Ageing and COVID-19

Maria Łuszczyńska (ed.)

Routledge, 2021

Content

Introduction

COVID-19 as the unknown

At the beginning, I would like to convey the author's disclaimer that he consciously raises a number of sensitive topics that deviate from the usual views. The article is of a working nature, its main purpose is to provide material and stimulate constructive discussion, including in the area of omitted topics or conclusions. The author is of the opinion that the current situation forces for a more effective and open discussion, a constructive dispute, in which opposing views often intersect, in order to consolidate the actions necessary for our survival as a species and survival of the planet. Therefore, I do not treat any of the presented views as the only truth, I ask the readers only to assume that my intentions are positive when I proclaim these views.

The goal which the editor of the book on senior age related issues set for the author as a doctor and a psychotherapist was to elaborate an introductory chapter covering analysis of the phenomenon of the COVID-19 pandemic, with particular emphasis on the reference to the mentality of the epoch, its way of understanding the surrounding phenomena and motivation for taking further action.

In the phenomenon of the COVID-19 pandemic, the author distinguishes between a group of medical and biological issues and a group of economic and social issues. Both groups take part in the global civilizational crisis related to the breakthrough of the industrial and post-industrial era and the accumulation of negative consequences of extensive development during the industrial era. The author presents the view that the COVID-19 pandemic is one of the consequences of the industrial era and only a catalyst for the intense phase of the global crisis.

In his previous publications on mental barriers impeding the comprehensive capturing of the COVID-19 pandemic phenomenon [17,18], the author pointed out the difficulties in capturing the full picture of this phenomenon, which requires a synthetic view taking into account the point of view of various specialties. The problem is the current fragmentation of science into very many hermetic detail-oriented sciences and development of specializations and subspecializations operating within their own language and their own conceptual and terminological systems, often inconsistent with other specializations. At the same time, despite the technological efficiency of detailed sciences in the selected areas, the perception of the world, which is maintained, is often distant from the present day. Still the dominating

understanding of the human being within the in Western civilization is one of a privileged being, different from others, endowed with an immortal soul and distinguished by the ability to think, destined to rule the world. While progress in biological sciences proves that a man is the same multicellular colony as other living organisms on our planet and is an integral part of the biocenosis, the living surface layer of our planet. Despite many elements of autonomy in moving and acting, man is not able to live independently when cut off from other elements of the living organism, i.e. the biocenosis integrated into an ecosystem with the surrounding biotope.

The COVID-19 pandemic was not an unpredictable incident that unexpectedly disrupted the functioning of a well operating machine of civilization. The COVID-19 from 2020, compared to its predecessor SARS from 2003, is in total more deadly, although identical in origin and very similar in structure, and it gives an infected person a greater chance of survival. The secret lies in the 2-4-day latency in the manifestation of disease symptoms, when we infect others without having disease symptoms, and the frequency of asymptomatic or poorly symptomatic courses of the disease during which the carriers infect hundreds of people. Another distinguishing feature of COVID is the significant increase in the number of chronically ill patients with diseases resulting from the course of COVID infection in the respiratory, digestive and nervous systems.

At the outbreak of the pandemic the industrial-era civilization, which dates back to the second half of the 18th century, had already lost its functionality and stability as a result of extensive use of natural resources, including human health. It boasted that it had significantly prolonged human life, but it did so at the expense of its quality. The man, as an intrinsically integral element of the living layer of our planet (biocenosis, biotope), has been torn from it, and the parent biotope has been severely mutilated. In order to breathe, mas needs to be supplemented with green lungs, besides, they are closely integrated with the biocenosis in many other areas necessary for survival and is a transfer element of the uninterrupted flow of matter and information exchange, which is the basis of the functioning of the ecosystem. Human activities in the last 150 years of the industrial era led to a critical disturbance in the functioning of the ecosystem, to the extent that forced its deep reset in the form of the sixth phase of mass extinction of species, including the initiation of extinction of humans as a species. Due to the close functional connection of all elements of the biocenosis, its mutilation affects all its elements, including humans. This is most evident in the human population of the Western civilization, the most advanced of the industrial age. The humans of this civilization have largely lost the ability to exist independently, their biological and psychological functioning requires constant support. The degree of human mutilation determines the degree

of decrease in human immunity to infections by viruses with which they have lived for millions of years of development. The factual picture of the biocenosis of which man is an element and the biocenosis of every human body significantly differs from the commonly accepted anthropocentric worldview [17,18]. The anthropocentric understanding of the world, as discussed earlier, does not allow us to notice a rapid reduction of areas with a rich biosphere that allows for a full-fledged human existence and a rapid depletion of its composition, which is caused by human activity. For the same reason, we see the coronavirus only as a factor alien to our environment, as an enemy that appears unexpectedly and is an instrument of unethical warfare, which we must destroy in order to restore our original way of functioning. The imaginative, monumental image of a man - the Master of Nature, does not allow for the awareness that we are only a mega cell colony, similarly to the other creatures with a cellular structure that surround us and inhabit the biocenosis in which we are part. The anthropocentric view of the world denies the ability to think, feel emotions, fight for survival, even to the closest evolutionarily animals - mammals, massively bred and killed as part of the industrial process of producing food that is our food. For analogical reason the group of subcellular organisms, which are predominant in the animate nature in terms of quantity, and include viruses, viroids, phages, prions, and a number of other integral micronutrients of our biocenosis and our organism, are not included as parts of the living world. The human body contains fewer of its own cells than bacterial cells, the number of which is more than ten times greater than the number of subcellular organisms in our bodies. These microorganisms reach the interior of our body without major obstacles. The average human body transcytoses 3.1 x 1010 phages per day through the membranes of our body cells, and it is believed that this continuous stream of endogenous phages spread through the blood and organs is involved in providing us with antibacterial and antiviral protection [3]. Each human organism has a specific constellation of phages residing in it, currently we have little information on the factors determining the composition and interaction of phages in the human organism. We know that phages can penetrate lung epithelial cells, protecting against viral infections, and the competitive activity of phages against angiotensin-converting enzyme II (ACEII), which is a target for SARS-CoV and SARS-CoV-2 coronaviruses [1, 9].

At this point, I would like to explain the reasons for a wider discussion of the issues related to the relationship between the COVID-19 pandemic and the functional state of the microbiome - the flora of microbes living in our body. It is related to the view that the microbiome disorder is the basic factor opening the gate that prevents infection. So if a systemic damage to our immunity is the cause of the current SARS-CoV-2 pandemic, then fighting it will only stiffle the pandemic until the next offensive pathogen appears. The

functional state of our body's microbiome is closely related to the state of the microbiome of the surrounding biocenosis, the balance of which has also been disturbed. There is a very significant backlog of research into the microbiome, which has made us powerless when confronted with epidemic threats of the magnitude conditioning our survival as a species.

