, rather than just alleviating feelings of sadness and a change of environment. That is, it played a meaningful role in facilitating "neighbouring," a purposeful engagement in meaningful social interactions with neighbours (Glover, 2022). Neighbourhood social ties matter, particularly during stressful life events like a global pandemic, for they signify foundations of wellbeing and community capacity (Glover et al., 2022). The older adult

participants in this study "attempted to address their social isolation connecting with others, which, in some cases, led to a thickening of thin ties as their interactions became more regular and frequent (Glover, 2021). The strengthening of social ties happened for four participants in this study who transitioned from neighbours to friends by walking together. Walking was a leisure activity that strengthened social ties and facilitated meaningful social interaction during the pandemic (Glover et al., 2022).

Findings in this study are consistent with Pollard and Wagnild (2017) who found that women were more likely to walk for leisure. Seventeen out of 18 participants walked as a form of leisure. They walked to alleviate depression (Roe & Aspinall, 2011), to decrease their anxiety (Wilbur et al., 2009), enhance their social networks and social support (Reger-Nash et al., 2006) after the vaccines were out, and strengthen their overall wellbeing (Heesch, Burton & Brown, 2010).

Through participant stories, I found that gardening also kept participants socially connected. Participants gardened in their front yards during lockdowns to "talk to people walking by" (Elsa) and maintain social connections, which helped develop a sense of community (Stebbins, 2007). For Jude it was "my flowers were conversation starters . . . I liked gardening because people would stop and talk." For some participants in this study, gardening was a way for them to engage with other people and socialize (Jun et al., 2015), during a time where socializing was a challenge. Like my findings, Cheng and Peng (2016) also found that gardening was a big form of socialisation for older adults, and that gardening as a leisure pursuit played a central role in older adult's lives by providing opportunities to socialise (Wang & Wong, 2014).

Having Sex to Stay Connected

One form of hedonic and casual leisure, and a way to stay connected for some participants was sex (Berdchevsky & Nimrod, 2017). Participants who had sex did so to "see someone and feel good . . . it was a way to at least have some fun and link-up," as Sally put it. For Myrtle her "guys, were [her] leisure activities" as they made her feel "really good, it's so much fun, even just to see them both is nice." Sex kept both Sally and Myrtle positive, socially connected, and happier (Ku et al., 2016).

For sexually active participants, sex provided "a break from the loneliness," as Sally put it, by providing companionship. Companionship is defined as "social involvement in shared activities, recreational or nonrecreational, that is pursued for the intrinsic goal of satisfaction or enjoyment" (Rook, 1987 in Ramesh et al., 2021, p. 1). Distinct from social support, companionship does not aim to provide aid, but rather to experience pleasure (Ramesh et al., 2021; Sarason & Sarason, 1990).

The companionship participants received from the sexual partners served as a buffer from loneliness of the pandemic (Ramesh et al., 2021). It was also leisure, as described by participants. During the pandemic, at least one participant, Sally, had a "friend with benefits" arrangement. Sex as leisure seemed to enhance her sense of wellbeing and vitality (Loe, 2012). Myrtle had casual sex with two romantic partners during the entirety of the pandemic, as it brought her "joy, especially in these later years of life" like other older adults (Lindau et al., 2007). Sally and Myrtle, like many other older adult women, enjoyed sex as leisure (Nimrod & Janke, 2012), especially to help get their mind off the pandemic.

Sex as leisure in later life has not been as explored as it should be (Berdchevsky & Nimrod, 2017), perhaps because of the ageist assumption that older adults no longer enjoy sex, are asexual, or no longer have the stamina for it (Lai & Hynie, 2011; Taylor & Gosney, 2011). Sexual activity in later life helps with maintaining good health (DeLamater & Koepsel, 2015), an overall sense of happiness (Laumann et al., 2006), self-esteem, competence (Choi et al., 2011), vitality (Loe, 2012), and provides comfort with an aging body (Hillman, 2012). Sex is very beneficial, especially to older women (Kleinplatz, 2008). It represents a self-contained activity with intrinsic meanings and is a form of casual leisure (Stebbins, 2001). Freely chosen sexual activity to gain satisfaction from the experience is also a form of leisure (Godbey, 2008).

Though sex as leisure was important for Sally and Myrtle, physical distancing guidelines and the fear of the virus on top of already existing leisure barriers made it more difficult to have sex. Sally mentioned how hard it was "to online date at my age . . . the pool is already so small and adding a pandemic on top of that just made it near impossible." As Ramesh et al., stated:

> The pandemic would affect the different dimensions of sexuality. These include fear of infection because of physical intimacy, worsening of already-existing symptoms of sexual dysfunction because of added anxiety, negative changes in the dynamics of the relationship, (p. 6; see also Banerjee et al., 2021).

It seemed the constraints on "physical distance dating" (Sally) led to defeat and ultimately a reduction in sex in leisure activity (Kleiber & Nimrod, 2009). Though she still had sex, "during the first lockdown especially," there was notable changes in her leisure behaviour, namely a decline in having sex and home alone more (Nimrod & Janke, 2012). For Sally, physical distancing guidelines coupled with the fear of getting sick, resulted in "touch starvation" (Banerjee et al., 2021). Touch starvation (lack of physical touch) has been found through the

COVID-19 literature to be associated with a disruption in resilience, and increase in stress (Field, 2014). The blend of gendered and ageist sexual double standards that see older women as sexless (not interested in sex), moreover, made it hard for older women to engage in sex as leisure (Lai & Hynie, 2011) during the pandemic.

Though not the most common form of leisure identified in this project, sex as leisure in older adulthood warrants greater recognition for its health benefits. Engaging in sexual activity regularly improves overall health and wellbeing, which also boosts mood, belonging, security, and ultimately, resilience (Banerjee et al., 2021). The taboo narrative that older adults do not have sex is a common, yet faulty assumption (Taylor & Gosney, 2011). Contrary to a popular belief, George and Weiler (1981) found that most older adults are sexually active, "yet researchers and policymakers are still guided by stereotypes of aging, leading to flawed methodologies and unrepresentative policy developments" (Ramesh et al., 2021, p. 4). Sex for Sally and Myrtle served as not only a protective factor against loneliness, but also aided in companionship and pleasure, while serving as their "favourite leisure activity… having sex is fantastic" (Sally).

Drinking to Stay Connected

Like sex, drinking alcohol was another common hedonic leisure activity in which some of the participants engaged during the pandemic to stay connected and unwind (Sayette, 1999). Participants drank with friends over zoom, engaged in virtual wine clubs, had "bubble drinking [buddies]" (Sally) where they would drink in person with people in their circle, and drank a "glass of wine with friends over the phone" (Delphine). For some participants, drinking with friends and family (either in person or virtually) maintained meaningful connections, and kept

them “having fun with my friends… a drink or two always makes us laugh more and we needed that during lockdown” (Mary).

Alcohol affects the part of the brain that controls inhibition, which can cause relaxation and less anxiety once consumed (Mental Health Foundation, N.D.). By producing endorphins, which bring forth confidence and happiness, alcohol consumption contributes to social bonding (Johnson & Dunbar, 2016). Accordingly, drinking alcohol can serve as a social lubricant insofar as it facilitates and complements social interaction (Monahan & Lannutti, 2000). It also contributes to sociability. Unrecognized in dominant public health narratives (i.e., negative health outcomes, addiction) (Canada’s Guidance on Alcohol and Health, 2023), drinking alcohol can have positive health outcomes insofar as it can encourage social connection. For those participants who used alcohol as a social tool, it helped maintain meaningful social connection for them. Participants would likely argue the benefits of social health from drinking outweighed the harms of alcohol (Dunbar et al., 2017).

Drinking alcohol can be a delicate balance, however. On one hand, moderate amounts of alcohol can foster and maintain social connections (Johnson & Dunbar, 2016); on the other hand, drinking excessively can be addictive and poisonous (Canada’s Guidance on Alcohol and Health, 2023). As Moran and Gallant (2020, p. 1) suggested, however, we tend to “impose a presupposed problematized bias” on alcohol and ought to consider its social contributions to health and wellbeing. Some participants like Delphine were aware of the negativity surrounding alcohol as she disclosed, she “drank more than [she] cared to admit, but during stay-at-home orders, it was something to do with friends.” With this understanding of the pros and cons of drinking, this topic warrants future research.

Staying Active

The third leisure theme I identified in my findings, staying active, was consistent with existing literature. Leisure in this study was described as a coping style that also provided a sense health maintenance by staying active (Loy, Kleiber & Dattilo, 2003). Active leisure refers to an activity that involves some form of physical exertion during free time (Joudrey & Wallace, 2009). The most common forms of active leisure in this study were walking and gardening. Participants did both to stay active and "move the limbs," as Elsa put it. All 18 participants engaged in active leisure through either walking or gardening. Seventeen of 18 participants in this study engaged in physically active leisure through walking, which held numerous benefits, including relaxation, mobility, and social interaction, (Adamson and Parker 2006). Physically active leisure (especially walking) supported participants in developing new routines (Barnett et al., 2012) when the pandemic took away their usual ones. As Constance mentioned, she "had to make time for walking. It was my daily thing", to stay active, and "keep healthy." Consistent with existing literature, findings in this study show that active leisure activities that took place outdoors had positive impacts health and wellbeing as they took place in fresh air and provided physical activity and socialization opportunities (Tütüncü & Aydın, 2014). Gardening and walking were active leisure pursuits that allowed participants to experience fun, pleasure, and joy (Phoenix & Orr, 2014), during a time where participants needed it most.

As one of the easiest, safest, most inexpensive forms of leisure that can be done by almost anyone (Richardson et al., 2005), walking is accessible to most able-bodied people. Walking was the most common form of active leisure found in this study, and it served as a highly accessible coping mechanism, resilience strategy and enjoyment. Walking stood out as an activity in which most participants engaged during the pandemic, both pre-vaccine and post-

vaccine. Out of 18 participants, 17 of them engaged in walking as a form of leisure, making it the most common pandemic activity among participants–the one participant, Delphine, could not walk due to back pain. Its popularity is perhaps no surprise, given that it was one of the few sanctioned activities in which participants could engage during the height of public health restrictions. It also represents what Glover (2022) called "leisure-in-public," those activities that take place outside of the home in the view of others for hedonic purposes. During the pandemic, Glover argued people sought to get out of their homes and engage in activities where they could see others.

By seeing others and leaving their homes, participants felt motivated "to move more . . . seeing my neighbour walk made me realized I needed to get up" (Mary). Walking was the most common way participants stayed active, which remains consistent with existing research, as it is the most reported activity in adults who meet physical recommendations (Simpson et al., 2003). The preference for walking has been found to increase with age (Eyler et al., 2003), which makes it one of the most preferred leisure activities for older adults (Lee & Buchner, 2008).

The second most common form of active leisure was gardening. Elsa recalled how she would "break a sweat planting" and Jude "kept fit from gardening. It's an exercise on its own." Gardening as a leisure pursuit helped participants maintain an active lifestyle (Cheng & Pegg, 2016). Consistent with existing leisure research, my findings also identified gardening as a popular leisure activity for older adults (Ashton-Shaeffer & Constant, 2006), as five participants gardened for leisure. Though they engaged in gardening to talk to others and make their "space look nice" (Elsa), they also engaged in it to stay active. Some days, Elsa and Jude were not in the

mood to go for walks, so instead, they would garden to "break a sweat" (Jude), as they felt "planting and trimming" (Elsa) kept them active (Cheng & Pegg, 2016).

The Three Themes of Leisure

Irrespective of the type of leisure, most activities seemingly assisted participants in coping with their circumstances during the pandemic. Newman and colleagues (2014) suggest that leisure plays a role in promoting subjective wellbeing for older adults, which is what my findings suggest, as well. For participants, leisure was about (1) staying distracted, (2) staying connected, and/or (3) staying active. Though participants engaged in different leisure pursuits (i.e., puzzles, crystals, gardening etc.) and the same ones (i.e., walking), leisure proved to be a strategy for participants to "keep resilient and remember what fun is" (Eunice).

Invasive, Substitution and Busy Leisure

Invasive leisure, a term coined by Rojek (1999), warrants some discussion before moving forward. It refers to harmful forms of leisure that affect health and wellbeing negatively. The invasive leisure activity that participants mentioned throughout the interview process was not social drinking, but rather solitary drinking. Solitary drinking has the potential to become a problem (i.e., addiction), as the act is usually linked to depression and anxiety (Carnegie Mellon University, 2021). Drinking alone is typically situated in leisure time and spaces and serves as a retreat from life stressors (Rojek, 1999; Katz, 1998). Some participants felt they could not escape the challenges of the pandemic, including maintaining meaningful relationships with others, so they looked to their leisure as a refuge (Rojek, 1999).

Solitary drinking served as an invasive leisure activity because it involved excessive consumption of a substance that can do harm to one's health with no social benefit. Invasive leisure often involves a slow retreat from society, whereby "the individual shrinks away from engaging with others and often cultivates solitary recreational habits" (Rojek, 1999, p. 11). For those who engaged in solitary drinking, they presumably felt alienated from society because of changes to their social condition, which led to feelings of loneliness and uncertainty about what the future would hold.

Interestingly, all 18 participants agreed that leisure enhanced their overall wellbeing and improved their mood (Newall et al., 2013), lowered their stress, (Han & Patterson, 2007), helped them achieve meaningful happiness (Ekelnad, 2016), and alleviated their loneliness (Toepoel, 2013). Though this consensus pervaded among participants, their assessment did not necessarily reflect their experiences. The leisure activity of solitary drinking among some was unhealthy and disconcerting. Those who identified solitary drinking as a routine leisure activity during the pandemic acknowledged experiencing a decrease in mood and increase in stress in association with it (Weerakoon et al., 2020). Some conceded drinking more than they cared to admit and wondered aloud if and how their behaviour would change when the world returned to normal. Consistent with the alcohol literature, solitary drinking drove at least one participant into a spiral of existential thinking (i.e., what is the point of a life lived alone?) which seemingly contributed to feelings of depression and loneliness (Senkevich, 2016). Other participants engaged in unproductive activities in parallel with solitary drinking, including reminiscing sorrowfully about socializing with friends and searching for content on the internet that fed conspiratorial thinking.

Judging by the delivery of their pandemic stories, those who engaged in solitary drinking appeared to feel melancholy while doing so. It contributed to feelings of loneliness. Jude articulately referred to solitary drinking as "lonely leisure." She contrasted it with what she described simply as leisure, which, for her, included dancing, having fun, and enjoying retirement. Accordingly, she struggled to see sitting alone on her deck and not speaking to anybody as leisure. The social dimension of leisure was particularly important to her and, if missing, changed her perception of the activity. Jude implied that any activity that affected her mood in a negative way and/or made her feel lonely could not be regarded as true leisure. Her time spent alone led her to drink as she was constantly reminded, she could not be with friends, which led to feelings of loneliness.

Participation in leisure activities and the social support that comes from them represent a meaningful part of older adults' lived experiences (Chun et al., 2022). When face-to-face social connection was taken away during the pandemic, participants' social leisure (Cuypers et al., 2012) diminished almost entirely. In many cases, it was replaced by "lonely leisure" (as mentioned above) which for some participants remained a strategy for resilience, even though it was not their preferred type of leisure.

Substitutability in Leisure

Though participants all sought out hedonic forms of leisure, modifications and substitutions still had to be made to their choice of leisure activities. Speaking to the modifications made in leisure and the lack of participation in participant's "first choice" leisure activities, as Cordelia put it, introduces the idea of "substitutability in leisure" (Harmon & Woosnam, 2016). This idea reflected the behaviour of participants, especially extraverts, whose

preferred leisure either changed significantly because it could no longer include others, face-to-face, or because it was no longer an option because of stay-at-home orders and lockdowns. Iso-Ahola (1986, p. 369) defined substitutability as an activity in which "the originally intended or desired behavior is no longer possible and must therefore be replaced by another behavior if leisure involvement is to be initiated or continued." While Harmon and Woosnam (2016, p. 4) did note "the decision to switch from one activity to another is often intrinsic," clearly, public health restrictions forced participants in this research to modify or abandon their preferred leisure.

Introverts' leisure largely remained the same, as it already took place in solitude (in the absence of others) and in the context of their homes. By contrast, extraverts were forced to stop in-person sociability and resort to leisure they could do alone. While they still enjoyed the activities in which they engaged and viewed them as a resilience strategy in getting them through the worst of the pandemic, participants acknowledged their sense of community and connections were weakened significantly.

E-Leisure

All participants engaged in e-leisure—that is, leisure that took place on their smartphone, I-pad, tablet, or computer (i.e., leisure taken up through digital technologies, Genoe et al., 2018). For participants, much of this activity served as dedicated time for social connection (Genoe et al., 2018), from video calling friends and family, participating in Zoom wine tastings, and attending virtual book clubs. E-leisure in this study was largely mediated through video conferencing apps, namely FaceTime, WhatsApp, Zoom, and Skype, which helped participants maintain social connections during lockdowns and physical distancing restrictions (Lopez et al.,

2021). E-leisure made location and distance irrelevant because it occurred in “cyberspace” (Nimrod & Adoni, 2012), a place where people came together to socialize (Farmer, 1989; Nimrod & Adoni, 2012). Even though participants in this study were physically alone in their homes, they used e-leisure to interact socially online and feel connected (Nimrod & Adoni, 2012).

Like Lopez et al. (2021), this project found e-leisure helped alleviate the negative effects of isolation imposed by lockdowns and stay-at-home orders. E-leisure was helpful

> in resisting stagnation and/or making days more pleasant during extended periods of lockdown. For example, participants discussed activities such as putting on music, listening to online talks, and connecting with relatives as useful to cope with the emotional impacts of isolation. While participants discussed using email, telephone, and social media for a variety of activities prior to the pandemic, the video connections supported by Zoom/FaceTime/WhatsApp used by participants supported a range of activities (e.g., sharing calligraphy online, zoom dinners, and celebrating birthdays with family members) (Lopez et al., 2021, p. 7)

This finding supports observations by Lopez et al. (2021) that e-leisure was an essential tool for participants.