Within the biotope the human body constitutes a transit element of an uninterrupted stream of exchange of both building elements, that constitute the elements of biocenosis, and information related material in many ways of transmission. Civilisation of the industrial era led to discontinuation or unfavourable modification of this transfer and disturbed our immunity. The framework of the present publication do not allow for a more extensive discussion of this topic. I refer those interested in it to other publications of the author [17,18].

The drama of the situation is caused by the sin of omission in the area of research and development of new antibiotics and the therapeutic use of phages. Due to the significant investment risk related to the development of a new antibiotic at a cost of one billion dollars, where resistance to it can develop after several years of use, only a few companies continue to implement them, and to a limited extent. This resulted in a situation in which Carbapenems, the last implemented group of antibiotics - detected as a defense substance of one of the soil bacteria - were implemented for treatment 36 years ago. Antibiotics from this group are treated as a last resort drug and should be protected against unjustified use, in accordance with WHO regulations. Meanwhile, their main method of use is massive preventive application in industrial farms for the production of slaughter meat, which, as it has been known for many years, leads to the creation of new antibiotic-resistant bacterial strains. In countries aware of the threat of this problem, the preventive use of last-resort antibiotics was banned in industrial farms for the production of slaughter meat, which, unfortunately, is in a number of Western countries, including Poland.

Antibiotic resistance, according to OECD4 estimates, may cause 700,000 deaths worldwide (quoted after the Polish Supreme Audit Office's report of 2017/2018). In 2011–2014, the use of antibiotics in agriculture increased by 23%, and Poland ranks second in Europe in terms of the use of the most potent antibiotics in animal husbandry in the treatment of human diseases. The results of screening tests in the field of antibiotic resistance carried out by the Sanitary Inspection bodies are disturbing. Resistance to antimicrobial drugs was found in 25% of samples of poultry meat, 15% of beef and 10% of pork (quoted after the Polish Supreme Audit Office report of 2017/2018 [4].

The first case of total resistance to antibiotics was observed in Asia in 2011, and after a short time also in other areas, including Poland in (2011). It mainly refers to a New Delhi Superbacterium, which is the colloquial name of Klebsiella pneumoniae NDM - pneumonia

rod, which belongs to the group of intestinal bacteria. The New Delhi bacterium is responsible for life-threatening pneumonia, inflammation of the urinary and digestive systems, meningitis and many other diseases. Very often it causes sepsis, which ends in the death of every second patient. In Poland, the disease appeared in hospitals in 2011 in Warsaw, and again in 2012 in a hospital in Poznań. However, hospitals did not take appropriate precautions (e.g. infected people were not isolated, which is a necessity) and patients infected each other while wandering between wards. Consequently, in a short time the number of infected began to increase rapidly. According to the data of the National Reference Center for Antimicrobial Susceptibility, in 2013 there were 105 infected people across the country, and in April 2016 this number was 1100, most of them in Warsaw. However, these figures are underestimated and there are certainly many more infected. In 2018, the New Delhi bacterium was detected in a patient of the Department of Cardiac Surgery and Vascular Surgery after a heart transplant on the night of July 22-23.

The gene for resistance to colistin (an antibiotic of last resort), called the MCR-1 gene, was discovered by scientists at the South China Agricultural Academy in Guangzhougen in 2015 and was generated in industrial poultry farming. Although five years have passed since this fact, despite the alarming warnings of experts, as was the case with warnings about the threat of a pandemic related to the virus, the implementation of practical countermeasures preventing another epidemic is ignored.

A similar sin of omission concerns delaying the implementation of targeted treatment and prophylaxis of bacterial and viral infections with the use of phages. A practical achievement of the research conducted in the Soviet Union in the first half of the 20th century was the development of a phage-soaked dressing for frontline soldiers. After the collapse of the USSR the research was abandoned. These studies were successfully undertaken and continued in Immunology and Experimental Therapy of the Polish Academy of Sciences in Wrocław, mainly thanks to prof. Andrzej Górski, however, despite numerous efforts, the team of scientists from the Polish Academy of Sciences did not manage to overcome the organizational and financial threshold allowing for the implementation of industrial production of a phage drug. A recently concluded agreement on continuation of implementation research in China gives rise to hopes.

The triumphant propaganda of success of the industrial era does not allow for awareness of active human participation in the cataclysmic COVID-19 pandemic. The job is supposed to be done by developing a vaccine against the SARS CoV-2 virus, or by burning the books of wisdom together with their authors, as did the first emperor of China, just to reject the fact of reaching the end of the industrial era, for which nature has billed us. We do not want to accept

the fact that the pillaging exploitation of natural resources and of the human organism brought about a disbalance in biocenosis, of which the man is a part and as a result, the human organism lost its capacities to adapt to a harmonious co-existence with microorganisms, including coronaviruses.

Summing up briefly the importance of the discussed facts about bacteria for the COVID-19 pandemic: the mechanism of epidemic emergence in both cases is analogous, in both cases the warnings of experts prior to the outbreak of the epidemic are ignored, in both cases there are mental mechanisms that hinder full awareness of the situation. In the case of the COVID-19 pandemic, its course was woven into the steam of a para-war confrontation between the US and China.

Crisis phenomena within industrial civilization have been maturing for decades to the stage of revealing themselves now in a form of a global crisis, while the corona virus SARS-CoV-2 was only a catalyst accelerating their avalanche like disclosure. The global crisis, discussed in the media under the label of the COVID-19 pandemic, is associated with the final collapse of a number of important mechanisms of the industrial era, related to economic, social, ideological, environmental and medical scopes. They also include the collapse of the global financial system, in which a significant amount of generated cash is not covered in kind, because its main collateral is an excess amount of debt, with a volume significantly exceeding the possibility of paying it off. The existing contractual balance of the interests of the global big players in the financial market has been disturbed, threatening with the collapse of its essential elements.

The idea of globalization also collapsed. Due to the division of the world into economic, political and military blocks, that do not cooperate with one another, and a significant epidemic threat, the collapse affected the flow of strategic raw materials, financial resources, the functioning of international production and investment lines and the flow capacity of goods and people both as tourists and qualified workforce. The idea of globalization in its twentieth-century shape lost its functionality. The myth of the benefits of pan-urbanization of the globe collapsed, although it had been visible for decades, it did not cause correction of the continued large-scale activities. Only the occurrence of previously uncalculated significant economic losses, resulting from side effects emerging in the form of visible consequences of human-induced global climate change and mass extinction of species, caused the collapse of economic calculation of the basic activities of the industrial age. However, the main beneficiaries of these activities do not want to pay off the bill for their deterred costs, they separate themselves economically and militarily, and their main way to respond to the critical threat of unemployment, hunger and local conflicts of existence of millions of people is

isolation and arrogance of power. The challenges of the current global crisis and the changes implemented under the protective mask of the epidemic state of emergency take away what is left of the democratic traditions of the state as a community of equal citizens, sovereign and superior decision-maker, take away the privacy and inviolability of the home and personal property. This causes great ideological challenges which, given the progressive dysfunction of the structures of democratic states and the triumph of centralist China, can be resolved in most countries more often in street confrontation than in democratic institutions intended for this purpose. On the one hand, there is a need for great universal consolidation and individual sacrifices to overcome the great challenges of the global crisis, on the other hand, it is accompanied by a great distrust towards the broadly understood power and the fall of authorities, causing resistance and lack of conviction to pay a tribute of any of one's freedoms.