Developed before the advancement of online social networking, Iwasaki and Mannel’s (2000) leisure coping model focuses on face-to-face interactions to build social connections. The findings in this study show that when face-to-face interactions are unavailable, however, people in this modern age rely on online connections, which needs to be reflected in an updated leisure coping model. Online connections (especially though video and phone calls) played a big role in keeping participants connected with their friends and loved ones. Though I recognize and believe the importance of online connections needs to be reflected in the model, I see a setback with privileging online connections over face-to-face interactions. Like Pinker (2014), I agree that

face-to-face connection is vital to humans' overall health and wellbeing and is a form of connection that should be prioritized and encouraged.

Though participants only spoke in a positive light about the online world and how it kept them connected, e-leisure did seem to exacerbate mental health issues for some participants (Twenge, 2013). For example, Jude went deep into Facebook to learn about the anti-vaccine side of the pandemic and spiraled into conspiracy thinking. While it kept her connected to like-mind thinkers, the connections she made seemed to be shallow and superficial (Twenge, 2013). None of the connections translated to in-person friends that she could have relied on for in-person emotional support and real-world help (Turkle, 2012). Meanwhile, these online ties fed her with information that fueled her conspiracy thinking and ultimately affected her relationships with family and friends negatively. Though technology and online connections connect participants virtually, it made some participants lonelier and unhappier.

Interestingly, participants made no mention of "grey divide" (Delello & McWhorter, 2017) in technology. The grey divide suggests that older age worsens the already existing digital divide (Delello & McWhorter, 2017), which paints a bleak picture of older adults—that they lack the ability and skill to adapt to a technological landscape (Chopik 2016; Seifert el al., 2020). In contrast, participants in this study viewed technology and its use for leisure and social connectivity as something they navigated with little, if any, problems. They did not admit to using it for gaming (i.e, xbox), watching porn, exploring the dark web, or playing any games on apps (i.e., solitaire), but rather for the sole purpose of staying connected. I suspect the circumstances (i.e., the pandemic) led them to using technologies more readily because maintaining connection with their strong ties was dependent upon it.

To be sure, technology can enhance and enrich the lives of older adults by facilitating better interpersonal relationships, social connectivity, and alleviation of loneliness (Chopik, 2016). The existing literature shows that more frequent technology use keeps older adults social "with better self-rated health, fewer chronic illnesses, higher subjective wellbeing, and fewer depressive symptoms (Chopik, 2016, p. 1). As e-leisure helped keep participants socially connected and helped with loneliness and social isolation, I see merit in further research surrounding technology, e-leisure, and older adults. Given its significant role in participants' pandemic experiences, older adult's usage of technology for leisure warrants further examination.

Pandemic Resilience

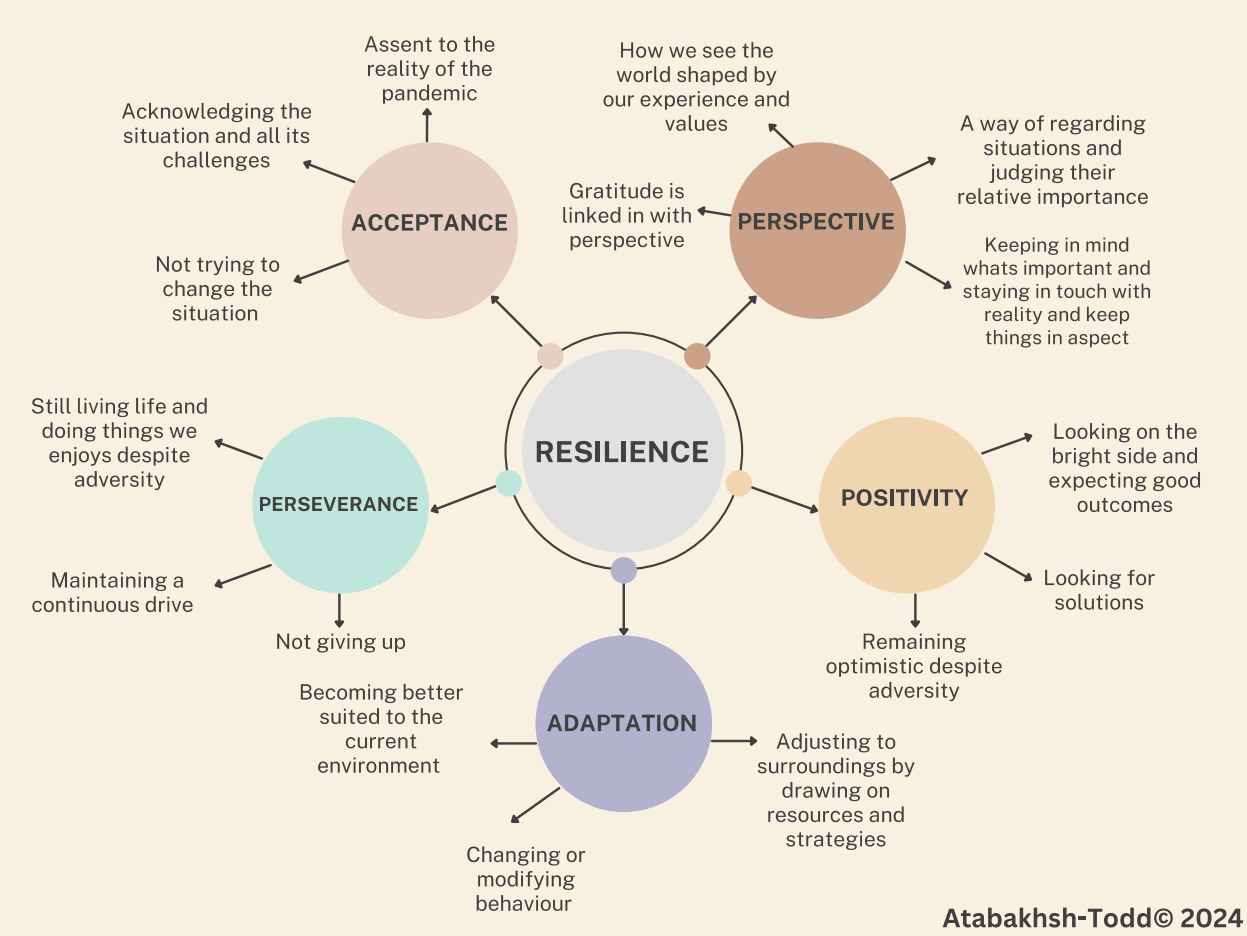


Figure 5: Dimensions of Resilience

Through conversations with participants, I identified five dimensions of resilience: acceptance, perseverance, adaptation, positivity, and perspective (see Figure 5). Interestingly, participants did not speak much about external factors of resilience (i.e., socioeconomic status, access to health services, physical activity, their environment, etc.), but rather emphasized internal factors. In its growth and evolution, the definition of "resilience was initially established as an innate characteristic, a personal attribute experienced by individuals who succumbed to major fatalities (Fletcher & SarKar, 2013; Lima et al., 2023, p. 1). In current models, however, resilience is assumed to be a process with potential to be developed, bearing in mind contexts,

resources, and abilities (Infurna, 2021). For the older adults in my study, it seemed resilience was about behaviours, problem-solving, intrapersonal control, and life experiences that increase resilience through adaptation and coping (Jurek et al., 2021; Musich et al., 2022). Understanding that different stages of the life span my view resilience differently suggests it evolves through critical experiences (Rantanen et al., 2018). I suspect the focus on internal protective factors stems from a generational difference in understanding of resilience.

Perhaps one of the biggest takeaways from my findings is that resilience is *complicated*. Though all 18 participants said with confidence that they were resilient, their stories did not necessarily. The suggestion that resilience is simply being able to "bounce back" comes from its use in the physical sciences, for a "resilient" material can return to its original state after being bent or stretched (Pemberton, 2015). Lazarus (1993) even cited the example of elasticity in metals, with a resilient metal bending and bouncing back (instead of breaking) when stressed. But humans are not materials and resilience is not always about bouncing back. Resilience within humans is more about a "dynamic process encompassing positive adaptation within the context of significant adversity'' (Luthar et al., 2000, p. 543).

Through participant stories, I identified five dimensions of resilience: acceptance, perseverance, adaptation, positivity, and perspective. These dimensions align closely with key components commonly recognized in resilience research and practice (Rantanen et al., 2018). By identifying these five dimensions of resilience, I have highlighted the multifaceted nature of resilience, the diverse strategies and qualities that contribute to adaptive coping, and the significance of resilience for older adults. Each dimension embodies the meaning of resilience for participants. What follows here are the five domains of resilience that were identified through participant stories and a further discussion about each.

Perspective

The first dimension of resilience, *perspective*, involved taking a step back, exercising gratitude, and reframing the problem (Smith et al., 2013). Participants like Violet maintained perspective by

> thinking about good things and not think about poor me, because there were so many other people that had to go to work like nurses that were fearful every day, and then had to come home to their family, not knowing whether they were giving them the virus or not. And then here I am. Staying in a beautiful house. And able to go for a walk and not have to worry about infecting anybody. So, I just had to keep thinking about how lucky I was.

Violet like other participants kept perspective and focused on "what was important" which was "health and family," and exercised gratefulness everyday by keeping in her mind that "it could have been worse." Participants maintained perspective in understanding that they were home safe, everyone they loved was healthy, and that like all other "bad storms . . . this too shall pass," as Eunice explained.