The factor that further complicates mobilization in order to meet the demands of the moment is a significant acceleration of civilization changes and changes in the human environment at the turn of the industrial and post-industrial eras, which exposed man's limitations, his difficulties in following the pace of changes and processing overwhelming information, all the more so because traditional social structures, that served as his support point collapsed and unfavourable psychosocial conditions for creative exchange of thoughts and constructive discussion were created. An additional factor hindering the free exchange of ideas is the widespread commercialization and politicization of the media. If we consider that currently the implementation of change processes accelerated hundreds of times - in some cases - thousands of times, whereas previously it used to spread over hundreds of generations, one should rather expect a turbulent course of the process of adapting to new living conditions and a struggle to maintain the shrinking resources of territories with favourable living conditions. The implementation of such a variant of the development of the situation will activate primary mode of thinking which is functional only in a short-term perspective of the battlefield. In a stable situation it impairs mental functioning, radically reduces the efficiency of more complex activities, including creativity and it impedes biological functioning and psychological well-being of people by disrupting vegetative and hormonal balance. The discussed thinking and, more broadly, mental mechanisms, due to the involved emotional and personality components, determine the specific perception of the world by a significant part of people who want to keep the vision of the world in the perspective of a simplified image of the world, congruent with its current template. It also is the reason why many people nowadays interpret objectively unambiguous facts in a way unhampered by logic and generally available knowledge. This applies in particular to the COVID-19 pandemic and climate change. A characteristic feature of this type of thinking, the products of which can be

seen in its pure form in blogs, is a high degree of emotiveness, symbolic thinking, wishful thinking and the use of archetypes which were fully functional in primitive communities (the mechanism of returning to the stereotypes of symbolic thinking described in the publication B. Wasilewski's book from 2013 [14].

Shifting the mental functioning of citizens to a confrontational, authoritarian mode of thinking has been and is used to build authoritarian systems or to prepare nations for war. There is a concern that this mechanism could be used as a temporary means of calming the current social unrest and will constitute a barrier to the peaceful consolidation of politically divided people, so necessary today to save our planet. Many people, whose way of mental functioning has been very distant from the discussed archaic forms of thinking so far, have now changed it because of a sense of threat stimulated by the media and politicians, that impregnate people with omnipresent fear and aggressiveness, and overload them with traumatic information that they are unable to organize.

The recent transition of the US-China conflict from a latent phase into an open conflict phase with the use of economic and propaganda warfare, including the exploitation of the fact of the COVID-19 pandemic, has a strong impact on people's attitudes and their mode of mental functioning. There is a fear that this influence, combined with an increase in governmental authoritarianism will be treated as a way to contain social unrest and prepare for a possible military confrontation. The described mechanism also applies to other countries. The intensity of the information war using the fear of the COVID-19 epidemic is reflected in the wide information campaign undertaken by WHO: WHO Campaigns / Connecting the world to combat coronavirus / How to report misinformation online, 2020. The impact of counteractive measures by the WHO when confronted with significant financial and technical resources of the powers involved in the confrontation and used by their armed forces for cyberspace fight have little chance of making an impact, especially when WHO has recently been cut off from the main source of funding.

Voters whose mental self-realisation and life fulfilment is through authoritarian ways choose authoritarian leaders. The adoption of an authoritarian, orthodox way of thinking is fostered by the emotional instability of individuals or specific communities. The culminating moment of this impact is the period of the COVID-19 pandemic, but the decades-long process of increasing depression rates in the population of Western civilization is the foundation for the impact that this factor has. Studies conducted over the past decades have shown a significant spread in the incidence of depression in different cultural circles, from 2.0-10.0% of the general population in the countries of Far East Asia to 15-25% in wealthy countries of Western culture [22] Affective disorders and related psychosomatic disorders have become

the main civilization threat in Western culture and one of the main obstacles to its further harmonious development - see data from WHO [21].

Health security also collapsed and humans entered the extinction phase as a species despite focal numerical overproduction. Healthcare challenges are discussed in greater detail elsewhere in the text.

The obsolescence of the ethos of the superman, a human demigod, the ruler of the planet, and the conqueror of the world, generated in the industrial era, is accompanied by the erosion of the existing social structure, which is an amalgam of various forms of social functioning, which has not been replaced by a new functional structure, which resulted in the breakdown of the existing social support networks, causing negative social effects and health issues such as physical loneliness, mental alienation, depression and the lack of social interaction necessary for mental functioning, including mutual support.

The outbreak of the COVID-19 pandemic caused a sharp deterioration in the mental state of multi-million populations. The currently available data are being meta-analyzed by Salari et al. (published on 6 July 2020), the experience of increased stress was found on average in 29.6% of the respondents (5 studies with a total sample size of 9,074), the incidence of anxiety in 31.9% of the respondents (17 studies with the sample size of 63,439), the incidence of depression on average in 33.7% of respondents (14 studies on a sample of 44,531 people). The studies mainly cover the countries of Far East Asia where previously the level of depression was in the range of 2.0%-10.0%. and they concern healthy people who are only at risk of the disease and quarantine. The incidence of anxiety, depression and stress during the COVID-19 pandemic has been shown to be higher in women than in men. Although the elderly are at increased risk of COVID-19 infection and mortality, the results of previous studies show that during the pandemic, the level of anxiety, depression and stress is significantly higher in the 21–40 age group. The main reason for this seems to be because this age group is concerned about the future consequences and economic challenges of the pandemic. Psychological symptoms were also found to be more frequent among people with higher levels of education, which is probably due to this group's high self-awareness in terms of their own health. In underdeveloped and developing countries, the COVID-19 outbreaks have a greater psychological impact on the population given that these countries are also affected by many other infectious diseases. Uncertainty about the health status, patient observation, treatment care and its ineffectiveness in these communities can also increase the vulnerability of such communities to the psychological effects of COVID-19.