To be sure, keeping things in perspective and keeping a hopeful outlook about the future has been associated with better emotional adjustment, physical health, and general wellbeing (Smith et al., 2013), which contributes to resilience (NIH, 2020). Participants kept things in perspective by *reframing* the pandemic. Reframing is a coping technique that helps individuals become conscious of their internal monologue, while widening their perspective of challenging circumstances (Seaward, 2006). It embodies the notion that "it could have been worse," as Violet understood it, and it reminded participants to "stay out of [their] head," in Constance's words. Resilient individuals confront their fears and reframe and restructure their adverse experiences (Foa et al., 2005). By reframing the pandemic, participants kept things in perspective and became aware of their thoughts and tested negative perceptions by questioning

their validity (Hughes et al., 2011). In doing so, participants chose to see the pandemic in a different lens and changed the way they thought about their situation (NIH, 2020) by putting it "all into focus . . . it's just a storm that will pass," Eunice explained.

Staying consistent with the resilience literature, participants kept things in perspective which has been shown to be an important way to boost resilience (NIH, 2020). Jude felt she was "resilient because, you know, at this age, you've been through ups and downs and, separations and all sorts of things in life, and upsets", which helped her maintain perspective. Taking into consideration that all participants were in their older adult stage of life, the number of experiences, changes, and shift in dynamics (i.e., children leaving home) they have undergone, has helped them learn how to maintain perspective (Beardslee, 1989).

Acceptance

The second dimension of resilience, *acceptance*, involved participants accepting their situation. Acceptance is conceptualized as letting go of the desire to change one's situation, is a non-judgmental attitude toward what the individual experiences, and is about "being fully present" (Follette et al., 2004; Hayes et al., 1999). Existing literature considers acceptance a protective factor against stress and trauma insofar as people with an "acceptant perspective take their trauma-related experiences with no judgment and regulate their internal emotion better (Yookung et al., 2019, p. 3; Follette, Pal, & Pearson, 2006). Acceptance plays a major role in a person's resilience as accepting one's situation promotes psychological permanence after a traumatic or stressful event (Yookyung et al., 2019)

In this study, acceptance meant being present with one's experience (Hayes et al., 1999), acknowledging the pandemic, and recognizing what was in the limits of participants' control

(Hayes et al., 2004). Those who practiced acceptance let go of the need to change things beyond their control (Follette et al., 2004). To be clear, letting go was never about giving up; rather, it was about focusing on what participants could control and "just focusing on that," as Elsa put it. Participants spoke of "not making a fuss" (Elsa), "not fighting it" (Mary), and "not focusing on the shit that didn't need energy, that couldn't be changed" (Eunice). For Cordelia, acceptance was "knowing there was a pandemic and not avoiding it." She sat with her reality and accepted the pandemic for what it was rather than viewing it as an agonizing event that must be avoided (Orsillo et al., 2004). As Eunice put it, the pandemic was "out of my control" and it was something she "just accepted, why fight the universe?"

Looking at existing positive psychology literature, it is evident that resilience and acceptance go hand in hand (Yookyung et al., 2019). As participants in this study have shown, both resilience and acceptance have proven to be protective against stress and trauma (Bajaj & Pande, 2016). Resilience factors, such as acceptance (of both self and life), predict improvements in psychological health and social relationship domains of quality of life (Calvete et al., 2018), as individuals' acceptance mediates the impact of resilience on their adjustment (Yookyung et al., 2019). Blackburn and Owens (2016), they found that resilience influenced individuals' post-traumatic stress symptoms, showing that individuals with high resilience had fewer post-traumatic stress symptoms even if they experienced traumatic events, because of their ability to accept their situation. Acceptance is one of the first steps in dealing with adversity with a positive evaluation (Robins et al., 2004). As a mindset adopted by most participants, it allowed them to embrace the experience of the pandemic by being present with it, not fighting it, and holding no judgement over their feelings (Hayes, 2004).

Adaptation

The third dimension participants identified, *adaption*, has been outlined as ‘‘behaviorally manifested social competence, or success at meeting stage-salient developmental tasks’’ (Luthar & Cicchetti, 2000, p. 858), which is a core part of resilience (Fletcher & Sarkar, 2013). Adaptation is the ability to adjust to new information and experiences (Fletcher & Sarkar). For resilience to be exercised, both adversity and adaptation must be apparent (Fletcher & Sarkar, 2013). Adaptation is a big part of resilience (Luthar et al., 2000). Resilience is a “dynamic process encompassing positive adaptation within the context of significant adversity’’ (Luthar et al., 2000, p. 543) and is about “successful adaptation despite challenging or threatening circumstances’’ (Masten, Best, & Garmezy, 1990, p. 426).

Adapting to a difficult situation is a part of being resilient (Castro & Murray, 2010), as the characterization of resilience embodies numerous forms of effective adaptive behavioural and cognitive responses to stressful events (Luthar et al., 2000). Resilience involves remaining “flexible in our thoughts, feelings, and behaviors when faced by life disruption” (Pemberton, 2015, p. 2), and the ability to adapt (Luthar & Cicchetti, 2000). While COVID-19 affected everyone, some adapted more effectively by engaging in new leisure activities in the home, working from home, and maintaining social connections through communications technology (video calls and texts).

With the pandemic, participants had to assume and let go of roles. Taking on multiple role transitions can be quite challenging (Ashforth et al., 2000). Some participants had to adapt to a new way of living after losing their jobs or being no longer relied upon to provide daycare or other assistance. Though difficult, participants responded by “reallocating resources across multiple simultaneous demands; and adjusting expectations on progress, [as it] may be

particularly important during the pandemic, given the changes to people's work and personal lives" (Vowels et al., 2021, p. 2). Reallocating resources through adapting meant that participants had to shift their focus and routine from engaging in physical social connections, going into the office, and doing volunteer work, to staying at home, relying on technology for social connections, and going for more walks.

By successfully adapting, participants enhanced their psychological wellbeing (Little, 2021). Little empirical evidence seems to exist on how the pandemic affected how individuals have adapted to change (Vowels et al., 2021), though previous research has stated that to cope with new circumstances, adapting is a crucial part of responding to change and enhancing wellbeing (Burke et al., 2006). Though participants engaged in different strategies and on different timelines (some took longer to put things into perspective and adapt), all participants adapted to pandemic challenges.

Positivity

The fourth dimension of resilience, *positivity*, refers to the state or character of being positive (Lenfest, 2019). While keeping things in perspective, accepting, and adapting, participants remained positive. Though moments of distress and pessimism characterized the beginning stages of the pandemic, participants generally remained positive throughout. The resilience literature shows that resilient individuals have constructive, zestful, and overall optimistic approaches to life (Block & Kremen, 1996). Resilience refers to the ability that individuals can positively adapt and respond to stress and adversity (Shi et al., 2019, p. 1; Luthar et al., 2000), as resilient individuals exhibit positive emotionality (Wolin & Wolin, 1993) and naturally draw on positive emotions in times of stress (Tugade & Fredrickson, 2004).

Remaining positive helps buffer against stress and aids in coping (Folkman & Moskowitz, 2000). Positivity and positive affect, facilitates resilience by expanding one's attention and promoting flexible thinking and coping abilities (Shi et al., 2019). Wright and colleagues (2022) also identified positivity as a component of resilience. They conversed with 11,000 adults via text and found that "thinking positively" was the most common theme that participants exhibited in times of stress (Wright et al., 2022). Even participants in this study who had a negative experience of the pandemic still had moments of positivity by "taking a step back and realizing eventually things had to be okay" as Jude put it. Participants stayed positive with humour (Werner & Smith, 1992), relaxation practices (Wolin & Wolin, 1993), and optimistic thinking (Kumpfer, 1999). Moira used her "dark sense of humour to make light of the situation," while Jude "mediated to refocus my thoughts," and Lana kept her optimistic mindset by "being positive, seeing that there's an end in sight."

As well, positive coping strategies, such as positive reappraisal, problem-focused coping, and attaching positive meaning to events (Folkman & Moskowitz, 2000) helped with resilience. Participants engaged in positive coping strategies by "waking up every morning and being positive" (Sally); "believing everything would be ok" (Constance); and "that everything has a silver lining" (Eunice). Participants like Lana exercised gratitude and was always "grateful and to just have a roof over my head."

Positivity is also about seeking social support when needed (Nes & Segerstorm, 2006), which helps with sense of belonging, sense of purpose, and bonding with individuals (Pemberton, 2015). Sally and Eunice relied on each other as Sally mentioned that "reaching out . . . just kept me happy . . . seeing Eunice I always felt happy." Sally, like others knew when to reach out to friends for social support to keep her mindset positive. All extraverted participants

and most introverted participants in this study did seek out social support to stay positive, and keep encouraged and optimistic (Mak et al., 2011).