More severe affective disorders and in some cases full-blown mental disorders are observed in people suffering from COVID-19, because in some cases the central nervous

system is also affected by the disease process. Increased levels of anxiety, depression and stress in the general population at risk of contracting COVID-19, potentialized by the occurrence of COVID-19-related post-traumatic stress disorder (PTSD), negatively affect the incidence and course of chronic diseases and, by secondary immunity reduction, increase the susceptibility to developing COVID-19. Oncological and cardiological diseases are particularly sensitive to negative psychosomatic effects [2, 8]. It has been shown that the depressive-anxiety component of the disease process is related to the phenomenon of a proportional increase in the frequency of chronic courses of civilizational diseases and the number of cases of long-term disability or permanent disability. The current observations and research on the COVID-19 pandemic are preliminary, the more so as the full medical, economic and social consequences are only gradually being fully revealed. The discussed relationships are of particular importance for the population of old people, which is affected by a high percentage of chronic diseases and the incidence of emotional disorders, because depressive symptoms increase with the increase in the number of accompanying diseases. The prevalence of anxiety-depressive disorders in the elderly depends on the presence of chronic diseases, the degree of disability and dependence on the help of family and third parties. In some of the studies, senior individuals forced to use social welfare due to disability or financial problems showed over 70% tendency to develop depressive symptoms. Depressive symptoms were found in 30%-40% of people diagnosed with bronchial asthma. People after a heart attack show similar results. In some studies, neoplastic diseases caused depressive disorders in 24% of patients. But there are also observations of groups of patients with cancer, in which 91% reported depressive disorders. Depression in the elderly occurs in 30%-50% of people after stroke, where PSD (Post-Stroke Depression) is its specific form and occurs after a span of six months to a year after a stroke.

Memory impairment (dementia, Alzheimer's disease) is a particular problem in old age. Elderly people may have memory impairment, difficulty concentrating and short-term memory problems. Recently, scientists have been conducting research on the relationship between depression and Alzheimer's disease. It is believed that depression may be both a contributing factor and a component of Alzheimer's disease. Depression in the elderly is often very symptomatic of Alzheimer's disease, creating diagnostic difficulties and often delaying diagnosis and proper treatment.

The above-described background of rapid civilization changes, their acceleration and instability characteristic of the breakthrough of the civilization epochs make the old people, who have always been the posthumous children of the preceding civilizational period, be now separated from the current technical, informational and mental flow to a degree that

significantly increases their disability and rejection. The existence and material mechanisms that previously maintained the importance of seniors, such as the transfer of a family business or a farm, have mostly disappeared, and the depreciation of all authorities has stripped them of the authority and heroic deeds of the past. Family ceremonies related to the passing and death have been turned into a corridor death in oblivion, which everyone wants to forget as soon as possible. A typically Polish phenomenon of old people maintaining their flat or a farm as their lifetime achievement at the expense of a huge personal sacrifice which is supposed to attract their children back to the country from a temporary emigration, often becomes a pitiful failure. Pious listening to "the wisdom and judgments of the old people", who are now more often treated as shabby gages, guilty of failing to provide their children with material values or education, which were available to their peers from wealthy countries that have not been affected by the cataclysm of war and occupation. The undertaken countermeasures, such as the universities of the third age, which I personally support, and the actions of local self-governments and social organizations, still cover only a marginal part of the old people community in Poland, which is becoming the dominant social group.

The outbreak of the COVID-19 pandemic caused a sudden worsening of the mental condition of multimillion populations, as referred to above.

The current observations and research on the COVID-19 pandemic are preliminary, the more so as the full medical, economic and social consequences are only gradually being fully revealed. The discussed relationships are of particular importance for the population of old people, which is affected by a high percentage of chronic diseases and the incidence of emotional disorders, because depressive symptoms increase with the increase in the number of accompanying diseases. The prevalence of anxiety-depressive disorders in the elderly depends on the presence of chronic diseases, the degree of disability and dependence on the help of family and third parties. In some of the studies, senior individuals forced to use social welfare due to disability or financial problems showed over 70% tendency to develop depressive symptoms. Depressive symptoms were found in 30%-40% of people diagnosed with bronchial asthma. People after a heart attack show similar results. In some studies, neoplastic diseases caused depressive disorders in 24% of patients. But there are also observations of groups of patients with cancer, in which 91% reported depressive disorders. Depression in the elderly occurs in 30%-50% of people after stroke, where PSD (Post-Stroke Depression) is its specific form and occurs after a span of six months to a year after a stroke.

Memory impairment (dementia, Alzheimer's disease) is a particular problem in old age. Elderly people may have memory impairment, difficulty concentrating and short-term memory problems. Recently, scientists have been conducting research on the relationship

between depression and Alzheimer's disease. It is believed that depression may be both a contributing factor and a component of Alzheimer's disease. Depression in the elderly is often very symptomatic of Alzheimer's disease, creating diagnostic difficulties and often delaying diagnosis and proper treatment.

The above-described background of rapid civilization changes, their acceleration and instability characteristic of the breakthrough of the civilization epochs make the old people, who have always been the posthumous children of the preceding civilizational period, be now separated from the current technical, informational and mental flow to a degree that significantly increases their disability and rejection. The existence and material mechanisms that previously maintained the importance of seniors, such as the transfer of a family business or a farm, have mostly disappeared, and the depreciation of all authorities has stripped them of the authority and heroic deeds of the past. Family ceremonies related to the passing and death have been turned into a corridor death in oblivion, which everyone wants to forget as soon as possible. A typically Polish phenomenon of old people maintaining their flat or a farm as their lifetime achievement at the expense of a huge personal sacrifice which is supposed to attract their children back to the country from a temporary emigration, often becomes a pitiful failure. Pious listening to "the wisdom and judgments of the old people", who are now more often treated as shabby gages, guilty of failing to provide their children with material values or education, which were available to their peers from wealthy countries that have not been affected by the cataclysm of war and occupation. The undertaken countermeasures, such as the universities of the third age, which I personally support, and the actions of local self-governments and social organizations, still cover only a marginal part of the old people community in Poland, which is becoming the dominant social group.

The modern world is economically, politically and ideologically divided, which results in the division in medicine. Western medicine developed expansively in the last century, a flagship product of the now ending industrial age, which boasted of doubling human life expectancy in the 20th century and promised to bring about immortality. In practice, it built a huge pharmaceutical and medical industry, one of the most profitable industries and one of the largest employers, becoming the proverbial bottomless pit and one of the main financial problems of Western countries. Apart from the undoubted successes of medicine, there are often also apparent ones, difficult to assess in the global balance sheet. Decrease in mortality in Poland, observed after a significant practical inhibition of the universal health service as a result of epidemic restrictions is the evidence of a dead end, in which Western medicine is - dominated by the interests of the pharmaceutical industry and the medical industry. Despite the COVID-19 epidemic the decrease was of 8% in April this year compared to April 2019. A