Keeping a positive perspective likely reflected participant's age and experience. This mindset relates to the concept of "resilient aging" which demonstrates life satisfaction from a positive perspective of aging (Lima et al., 2023). Resilient aging is outlined as the positive attitudes of older adults that keep them resilient (Lima et al., 2023). Resilient aging was demonstrated through participants appreciation for new roles (being a grandmother), new transitions (retirement), and an overall appreciation for growing old. Resilient participants were able to keep a positive mindset and response to the stressful situation of the pandemic, with reactionary positive coping strategies (i.e., encouraging self-dialog, reaching out to friends, and exercising gratitude) (Fletcher & Sarkar, 2013). Through participant stories, it was shown that positivity was a big part of their resilience, as resilient individuals use positive emotions to find positive meaning in stressful situations (Fredrickson and Branigan, 2005) and maintain an optimistic view regarding the world and the self (Mak et al., 2011). Positivity emerged as an important component of resilience for participants, as remaining positive during the pandemic helped participants to cope, remain hopeful, and resilient (Tugade & Fredrickson, 2004).

Perseverance

Finally, the fifth dimension of resilience that participants identified, *perseverance*, refers to the voluntary persistence of goal-directed action despite struggles and obstacles (Merriman, 2017). Perseverance is the degree to which people will make long-lasting efforts while facing challenging situations (Datu, Valdez, & King, 2016). The word "perseverance" in Latin means "one who sees through to the end," and "one who doesn't yield" (Wheatley, 2010, p. 1).

Throughout their pandemic experience, participants chose to actively keep going, not give up, and persist in the face of adversity (Buikstra et al., 2010). Perseverance helped participants confront constraints (i.e., stay-at-home orders and physical distancing), increase their sense of self-regulation (be flexible and acclimate to changing government mandates), and expand their self-efficacy (i.e., it helped them believe in themselves and their ability to make it through the pandemic) (Jaeh & Madihie, 2019). The positive psychology literature surrounding resilience usually includes perseverance as an essential component (Robertson-Kraft & Duckworth, 2014; Buikstra et al., 2010). All participants in some way shape or form thought "just get up, get up and do something. Don't lay here and feel sorry for yourself. You got to do something else," as Billie put it.

Sisto and colleagues (2019) described psychological resilience as the ability to overcome difficulties with perseverance and good awareness of oneself and internal coherence through a personal growth project. For participants in this study, resilience was about persisting, and assuming a persevering attitude that was about not giving up and being open to change (Sisto et al., 2019). Resilience was about "getting through the worst of the storm" as Eunice described it. In Cordelia's words, it means being open to "making changes in life. In every stage of life, you know there are new things you have to do" referring to her "pandemic lifestyle" of "staying in rather than going out."

Perseverance was a significant contributor to how participants got through the pandemic. Their drive to keep going and move forward in the face of hardships was associated with greater mental toughness, "a state-like psychological resource that is purposeful, flexible, and efficient in nature for the enactment and maintenance of goal-directed pursuits" (Gucciardi, 2017, p. 18). As Zoe mentioned, she "didn't make it to 80 years of age without being tough." Zoe, like other

participant's mental toughness enhanced their likelihood of perseverance (Giles et al., 2018), as they felt they had to "keep going" because it was going to take "more than COVID to take me out" as Eunice put it. It was clear that during the stressful time that was the pandemic, participants persevered which helped keep them resilient and well (Tsai & Morissette, 2022).

The Horror is Over

Now that the pandemic has been declared over, the horror of COVID-19 has settled, and society has moved forward. Through participant recollections, it was clear that extraversion, introversion, vaccination status, and social connections all played a role in participant stories. Extraverts and unvaccinated participants struggled the most in terms of loneliness and social isolation, whereas introverts and vaccinated participants acclimated better. Perhaps one of the biggest takeaways of this chapter was something all 18 participants had in common: the importance of leisure for resilience. Leisure came to be regarded as an important dimension of participant's pandemic stories, largely because of its effectiveness as a resilience strategy.

In terms of gaps, social isolation and loneliness still deserve greater attention as societal crises. Even in the aftermath of the pandemic, social isolation and loneliness remain a problem. The U.S. surgeon general has named it an epidemic in the USA (Murthy, 2023), which proves that this research remains relevant, even with the formal end of the pandemic. We also need to learn from this pandemic for the future, especially understanding how and why some older adults adapted better than others (COVID-19 resilience). These questions and understandings introduce recommendations for practice and research that I will explore in the next chapter.

CHAPTER SEVEN: CONCLUSION

Summary of Project

Looking at the timeline I have created, the conclusion shows that participants are all settled into a "new normal" and are in a "perfect place" as Jude put it. Using narrative inquiry offered a contextually rich approach to this research, by allowing me as a researcher to delve deep into participant's experiences, perspectives, and lived realities of the pandemic. By focusing on storytelling, narrative captured the complexities of participant's expriences, and provided a rich context for understanding social contexts (i.e., living alone and with little to no social connections) that offered insights into how these contexts shaped individual lives during the pandemic. A narrative approach also provided a platform for participants as it amplified their voices by empowering them to share their stories and perspectives in their own words.

The main purpose of this Ph.D. dissertation was to explore, (1) how did public health restrictions affect older adults during the pandemic; (2) what did resilience mean to older adults and what resilience strategies did they use to stay socially connected during the pandemic; and (3) what role, did leisure play as a resilience strategy in addressing the threats of social isolation and loneliness during COVID-19? To explore this topic, I interviewed 18 older adult women who lived alone in the community during the COVID-19 pandemic to gather their stories and hear their experiences of the pandemic. Through participant stories, I found that during public health restrictions, extraverted participants experienced loneliness to a greater degree than introverted participants, as introverts were comfortable in their own presence and extraverts relied more heavily on face-to-face interactions. All 18 participants felt they were resilient, and maintained their resilience by keeping perspective, staying positive, persevering, adapting, and

accepting their situation. And finally, every participant looked to leisure as a resilience strategy to combat loneliness, social isolation, and pandemic changes (i.e., stay-at-home-orders) because it enabled them to stay distracted, stay connectioned, and stay active.

COVID feels like a bad dream for most of us at this point. As of May 11, 2023, we are officially no longer in a pandemic (CBC, 2023), but we will continue to experience the repercussions of COVID for many years to come, financially, mentally, emotionally, and socially. The purpose of this chapter is to offer recommendations for research and practice based on my research. The chapter will be organized first by discussing recommendations for research, recommendations for practice, how we can support older adults moving forward, limitations, and next steps.

Recommendations for Research

Through my dissertation, themes arose that ought to be highlighted. First, despite this study's focus on only female participants, loneliness and social isolation clearly affect men, too. Moreover, they affect men and women differently because of societal norms, differing coping mechanisms, and individual situations. Gender differences in socialization patterns deserve deeper examination, as women typically have larger and more diverse social networks, which may provide more opportunities for social support and buffering against loneliness (Taylor et al., 2011). By contrast, men may have smaller social circles, which can leave them more vulnerable to isolation if those social connections are threatened or left to wither (Umberson et al., 1996). Differences in socialization patterns can possibly stem from stigma, as men tend to internalize their feelings and not seek help, thereby perpetuating their sense of isolation (Umberson et al., 1996). Women may face less stigma around expressing emotions and seeking social support,

thus making it easier for them to address feelings of loneliness (Taylor, 2006). Recognizing gender differences in socialization patterns, loneliness, and social isolation, is important for developing targeted interventions and future research projects.

Second, for future research, intersectionality, and how intersecting social identities (e.g., race, ethnicity, gender, sexual orientation, disability) combine with age to shape experiences of social isolation and loneliness among older adults warrant attention. Intersectional approaches can help identify discrepancies in access to social support networks and resources and inform the development of interventions that address the intersecting needs of older adults from marginalized or underrepresented groups.

Third, the role of digital connectivity and its usage were evident in my findings, so exploring the role of digital technologies and online social networks in mitigating or exacerbating social isolation and loneliness among older adults needs more attention from researchers. Future research should examine factors influencing digital literacy, access to technology, attitudes towards online social interactions, and the potential benefits and drawbacks of digital connectivity for older adults' social wellbeing.

Loneliness and Social Isolation in Research

Research on social isolation and loneliness among older adults is vital for understanding the challenges they face and developing effective interventions to address these issues. Some research directions include researching prevalence and risk factors (i.e., living arrangements, health status, mobility limitations, and access to social support networks); technology and innovation (conducting studies on the use of digital communication tools, virtual reality platforms, and smart home technologies to facilitate social connections); examining policy and

community development (studying and evaluating existing policies and programs that promote social engagement); and researching cultural factors (research how cultural norms, values, and societal attitudes toward aging influence the experience of social isolation and loneliness among older adults).

Bound (2019) described loneliness as the leprosy of the 21st century. Despite various academics and researchers speaking of the importance of social connections and social integration as critical to quality of life and mortality, public authorities in Canada remain apathetic about the threats of social isolation and loneliness (Haslam et al., 2022). The severe pervasiveness of loneliness and social isolation during the pandemic suggests investigations of longer trajectories of loneliness and overtones with other negative effects of the pandemic (e.g., depression) deserve examination (Krendl & Perry, 2021). The pandemic worsened social isolation among older adults (MacLeod et al., 2021), which may have long-lasting effects. These outcomes warrant research (MacLeod et al., 2021). Given that gender plays a role in loneliness, efforts to monitor, prevent, and manage this silent epidemic is critical to position health authorities to respond more effectively in future crises (Goveas et al., 2021). As an increasingly recognized epidemic (see U.S. Surgeon General, 2023), social isolation and loneliness ought to be continued topics of research focus to understand prevention and support strategies.