similar link was observed in the aftermath of the health service lockdown related to health care strikes in Israel, Canada and California. Modern Western medicine is a product of a toxic industrial civilization that damaged the biotope and disabled vital defence mechanisms of man and the surrounding biocenosis, stepping into its place as an essential element of life support. From patient-oriented, classical, point-impact medicine to health emergencies, Western medicine is now evolving into a life-support industry, a production line of poorly coordinated specialists, each prescribing the same preparations, or drugs that collide with each other. Many older people take 15-20 preparations, which causes large-scale side effects. The main suffering of old people is loneliness, a sense of fear and helplessness in the face of progressive infirmity and impending death. Instead of the antidote in the form of hopeful contact with a physician, a living human being, the patient has contact with an analytical machine and a defensive medical officer. As a response to another complaint, the patient is given another drug, leading to absurdity - the most common first action of a geriatrician that the patient has been lucky enough to get in - is to decimate the amount of drugs taken, often duplicating themselves or remaining in toxic interactions with other drugs taken. In practice, the specificity of metabolism and drug response in old age are ignored. Metabolism related problems in seniors can have various causes. Bad nutrition, the effects of cancer, the effects of medications - all of this contributes to problems with the digestive system. The effects of dementia disorders also affect nutrition and fitness (forgetting to prepare a meal, incomplete or omitted / too large purchases, etc.). Malnutrition (also dehydration!) or overeating make the body function improperly, which in turn, affects the mental state of an elderly person. A significant factor is also the lack of physical activity of seniors - regular physical activity increases the overall mental and physical well-being of the elderly. It also reduces the risk of worsening of depressive symptoms, it reduces sleep disorders. Depressive states in elderly people are often associated with the side effects of drugs, including sedatives such as benzodiazepines and haloperidol, chlorpromazine or fluphenazine, which is exacerbated by frequent addictions to tranquilizers and hypnotics. The discussed problems were multiplied by the consequences of the COVID-19 pandemic, such as quarantine with isolation from the loved ones or a significant reduction in the availability of health care. The isolation of old people during a pandemic often poses a risk of not only loneliness, but also lack of supplies of food, medicines and hygiene products. Under the slogan of protecting their health, contacts with the family, which were so symbolic before, are often suspended. Nursing homes are a separate topic having the highest number of victims during the pandemic. They are focused on minimal costs, they employ staff working in several houses, who are a seedbed of infections, and provide nursing and medical care which usually is insufficient. What is most needed for a

modern patient, and especially for an elderly patient, is a direct contact with a doctor. Not with a robot that speaks a human voice, but directly with a doctor. There are numerous administrative and technical obstacles on the way, and when they are overcome, it turns out that the doctor is not prepared for this conversation, treats the patient as a problem and a threat and tries to delegate another person of support staff to his place or postpone the matter indefinitely. The author discusses in detail the issue of psychological patient-doctor relations as well as the psychological threats associated with the profession of a health care worker in other publications [13].

Returning to the topic of depression and anxiety disorders, which are one of the main health problems of seniors, they constitute a particularly important problem during the COVID-19 pandemic, so they should be discussed in more detail. Attempts to solve the problem of affective disorders through the widespread, chronic use of antidepressants have failed. The widespread use of antidepressants in the US has not reduced the incidence of affective disorders, although it has massively increased the spending on treatments and the revenues of pharmaceutical companies. In some urban agglomerations, such as New York, water pollution with excreted metabolites of antidepressants has become a serious environmental problem. Lobbying of pharmaceutical companies is one of the reasons of the almost non-existent budgets for research into potential causes of affective disorders other than biological, including the anthropological and cultural approach to the problem of affective disorders, which has been addressed by the author and researchers related to him a long time ago already, interested in interdisciplinary cooperation on this problem [15, 16, 19, 20]. Maintaining a narrow understanding of depression as a disease analogous to all other disease entities and applying an analogous treatment and prevention methods to it, faces significant barriers both in theoretical and practical terms – both treatment and prevention. The declared majority of cases of depression do not meet the nosological criteria for being considered a disease, therefore the terms "depressive episode" or "depressive syndrome" are used in diagnosis. Their prevention and treatment are dominated by psychotherapeutic and sociotherapeutic influences and they predominantly have a chronic course associated with somatic diseases. In most cases of depression a consistent procedure and analogous to the procedure in cases of somatic diseases, leads to invalidity accompanied by a partial or complete withdrawal from professional and personal activity of the patient and adaptation to passive endurance in a separated island of the "Archipelago of health care" [13]. In a situation of a rapid increase in the incidence of depression and anxiety disorders in the countries of Western civilization, reaching 25% of the general population, there are no financial and organizational possibilities to provide for the treatment and prevention of those disorders in an

analogical way, typical of somatic diseases treatment and prevention. An additional factor complicating the situation is the rapidly progressing "psychosomatization" of basic biological diseases, where the psychological component of the disease, including affective disorders, is most often decisive for the transition of the disease into a chronic one, and it becomes the dominant component of the disease. The above-mentioned reasons lead to the view [20] that most cases of depression accompanying somatic diseases are adaptive symptoms of a defensive-adaptive nature, which are a manifestation of the proper functioning of the body, signalling a disease similarly to pain and leading to the exclusion of an individual from social functions in order for the individual to gain energy to fight disease. In this sense, depressive reactions are an integral part of the symptomatic syndrome of somatic diseases [10, 11, 12]. Depression, which is a physiological defence reaction, becomes an independent disease in an unfavourable, prolonged course of a somatic disease, constituting a complication of the course of the disease itself. The understanding of depression outlined in this way is clearly visible from the point of view of anthropological analysis or evolutionary psychology. The mechanisms of emotional reactions are very old, inherited from their predecessors in phylogenetic development - such as the anxiety mechanism, which is now one of the main elements of the human social functioning structure. In this sense, anxiety is a defence mechanism if it is in the physiological range of severity and is adequate to the environmental situation, allowing for its constructive use, thus fulfilling the features of a favourable defence-adaptive mechanism. According to the author [15, 19], a similar situation takes place in the case of depressive reactions. According to the author, from the phylogenetic perspective, they are old reaction mechanisms to a biological, psychological or social threat. The depressive reaction encompasses the whole organism, slowing down its functioning and reducing energy expenditure while at the same time stimulating biological defence mechanisms. Prolonged depressive states and the related stress lead to the inhibition of cellular and humoral immunity. As confirmed by the meta-analysis of 300 studies, a strong inhibitory effect of stress on cellular and humoral immunity has been proven [6]. Many further studies have shown a stimulating effect of stress hormones both on the formation of neoplasms and their offensiveness and their growth rate. Behaviour related to depression transmits a signal to the rest of the group at the same time, resulting in the group unburdening the individual from effort related activities and taking care of them. The image of depressive reactions that functioned in anthropoids millions of years ago and in modern man tens of thousands of years ago was significantly different from the one observed today. The living conditions then required frequent movement and a good physical condition. This allowed only for a relatively short period of a limited migration by the herd's due to dysfunction of one of its members.

Thus, everything indicates that the depressive reactions occurring at that time were short-term, severe in course, with a strong accompanying somatic reaction supporting recovery. In the absence of a positive effect of this reaction, according to the author's hypothesis [19, 20], evolutionary auto-elimination mechanisms are activated, subordinated to the benefit of the group's survival at the expense of the fate of an individual. The process of activation of biological auto-elimination mechanisms was called by the author Thanatosis [18]. The concept of thanatosis in the meaning described by the author uses, on the one hand, the In the understanding described by the author, the term of thanatosis uses on the one hand the term of thanatosis functioning in ethology [5] denoting the behaviour of animals imitating their death in a threatening situation, and the concept of apoptosis from the field of cell biology, where cells activate their self-elimination when they lose control over their own modifications in a way that threatens the rest of the body's cells. Despite the progress of civilization development, archaic mechanisms of thinking and acting survived in modern man and they surface in a situation of the social structure destabilization [11]. Thanatosis can take place as a fast-running process of self-elimination by means of a sudden cardiac death, which remained as a phenomenon mainly in primary cultures, it can also have a subacute or chronic course, carried out by means of inhibition of biological defence mechanisms. Then, the immune defence is suppressed at the humoral and cellular level, which leads to the activation of disease processes with an inflammatory component and neoplastic processes [2]. Depressive symptoms worsen becoming a fully symptomatic depression, accompanied by a loss of will to live and, most often, acceptance of moving further away from life. The mechanism of stimulating self-destruction processes through the loss of a partner and social bonds, is documented in studies on the relationship between increased mortality and reduction in social relationships, it is documented in studies showing a significantly higher mortality from a heart attack in single men. [7, 8] In other studies, the reduction of cellular immunity in people who lost their life partner was confirmed. This supports the thesis that the breach of the interpersonal relationship based on the bonding mechanism leads to the activation of the Thanatosis mechanism. The described dependencies are the reason for a significant deterioration of the course of chronic diseases observed in seniors and the frequency of neoplastic diseases in the situation of loss of a life partner. A similar effect is observed with the breakdown of an internal volitional support and the loss of meaning in life and the will to continue to endure, while it is an independent dimension of mental functioning, only partially related to depression. Only considering the anthropological perspective of perceiving depression, anxiety disorders and chronic civilizational diseases allows for a full picture of the

health condition of old people, which until recently was dealt with by diagnosing a senile depression, normally occurring in senile age, and senility and dementia related to old age.

References:

1. Górski A., Międzybrodzki R., Maciej Zaczek M., Borysowski J.*: Phages in the fight against COVID-19?*, Future Microbiology, 16 April 2020, 10.2217/fmb-2020-0082
2. Müller N., Myint A.M., Schwarz M.J. *Inflammatory biomarkers and depression*. 2011, Neurotox Res 19 (2), 308-318.
3. Nguyen S, Baker K, Padman BS et al. *Bacteriophage transcytosis provides a mechanism to cross epithelial cell layers.* mBio, 2017, 8(6), e01874–17
4. Polish Supreme Audit Office's report of 2017/2018; Raport NIK z 2017/2018 r. *Wykorzystywanie antybiotyków w produkcji zwierzęcej w województwie Lubuskim,* 2018, NIK, Warszawa; https://www.nik.gov.pl/plik/id,16217,vp,18741.pdf
5. Rogers S.M., Simpson S.J *Thanatosis,* Current Biology, , 2014, 24, 21, 1031-1033 DOI:https://doi.org/10.1016/j.cub.2014.08.051
6. Segerstrom, S. C., Miller, G. E. (2004). *Psychological Stress and the Human Immune System: A Meta-Analytic Study of 30 Years of Inquiry*. Psychological Bulletin, 130(4), 601–630. https://doi.org/10.1037/0033-2909.130.4.601
7. Schulman J. and Shapiro B.A. (2008): *Depression and Cardiovascular Disease: What Is the Correlation?*. Psychiatric Times 25 (9)
8. Swardfager W., Herrmann N., Marzolini S., Saleem M., Farber S.B., Kiss A., Lanctot K.L. *Major depressive disorder predicts completion, adherence, and outcomes in cardiac rehabilitation: a prospective cohort study of 195 patients with coronary artery disease*. Journal of Clinical Psychiatry, 2011, 72 (9), 1181-1188.
9. Steenblock Ch, Todorov V, Kanczkowski W, Eisenhofer G, Schedl A, Wong M-L, Licinio J, Bauer M, Young A,H, Gainetdinov P,R, Stefan R, Bornstein SR. *Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and the neuroendocrine stress axis, Molecular Psychiatry, 2020, 25:1611–1617, https://doi.org/10.1038/s41380-020-0758-9*
10. *Wasilewski B.W. Depression and anxiety as integrative part of menopausal syndrome-how far anti-depressive treatment should be integrative part of the therapy. J Psychosomatic Res. 2004, 56, 6, 670*
11. Wasilewski B. *How to differentiate among diagnostic psychosomatic disorders, depression, borderline personality disorders and normal health ?*. Psychologische Medizin, 2010, 21, 57.

12. Wasilewski B. *Psychosomatics – how it should be understood nowadays. Archives of Psychiatry and Psychotherapy,* 2011, 41–48
13. Wasilewski B. *Pitfalls and threats in the doctor - patient relation*. Sztuka Leczenia/Art of Healing, 2013, 1-2, 51-64
14. Wasilewski B. *Symbolized Thinking as the Background of Toxic Memories, In: M. Linden, K. Rutkowski (Ed.): Hurting Memories and Beneficial Forgetting. in life span development, posttraumatic disorders, and social conflict*, Elsevier Insights, Amsterdam, Boston, Heidelberg, London, New York, Oxford, Paris, San Diego, San Francisco, Singapore, Sydney, Tokyo, 2013; 93-102
15. Wasilewski B. *Psychosomatic functioning of individuals in evolutionary perspective*. J Psychosomatic Res, 2014; 76: 519.
16. Wasilewski B W. *Discussion on the Position of Alternative Medicine in the 21st Century.* J Tradit Med Clin Natur 2018, 7: 258. doi: 10.4172/2573-4555.1000258 https://www.researchgate.net/publication/323699198
17. Wasilewski BW. *How to Understand the COVID-19 Epidemic Phenomenon*. J Clin Rev Case Rep, 2020, 5, 7, 335-343, https://www.researchgate.net/publication/343098821,
18. Wasilewski B. *Updating the Perception of a Human Being and its Mental Functioning*, J Psychiatry Psychiatric Disord, 2020; 4 (1): 001-009 21 Commentary Volume 4, Issue 1, doi: 10.26502/jppd.2572-519X0085
19. Wasilewski B, Egan E . *Depression and Thanatosis an evolutionary perspective*. Morressier. 2019. https://doi.org/10.26226/MORRESSIER.5D1A036F57558B317A13FF9F
20. Wasilewski B, Yourtsenyuk O, Egan E. *Depression as a civilization-deformed adaptation and defence mechanism*. Insights Depress Anxiety, 2020, 4:008-011. DOI: 10.29328/journal.ida.1001013
21. WHO, *Fact sheets, Depression*, 30 January 2020 https://www.who.int/news-room/fact-sheets/detail/depression
22. Zeng, Y. *Review of work-related stress in mainland Chinese nurses.* Nursing & Health Sciences, 2009,11(1), 90-97.