Resilience in Research

Moving beyond a medical lens to understand how people cope with stressful life situations, I suggest understanding resilience through positive emotions, such as hope, compassion, kindness, and empathy (Ward, 2020), like the traits my participants identified in articulating their meaning of resilience. Ward (2020) wrote:

> Research exploring case studies of a less dystopian future are required – why/how do more positive outcomes occur, in what social groups do they occur, and can we transfer them more broadly? What part does individual and/or community resilience play in the emergence of hope, and is this socially structured? Given the relatively recent emergence of a "sociology of happiness" (Cieslik, 2015), research could explore how happiness might be enabled during and post-Covid-19 (Ward, 2020, p).

This perspective, to me, warrants further research. How can we strengthen individual resources and strategies to better prepare for the next societal disruption? Better yet, how can we give people hope and keep them happy? These are the sorts of perspectives we need to keep in mind when researching how and what keeps people resilient. To exercise this approach, researchers must consider the positive coping and resilience strategies (i.e., purpose in life, optimism, and social connections) that positively influence health and wellbeing (Musich et al., 2021). By considering positive coping and resilience resources and strategies, interventions could be examined and created to enhance them. Social isolation and loneliness can be alleviated through resilience strategies (Musich et al., 2021), which underscores the importance of resilience research, especially in times of crisis when social isolation and loneliness are exacerbated.

To date, most resilience research centres mainly on children and teenagers (Fengjian et al., 2017), with a focus on individual groups who have experienced trauma, particularly during childhood (Castro et al., 2007) and adolescence (Ali et al., 2010). Though it is essential to still study resilience amongst children and adolescents, understanding resilience and resilience strategies, creating policies, and developing theoretical frameworks across the life span, particularly in later life, is important (Ward et al., 2011). Resilience research on older adults must continue to move from its focus on negative risk factors to the positive resources that older adults independently possess (Musich et al., 2021), which means merging resilience and gerontology together.

Gaps in the Literature

This study reminds us that older adults are resilient, but the subject should not be ignored. Focusing on older adults and resilience will only build capacity for greater resilience in the future. Leisure as a resilience strategy for older adults warrants further attention, too. Understood to be a coping strategy or resource to strengthen one's quality of life, leisure warrants consideration for its contributions to resilience. Hidden resilience, such as taboo leisure strategies for older adults (sex, alcohol, marijuana etc.) also require more attention. Older adulthood is not all about knitting and back pain. It also involves dating, casual sex, drinking alcohol, smoking weed, and so much more that is not conventionally considered to be activities in which older adults engage. This study shows that older adults stayed resilient through non-conventional forms of leisure, which is a subject that needs more attention from both the coping and leisure literature.

Recommendations for Practice

My research emphasizes the need to support, allow, fund, and keep leisure pursuits available for older adults. The importance and value of leisure warrants greater recognition. Leisure proved to be an effective strategy to alleviate loneliness in older adults in this study and beyond (Nyqvist et al., 2023). It stands as a solution to addressing the growing public health crisis loneliness and social isolation (Nyqvist et al., 2023). Governments, policies, and public health must shift their attention to the importance of leisure in later life and how it serves older adults in their efforts to remain resilient.

As a current director of programs in long-term care, I see the value of leisure every day with my residents. While their questions pertaining to medication and quality of care will always

be important, their questions about their leisure get at the crux of their quality of life. “What will I do all day?” “Can I still listen to my music?” “Do you have social programs where I can make friends?” These questions speak to the role leisure programming plays in advancing quality of life in a way that no medication or care practice can address. Leisure provides purpose, meaning, and strengthens quality of life (Kim et al., 2007) in ways other supports cannot offer. The pandemic is instructive here. Once leisure was taken away, loneliness, depression, and withdrawal emerge as issues of serious concern. Leisure must be viewed to the same importance as medication, as it is a social prescription (connecting patients with non-medical sources of support within the community), which supports social connectedness and alleviates loneliness and social isolation (Drinkwater et al., 2019).

Should we ever find ourselves in pandemic again, we need to be more vigilant about “alarmist messages,” such as those that emphasized the negative aspects of the pandemic (i.e., number of seriously ill people or deaths). Instead, we should focus on the positive ones (number of recovered), (Pietrbissa & Simpson, 2020, p. 5). Messages of death and illness are counterproductive (Pietrbissa & Simpson, 2020) and just create more fear, panic, and despair within the population, especially older adults (Wister & Speechley, 2020). All older adult participants in this study expressed fear at the start of the pandemic in response to news and public health leaders. Future messaging should be cautionary, as opposed to alarmist.

Given the importance of social connection, in the future, we need to ask ourselves:

> Does the idea of physical distancing cement notions of other humans as carriers of risk, and thus in need of distancing in the future? Does the communicable nature of viruses and the focus on physical distancing lead to fear/loathing of the “other”? Will the post-Covid-19 world be more individualistic as a result of the fear of the “other” Is this a temporary way of “othering” based on panic and perceived heightened threats? Do we “other” everyone apart from those we live with? A linked area of research could focus on what/ who are the “symbols of risk,” and do they feed into judgement, blame and stigma? (Ward, 2020, p. 4)

Because we do not know the long-term effects of the pandemic, we need to monitor its longer-term effects on social relationships and connections. We must also to focus on creating policies sensitive to vulnerable groups (i.e., older adults at risk for social isolation) (Betini et al., 2021) that promote a sense of connection and group membership, in contrast to individualistic and isolating way of life promoted during the pandemic (Ward, 2020).

For older adults in terms of their resilience in practice,

> We need to continue to develop innovative ways to provide the necessary supports to older adults most at risk, and to learn from those most resilient… understanding the nexus of risk, vulnerability, and resilience has potential to identify key questions and shape a path forward, including but not limited to the following…What can we learn – both positive and negative - from societies with large proportions of older persons, such as Italy and Japan? What are the most important resilience resources (e.g., family/community supports)? (Wister & Speechley, 2020, p. 4)

Within practice, leaders ought to consider what policies and interventions work or do not work to boost resilience. Bigger than just the threat of disease, we need to understand how we can be better prepared for the negative social consequences of future societal disruptions. We need to think about best practices to promote positive responses in times of stress; what is working right now (i.e., policy, laws, mandates) that helps keep older adults resilient? (Raina et al., 2021). Strengthening recommendations for practice, surveillance, research, and preparation is critical to engage in best future practices for older adults.

This study underscores the point that greater awareness and education pertaining to the epidemic and public health crisis of social isolation and loneliness are sorely needed. Education campaigns targeting both older adults and the general population can help reduce stigma, raise awareness of available resources and support services, and encourage proactive strategies for promoting social connectedness and wellbeing in later life. With that said, we need to integrate

more frequent routine screening and assessment for social isolation and loneliness into healthcare settings, including primary care, geriatric care, and community health programs. Healthcare providers can play a crucial role in identifying at-risk individuals, initiating conversations about social wellbeing, and facilitating referrals to appropriate support services and interventions, and one of the best supports is social prescribing. Expanding access to social prescribing programs that connect older adults with non-medical sources of support and community resources to address social isolation and loneliness could involve increasing collaboration between healthcare providers, social service agencies, community organizations, and local governments to facilitate referrals can help alleviate social isolation and loneliness (Drinkwater et al., 2019). Even in this study, social prescribing could have been a big help for a few of the participants that needed it most.

Finally, given that neighbourhoods and neighbours played such a big role in this study, there needs to be better fostering of community engagement to create local age-friendly environments that promote social inclusion and meaningful participation for older adults. Neighbourhood and community-based initiatives, such as senior centres, neighbourhood associations, volunteer programs, and cultural activities can provide opportunities for social interaction, civic engagement, and peer support (Drinkwater et al., 2019; Glover & Bates, 2006). Exploring the role of neighbourhood characteristics, community infrastructure, and neighbour connections in shaping older adults' social networks and opportunities for social engagement can support create age-friendly communities that promote social inclusion and engagement. Future research projects are needed to gage the impact of neighbourhood engagement, transportation accessibility, green spaces, and community resources on older adults' social connectedness and

quality of life, as neighbours, neighbourhoods, and community (Glover et al., 2023) have proved to play a massive role in the lives of older adults.

How To Support Older Adults Moving Forward

How do we support older adults moving forward? How do we address social isolation and loneliness among older adults? Positively, the use of information and communication technologies (ICT) has become more prevalent among older adults since the pandemic (Lawless et al., 2020), which enables older adults to access social support and social connectedness and alleviate social isolation (Chen & Schulz, 2016) when faced with the need to isolate. Face-to-face connections, however, must be privileged, given what we know about the positive outcomes associated with them (see Pinker, 2014).

As social isolation was heightened during the pandemic, immediate outreach options, such as volunteers calling older adults who live in the community (MacLeod et al., 2021) was helpful. The model of "Senior Centre Without Walls" serves as a useful model for offering remote programs (either by telephone or virtually) that ought to be adopted by more community and non-profit organizations in Canada. Similarly, communities should adopt phone call outreach programs, such as "Seniors Overcoming Social Isolation (SOS)," which recruit health care student volunteers to call older adults who live alone in the community and are identified by their primary care provider as at risk of social isolation. The goals Of SOS were to "(1) to provide companionship and resources for unmet needs of older adults while (2) fostering health professional students' skills in communicating and understanding the needs of older adults in their community" (Office et al., 2020, p. 2). These strategies, if put in place now, would position communities to better respond to societal disruptions in the future.

Limitations

As with any study, my study has limitations that must be acknowledged. First, the data in this study are cross sectional. Thus, I "recognise that the interviews, even with member checks sometime later, represent a slice in time; life changes, for better or worse, and the reports shared must therefore be understood as temporally situated" (Kleiber & Nimrod, 2009, p. 14). What stories participants recalled and shared with me were their reality at that moment. Perhaps, if asked today, they would tell a different story, or understand their reality in a different way. Stories change.

Another limitation of this research was the homogeneity of my participant pool. I interviewed heterosexual women who were mostly white. I also did not interview anyone who lived remotely or could be classified as low-income (government housing). And finally, though I tried to recruit men, I was unsuccessful in doing so. The perspectives shared in this study, therefore, are arguably narrow.

Though I acknowledge the lack of diversity as a limitation in this study, I do not believe it lessens or devalues the stories I collected. Every story tells us something. As I mentioned to one of my participants Eunice, that I could only recruit all women, she laughed and responded, "good. We women have been sitting on the sidelines a long time. We can have our turn." Her response speaks to the importance of focusing on women as doing so offers a unique opportunity to prioritize women's health and wellbeing. I value the time and energy the participants in this dissertation committed to this project. I admire and am truly thankful for their contributions.

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Appendix A- Screening Question

Older Adults Experiencing Social Isolation and Loneliness During COVID-19: Resilience through Leisure?

This survey is used to determine your eligibility to participate in my research project. Please answer the questions listed below.

1)Are you 65 or older?

Yes

No

2) Do you live in the Kitchener-Waterloo area?

Yes

No

3) Do you have chronic heart failure, recent surgery, dialysis, transplant, or intractable rare disease, unstable mental health disorders (bipolar disorder, psychosis, schizophrenia)?

Yes

No

4) Are you independently mobile?

Yes

No

5) Do you live by yourself?

Yes, I live by myself

No, I live with others in the same household

6) Have you lived by yourself since the beginning of the COVID-19 pandemic to present day?

Yes, I have lived by myself since or before March 11, 2020.

No, I have lived with others in the same household at some point since March 11, 2020.

7) Did you engage in leisure activities during this time?

Yes

Sometimes

No

Appendix B- Sample Interview Questions

Demographic Questions

1) What is your age?
2) What gender do you identify with?

Reactions to Public Health Restrictions during the pandemic

1. What was it like to live alone during the pandemic?
   - Did you feel disconnected from others at any point? If so, when?
   - Did your experience change over time? If so, why?

2. How did public health restrictions, in particular, affect you?
   - Many older adults struggled at the beginning of the pandemic because of public health restrictions, such as physical distancing. Would you say you did so, as well? If so, why? If not, why not?
   - How did your experience with public health restrictions change over the course of the pandemic?

3. During the pandemic, older adults seemed to face the double threat of catching COVID and feeling lonely because of physical distancing restrictions. How did you balance these threats?

4. What was your life like before the pandemic?
   - Was it any different? If so, how?
   - How did things you did before the pandemic change?
   - How did social interaction change?
   - How did routines change?

Resilience during the Pandemic

1. What was your initial assessment of the pandemic? Did you see it as a threat? An opportunity? Did your assessment change over time?

2. During the pandemic, what did you do, if anything, to:
   - Adapt to pandemic living?
   - To stay healthy?
   - To have quality of life?

3. What does it mean to be resilient during the pandemic?
   - Would you characterize yourself as a resilient person because of how you coped with public health restrictions? Why or why not?
   - What does it mean to be resilient to you?

Social Isolation

1. Who in your life, if anyone, did you regard as someone you could rely on for meaningful support if and when you needed it during the pandemic?

2. How did your relationship with family and close friends change, if at all, during the pandemic? What about your relationship with acquaintances, those people with whom you're friendly, but not necessarily close? What about the familiar strangers you see in your community?

3. What strategies, if any, did you use to connect with others during the pandemic?

4. Loneliness is common among older adults. How did it affect you, if at all, during the pandemic?

5. What, if anything, made you feel isolated or lonely during the pandemic?

6. How important are social connections to you? Has your view of the importance of social connections changed over the course of the pandemic? If so, how. If not, why not?

Leisure

1. What leisure activities did you engage in, if any, during the pandemic?

2. How did these activities either contribute or alleviate your efforts to avoid feeling social isolated or lonely?

3. Ultimately, did leisure play a role in getting you through the worst of the pandemic? If so, how? If not, why not?

4. In this study, I'm interested in how leisure fit into your pandemic story. How would you say it did so?

Probing Questions

- Tell me about your experience during the pandemic as an older adult. How were you affected by public health restrictions?
- Tell me about your living situation during the pandemic. How did it contribute your sense of social connectedness or lack thereof?
- Describe your social network during the pandemic. Who in your life, if anyone, did you regard as someone you could rely on for meaningful support when you needed it?

- During the pandemic, older adults seemed to face the double threat of catching the COVID virus and feeling lonely because of physical distancing restrictions. How did these threats affect you?
- How did you view the pandemic as an older adult? What problems did the pandemic create for you? What did you do, if anything, to adapt to pandemic living and stay healthy?
- How did you respond to not seeing people? What strategies, if any, did you use to connect with others?
- Loneliness is common among older adults. How did it affect you, if at all, during the pandemic?
- What, if anything, made you feel isolated or lonely during the pandemic?
- How important are social connections to you?
- What were things like before the pandemic for you?
- Were there things you did before the pandemic that changed? Socially? Routines?
- What sort of leisure activities did you engage in during the pandemic? How did they contribute to or alleviate your social isolation and loneliness?
- What does it mean to be resilient during the pandemic? Would you describe yourself as resilient? If so, what makes you say so?
- Ultimately, what got you through the worst of the pandemic?

Appendix C- Social Media Script

Facebook Status and Instagram Story

Are you or a loved one an older adult living alone in the community from the start of the pandemic until now? I am looking for participants for a study on older adults, social isolation and loneliness, resilience, and the pandemic! See poster for more details!

[attach recruitment poster]

Appendix D- Recruitment Poster

Recruitment Poster

UNIVERSITY OF WATERLOO

PARTICIPANTS NEEDED FOR RESEARCH IN:

OLDER ADULTS AND RESILIENCE IN THE PANDEMIC

Volunteers are needed to take part in a study about *Older Adults, Resilience, Social Isolation/Loneliness & the COVID-19 Pandemic:*
Participants must:

- be 65 and older
- live in the KW region
- live alone in the community from the start of the pandemic (March 11, 2020) until present day
- are independently mobile
- engaged in leisure activities during the pandemic

As **one of 20** participants in this study, you would be asked to describe:

- Your experience living alone during the pandemic
- How you participated in leisure during the pandemic
- What you did if you felt lonely or socially isolated due to public health restrictions
- In what ways you are resilient

Study Description

The purpose of this narrative inquiry is to understand leisure as a resilience strategy to combat social isolation and loneliness among older adults who live alone in the community in Kitchener-Waterloo region during the start of the pandemic (March 2020), up until present day. Because physical distancing as a result of public health restrictions limited in-person social interactions, many older adults who lived alone during the pandemic were more prone to social isolation and loneliness. This research explores how leisure served as a way for older adults to address this issue and improve their quality of life.

Participation would involve a video call interview (approximately 30 minutes to one hour), at a time convenient to you.

In appreciation for your time, you will receive a $20.00 gift card to Wal-Mart.

For more information or to volunteer for this study, please contact:

Victoria Atabakhsh
Department of Recreation & Leisure Studies & Aging, Health & Well-Being
Faculty of Health
at Email: *vatabakh@uwaterloo.ca*

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board.

This study is for completion of a doctoral dissertation

Appendix E- Consent Forms

Consent forms

VERBAL INFORMATION LETTER – SCRIPT (PART I)

Date: TBD

Title of Project: Older Adults Experiencing Social Isolation and Loneliness During COVID-19: Resilience Through Leisure?

This interview will be facilitated by myself, [Victoria], a doctoral candidate working with Dr. Troy Glover, a faculty member at the University of Waterloo in the Department of Recreation and Leisure Studies.

Your verbal consent means that you agree to participate in this video call interview. You have made this decision based on the information you received prior to this interview, contained in the information package. At any time feel free to ask questions and request any additional details you want about this study.

Participation in this is voluntary and involves approximately one hour of your time. The discussion we have here today will pertain to your experience living alone during the pandemic. You may decline answering any questions you feel you do not wish to answer.

Your participation will be considered confidential. Your name will not be used in any paper or publication resulting from this study, however, with your permission, quotations may be used with a pseudonym in place of your real name. Identifying information will be removed from the data that is collected and stored separately. You may withdraw your consent up until 3 months after your interview when identifying information will be permanently erased. Additionally, you will not be able to withdraw consent once papers and publications have been submitted to publishers. Collected data will be stored in a locked office and on a password protected Google Drive for a minimum of 7 years.