Maria Łuszczyńska, Death and dying vs. COVID-19 - a hermeneutic approach toward understanding the social process

"Being unable to cure
death, wretchedness and ignorance,
men have decided, in order to be happy, not to think about such things."
Blaise Pascal

Introduction

According to anthropologists, awareness of one's impending death is one of the elements that distinguishes humans from animals. [36 p.35-37]. As a universal, future and inevitable event that affects every member of society, death has always aroused the great interest of both individuals and entire communities. The SARS-CoV-2 pandemic has intensified the social processes of experiencing dying and death, although it still remains unknown to what extent.

COVID-19 spread around the world throughout 2019 and 2020. Although it was disregarded and treated as a local threat at first, within a couple of months, it spread around the world. It began its crusade in the Chinese city of Wuhan and then developed into several dozen mutations typical for various regions of the world at a rather dynamic pace [44].[1] And it is still attacking. According to statistics published on Bloomberg.com as of 30 April, since January 2020, 151 592 370 people worldwide had been infected with the coronavirus. This means that based on official data, as of 1 May 2021, 2% of the world's population had been infected with SARS-CoV-2 [46]. These figures certainly do not reflect the pandemic's actual state as they fail to take into account people who self-medicate or have asymptomatic COVID infections. In addition, there may be limitations in the number of cases resulting from disproportionate testing. In many countries, particularly those less industrialized and less developed, national statistics do not reflect the true scale of the phenomenon. Estimates suggest that when considering these factors, the actual number of infections worldwide is ten

[1] Reykjavik-based deCODE, a company that analyses the human genome, has tracked 40 coronavirus mutations. Research results have yet to be published, however this research company can be trusted as key genetic risk factors of various diseases from cardiovascular diseases to cancer have been discovered in their laboratories. DeCODE Genetics tested 9 768 samples taken from Icelanders for SARS-CoV-2, and then subjected the isolated virus to full genome sequencing that revealed certain findings regarding the evolution of pathogens and its transmission chain. The company's director, Kári Stefánsson, announced that 40 mutations had been detected in the inhabitants of the island. One individual was infected with two separate variations of the virus. The Icelandic Ministry of Health tested anyone who had shown signs of infection or were qualified as people at risk of contracting COVID-19. Furthermore, deCODE Genetics tested 5 571 people who did not have any symptoms and were not at risk, but volunteered themselves for testing. It turned out that among them, there were 48 asymptomatically infected individuals. https://www.bloomberg.com/news/articles/2020-04-22/iceland-is-the-perfect-country-for-studying-covid-19 (1.05.2021)

times higher, i.e., one fifth of the world's population has been infected with Sars-CoV-2 within the last year. [45, 45].[2]

This proves the speed at which the virus has spread and the official number of deaths caused by SARS-CoV-2 indicate its danger. As of 1 May 2021, the number of people worldwide whose death is believed to be caused by COVID-19 amounted to 3 184 017 [46]. These numbers are updated on an ongoing basis. Given that doctors determine the cause of death, it can be assumed that these figures may also be underestimated and overestimated. The difference in numbers is due primarily to discussions about whether COVID-19 itself is a direct cause of death or contributes to the patient's general health condition and occurrence of underlying illnesses. Medical specialists claim that the actual number of deaths caused by the coronavirus pandemic will be significantly higher in coming years due to the unknown magnitude of delayed negative impact on human health.

Due to its magnitude, the COVID-19 pandemic has had an exceptionally significant impact on social life. Among the solutions introduced by certain societies, there have been complete or partial restrictions in social and professional interaction, closures of public space, including educational, cultural, recreational, sports and gastronomical facilities. The pandemic has also affected professional activity and has placed significant limitations on health care services, which consequently that has been dominated by a systemic reaction to SARS-CoV-2 infections. From the state's perspective, these restrictions were based on fear of an economic crisis resulting from extreme loss of human life due to the pandemic. On the other hand, citizens complied with these restrictions out of fear of death. On the one hand, this fear led to aggressive attitudes towards people who had come into contact with the virus (e.g., health care providers or sanitary service officials). On the other hand, it made people realize on a mass scale the common need to support members of a given society whose access to goods and services has been cut off. Fear of death brought to life both the best and worst in people, depending on their ability to control it.

In this chapter, a hermeneutic analysis of the phenomenon of death will be undertaken. Death is a universal experience of the human condition; however, in the era of the COVID-19 pandemic, it can reveal new social processes that may transform society's attitude to death. These reflections aim to answer how the COVID-19 pandemic may affect people's attitude to death and if it encourages or distances them from searching for answers to existential

[2] Here, reference should be made to two mathematical models created by two academic teams - a research team at Columbia University has constructed a mathematical model that gives a much more complete — and scary — picture of how much virus is circulating in our communities. https://www.npr.org/sections/health-shots/2021/02/06/964527835/why-the-pandemic-is-10-times-worse-than-you-thin. Another mathematical model created by scientists at the University in Białystok based on the number of deaths should also be noted, compare: https://covid-model.net/

questions. This the first modest attempt to present social phenomena in the perspective of the hermeneutics of death with regards possible changes in social awareness and identity in the "COVID-19 era".

The social understanding of death - from acceptance to tabooisation

The dying process, brought to an end by death itself, is the most universal of all human experiences. It is also often said that death is the fairest experience that treats everyone equally – regardless of social status, wealth and other factors determining our social position. The process of death occurs in parallel to the process of our lives. Death is a reliable life companion. Over the ages, many philosophers and philosophical thinkers have created multiple theories on human death. Practically every philosopher who has addressed ontological and epistemological issues has offered their own interpretation of human life and dying [42].[3]

Personal awareness of this common fact of human existence may elicit various reactions. On the one hand, people may be conscious of their mortality and make decisions regarding different attitudes – feelings, behaviours and thoughts. On the other hand, they can gradually repress knowledge of their inevitable mortality. Death is then experienced indirectly – as an event occurring in other people's lives in various degrees of social proximity. It may also be denied entirely and thus ignored until the final years or months of one's life. Death then remains unexperienced, marginalized, isolated and hidden. In this case, it could be said that the dying process, experienced by all, becomes the most profoundly repressed truth concerning humanity.

While reflecting on the social dimension of dying and death, the following elements constructing this dimension can be distinguished:

- the process of shaping social awareness about death, including thanatological education;
- relationships with those dying – social rituals, the social status of dying individuals and attitudes towards these people;
- social rituals associated with fatal illnesses, death and funerals;
- issues relating to procedures and customs of dealing with corpses;
- funeral ceremonies – rituals, cemeteries;

[3] I intentionally do not refer to specific scholars and specific points of view, because the objective of this chapter is not to provide such an overview. I believe that pointing out selected authors would set out a philosophical perspective in this text, which this would miss the main purpose of this chapter - analyzing the dying process and death in the social perspective. Professor Gogacz provides a solid philosophical overview of the concept of death, cf., http://katedra.uksw.edu.pl/gogacz/artykuly/028_filozof_ujecie_smierci_wydruk.pdf

- the commercialization of funeral services;
- the mourning process - people's social situation after losing a loved one;
- society's cult of the dead, notably the departed who enjoy above-average social attraction;
- legacies, insurance, inheritance, wills, and benefits/losses caused by death, not only financially but also in terms of intergenerational transfer.