If you have any questions about participation in this project, please feel free to discuss to ask any questions. My e-mail is vatabakh@uwaterloo.ca and my supervisor, Dr. Troy Glover's e-mail is troy.glover@uwaterloo.ca

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (REB #44621). If you have questions for the Board, contact the Office of Research Ethics at 1-519-888-4567 ext. 36005 or reb@uwaterloo.ca

PARTICIPATION AGREEMENT & VERBAL CONSENT FORM SCRIPT (PART II)

You may give a 'yes' or 'no' to the following questions. Given the information you just heard:

Do you agree to participate in this video call interview lasting approximately one hour?

YES NO (Please circle participant's choice)

Do you agree to have this interview audio recorded?

YES NO (Please circle participant's choice)

Do you agree to the use of quotations from your interview in any paper or publication resulting from this study with the understanding that you will remain anonymous?

YES NO (Please circle participant's choice)

Are you aware that you may withdraw your consent up until 3 months after your interview when identifying information will be permanently erased?

YES NO (Please circle participant's choice)

Do you allow for your data to be used in my doctoral dissertation, and possible conference presentations and journal articles?

YES NO (Please circle participant's choice)

Thank you.

Participant Name: _____(Please print)

Witness/Interviewer Name: _____

Witness/Interviewer Signature: _____

Date: _____

Would you like to be contacted about the results of this study following its completion?

YES NO (Please circle participant's choice) If yes, may I have your preferred contact information (i.e., email, mailing address)?

_____

To show our appreciation, we would like to offer you a $20 Wal-Mart gift card. What is your preferred mailing address for the gift card?

_____

_____

Thank you, again, for taking the time to participate in this study. I will now turn on the audio recorder and begin the interview.

Appendix F- Information Package

Information Package

This information packet will give you information you need to make an informed choice about participating in this study.

Background and Project Information
This study is for completion of my (Victoria) dissertation, with an intention of gathering experiences of older adults living alone in the pandemic. Specifically, this study aims to:

As **one of 20** participants in this study, you would be asked to describe:

- Your experience living alone during the pandemic
- How you participated in leisure during the pandemic
- What you did if you felt lonely or socially isolated due to public health restrictions
- In what ways you were resilient
- How you used leisure as a resilience strategy to combat social isolation and loneliness
- If leisure alleviated or contributed to pandemic related social isolation and loneliness

Resilience Through Leisure During the Pandemic to Combat Social Isolation and Loneliness
Storytelling is means to communicate important messages in powerful ways. This study will highlight stories told by older adults with the aim to uncover how you were resilient during the pandemic and how leisure played a role in your experiences of social isolation and loneliness.

Phone interviews: What will I be asked?

The interview is composed of four main parts:

1. **Introduction and explanation of the research** – I will briefly describe the study and gain your consent for participation (should you wish to give it). I will then turn on the audio recorder (if you consent to having the interview digitally recorded). Finally, I will ask for your preferred pseudonym (a different name that you will be identified by in future publications).
2. **Discussion** – I will ask you to describe your experience during the COVID-19 pandemic. How you engaged with leisure, how you handled the physical distancing restrictions, and how you would define resiliency. During this time, I will give you as much time as you need to think about the questions you are asked.
3. **Probing** – I will ask you a number of clarifying questions to help you describe these experiences.

4. **Conclusion** – I will conclude the interview and describe the next steps of the research process. I will then ask for your address to mail you your gift card as a token of appreciation.

[1]Anderson, C., & Kirkpatrick, S. (2016). Narrative interviewing. *International journal of clinical pharmacy, 38*(3), 631-634.

Why do you need to digitally record the interview?

I ask participants to have their interview digitally recorded so that I can transcribe (document your responses in a word processor) your interview. It is important to the research process that I reflect as much detail as possible. Should you feel uncomfortable with having your interview recorded, the I will need to hand write your responses in as much detail as possible.

How much time will I need to commit to this study? What activities are involved?

Participants will be asked to participate in three phases (see Table 1, below).

- ☐ ***Step 1 –*** *The Screening Questionnaire will be conducted to see if you are eligible for this study. This will be done through the emailed form. Screening should take less than 5 minutes.*
- ☐ ***Step 2-*** *C*all/email to schedule a phone interview time and date with the researcher. You can reach me (Victoria Atabakhsh) at vatabakh@uwaterloo.ca
- ☐ ***Step 3***– I will call you during your scheduled time to complete your narrative interview. I will ask you for your permission to audio record your interview and re-describe the purpose of the study and what your interview will be used for. I will then ask for your consent to participate in the study and remind you of your rights and risks (described below) before beginning the interview. You are welcome to ask any questions you like at any time during the phone call. Should you have questions at the end of your interview that require follow up, my supervisor (Dr. Troy Glover) will contact you to respond to the questions/concerns you may have. Dr. Glover is both a professor and experienced researcher with an expertise in leisure studies, social isolation and loneliness, and the research/dissertation process. He can provide further information and detailed answers to any questions you may have.

Table 1: Time Commitment and Activities

Step	Activity	Time/Location
1	Introductory phone call	10-15 minutes
2	Interview (video call)	45 minutes to one hour
	All interviews	***Interview times can vary. Typically, they will take between 45 minutes to an hour based on the number of***

		questions and the answers provided.

What are my rights? What are the risks of participating?

Your participation is voluntary. You may decline to answer any question(s) you prefer not to answer by requesting to skip the question. Further, you may end the interview at any time by advising the researcher of this decision.

Your participation will be considered confidential. Your name will not be used, however, with your permission quotations may be used with a pseudonym in place of your real name. Identifying information will be removed from the data that is collected and stored separately. Within three months of the interview, identifying information will be permanently deleted. You can withdraw your consent to participate and have your data destroyed by contacting us within this time period. After this time, it is not possible to withdraw your consent to participate as we have no way of knowing which responses are yours. Additionally, you will not be able to withdraw consent once papers and publications have been submitted to publishers. Collected data will be stored in a locked office and on a password protected Google Drive for a minimum of 7 years.

As this study asks for your experience during the pandemic, discussing negative, challenging, and vulnerable stories may be upsetting. Should you find yourself feeling uncomfortable with recalling your own story, please notify me immediately. Counseling contact information is provided below should you require additional support.

Resources for mental wellness:

- *Canadian Mental Health Association* - http://toronto.cmha.ca/mental-health/find-help/
- *Carizon Community Services, Kitchener* – www.carizon.ca
- *KW Counselling Services* – www.kwcounselling.com
- *Crisis and Outreach Service for Seniors*- www.woodgreen.org
- *Women's College Hospital* - http://www.womenscollegehospital.ca/programs-and-services/mental-health/groups

Token of appreciation and staying informed

At the start of the interview, I will ask you for a preferred mailing address. This information will only be used by me to send out your gift card as a token of appreciation. The Walmart gift card will be valued at $20. The amount received is taxable. It is your responsibility to report this amount for income tax purposes. You will also be anonymously acknowledged in any forthcoming publication or presentation, and you will receive a thank you letter with the gift card.

Should you wish to stay informed with the developments of this project, you may choose to leave your contact information of your choosing (e.g., email address, telephone number). I will only use this information to send you updates about the project (i.e., conference presentations, publications) if you wish.

How will I provide my consent?

You will be asked for your verbal consent at the start of the interview, at which time you will be asked if you are comfortable having the interview audio-recorded.

How will my responses be used/shared?

Your responses will be grouped with others' responses and analyzed for use in my doctoral dissertation, conference presentations, and journal articles

Do you know someone who would be interested in participating in this study?
If so, please feel free to pass on this information and tell them to contact me at the information below.

Who is an appropriate participant for this study?

Community-dwelling older adults aged 65 and older who are independently mobile (Lee et al., 2021) have lived alone in KW since the beginning of the pandemic to present day and who engaged in forms of leisure throughout this time.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me or my supervisor at the contact information listed below.

Contact information

Doctoral Candidate
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vatabakh@uwaterloo.ca

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troy.glover@uwaterloo.ca
Phone: (519) 888-4567, x43097

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (REB #44621). If you have questions for the Board, contact the Office of Research Ethics at 1-519-888-4567 ext. 36005 or reb@uwaterloo.ca

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Appendix G- Thank You Letter



[Date]

Dear ***(Insert Name of Participant),***

Thank you for participating in this study focused on the experiences of older adults during the pandemic.

The information you provided during your interview will help me with my doctoral dissertation and to further shed light on the resilience that older adults possess, especially during the pandemic. To show my appreciation, please accept the $20 Wal-Mart Gift Card enclosed.

Please remember that your participation will be kept confidential. You will not be identifiable by the information shared through teaching or research community. Stories will be grouped together throughout my dissertation. If you are interested in receiving more information regarding the results of this study, or would like a summary of the results, please provide your email address, and when the study is completed, I will send you the information. I anticipate the study results to be ready by June 2024. In the meantime, if you have any questions about the study, please do not hesitate to contact me by email or telephone as noted below.

This study has been reviewed and received ethics clearance through a University of Waterloo Research Ethics Board (REB #44621). If you have questions for the Board, contact the Office of Research Ethics at 1-519-888-4567 ext. 36005 or reb@uwaterloo.ca

Sincerely,

Victoria Atabakhsh
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Faculty of Health
University of Waterloo
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