Over the years, various societies and cultures have created social norms to deal with death in relation to the elements mentioned above.

In particular periods of history, attempts were made to become accustomed to this event by means of developing a set of behaviours and rituals that were to be applied within the communal experience of death. Initially, death and all associated ceremonies changed the community's time and space in an essential way. Moreover, it impacted the family and the entire village, local environment, urban residential areas, and larger spaces of social perception. At the dawn of social history, people died in public, and the entire community reacted to their death. In primitive cultures, anyone was allowed to enter the dying person's residence, even if they were unknown to the family. For example, in early Poland, the funeral ceremony consisted in displaying the corpse in the house of the departed (usually for three days) accompanied by all-night mourning and prayer. On the day of the funeral itself, people gathered to take the deceased's body from the home, hitting the threshold three times as a sign of his/her bidding farewell to that place. Afterwards, the body was led to the grave in a funeral procession, followed by a mourning feast (the so-called funeral meal). After these ceremonies had concluded, the mourning process began that customarily lasted a year; however, there were cases in which the mourning period could have lasted for years or until the death of the person in mourning.

In the Middle Ages, death was a universal human experience; awareness of it accompanied people's daily thoughts and actions. The remembrance of death contributed to the emergence of axiological systems upon which the social order was built. Temporal concerns were considered in the context of the "vanity of life". The medieval saying *memento mori* (remember that you have to die) constantly served as a reminder that everyone was mortal and simultaneously functioned as the moral regulator of human behaviour.

Death is also a common human experience in the face of epidemics decimating the population, high infant mortality, frequent wars, all forms of battle, and public executions. Almost every adult has had to confront death and the sight of dead bodies. Moreover, both adults and children die. Cemeteries were located in the centre of the settlement as a reminder of the inevitability of death.

The social understanding of dying and passing was deeply rooted in faith, which gave birth to a specific belief: dying was considered a process of passing, and death was the next stage of life and not its conclusion. This faith enabled people to better cope with dying. Furthermore, death was also treated as an indisputable decision made by God, which evoked fear or even extreme terror, but it was met with passive acceptance rather than resistance. After all, God gives life and decides when it comes to an end. Although there were many emotional reactions to the death of loved ones, including despair and sadness, death was always treated naturally and openly. Moreover, the person dying was generally aware of their condition. Death was preceded by various religious and family rituals that provided those still living with a specific pattern of behaviour in dealing with the situation. According to the Christian tradition, people who were dying had to reconcile themselves with God, say goodbye to their family, convey recommendations concerning the time after their death, and pass on a kind of will. As a rule, property was distributed. This openness to death made it a "tamed death" [1].

Changes in social attitudes towards death can be observed in the Enlightenment era. Developments in science and the progressive secularization of life began to diminish the impact of religious interpretations of death. Traditional rituals of passing also started to disappear; death began to be treated not as a vehicle transporting people from one existence to another but as a transition to nothingness. The role of the clergy, who assisted in carrying out the act of passing and offered interpretations of death to help people accept it, also diminished. The suffering encountered by the dying person, which earlier could be offered to God and treated redemption for sins, slowly ceased to fulfil this role and became an unnecessary and terrifying experience.

These changes triggered an increased fear of death and dying. However, death remained an element of everyday life. Children were not protected against knowledge of it, as is currently the case. At the same time, medical advancements gave the hope that death could be postponed.

An increasingly better understanding of anatomy and physiology and discoveries such as the microscope made it possible to diagnose and treat illnesses more and more effectively. Therefore, death was no longer inevitable when life-threatening situations arose. Such medical achievements offered hope that death can be conquered; however, at the same time, accepting and treating it in a natural way became more difficult.

During the Industrial Revolution, all of these trends intensified. The acceleration of medical advancements and the emergence of new medical technologies meant that once deemed incurable illnesses were commonly treated. Knowledge of aseptic procedures and the

possibility of using ether in anaesthetics during surgery contributed to new successes. Personal hygiene and living conditions improved, and the average life expectancy increased. Mortality rates decreased, which was particularly visible in statistics on infant and child deaths.

At the same time, institutional medicine was developing: treatment, and therefore dying, occurred in hospitals increasingly more frequently. As a result, these events were distanced from natural human environments and moved from the sphere of direct family experience to medical facilities. "Specialists" began to be engaged in the dying process, and those dying were surrounded by doctors and nurses and not their loved ones. People began to be seen as "patients" in categories of "health or illness" and as those dying in profound isolation, often without their families with them, in conditions of sterile isolation.

Distancing younger generations from death in the first half of the twentieth century made the death of older people increasingly more noticeable. Visions of incurable illness emerged wreaking fear and havoc and were symbolized by screens and hospital isolation rooms separating/isolating the dying patients to hide their agony. Therefore, the hospital became a place of alienated, defenceless death with a lost individual character.

Patients do not want to die in a hospital; however, dying at home is not possible for many of them. Families and caregivers are not able to provide them with the appropriate conditions, around-the-clock care or, for various reasons, are unable or unwilling to do so.

The rise in the power of medicine also led to a re-evaluation of its purpose. Providing treatment and life support up to the final stages of life has become imperative for doctors, and a patient's death is considered a medical failure. Therefore, treatment is initiated even when everything suggests that nothing can be done to save a patient's life. Spectacular healings in hopeless cases indeed occur, which sustain faith in the efficacy of fighting death until the very end. However, such situations are rare, and in the majority of cases, they lead to additional suffering for the person dying, particularly when intensive and aggressive treatments are applied.

Moreover, new ethical problems arise. Such issues include the definition of death and determining the moment it occurs, moral conflicts associated with prolonging life or hastening death, medical experiments and organ transplants from deceased donors, and even questions related to speaking with the dying about their impending death.

Death ceased to be a direct social experience and began to be subject to tabooisation – it was forced out of the common social experience. Tabooisation intensified more or less in the period of the First and Second World Wars due to vast number of deaths and defensive desensitization to it. In the mid-twentieth century, death ceased to be a public ceremony and

was “pushed into the realm of deep privacy”. “Discrete” funerals attended by the deceased’s closest family and friends were much more common. The family asked that condolences not be offered, signs of mourning disappeared, and expressing pain and despair after losing loved ones became unnatural and unfashionable.

Several factors testify to tabooisation:

- reluctance or even avoidance of any contact mediated by the senses, e.g., something or someone associated with dying and death. This tendency can be vividly observed in situations in which someone requires reanimation in a public setting. The reaction of witnesses clearly shows that what occurs in such situations can be described as the depersonalization of death;
- restraint in showing emotions, or suppressing and not flaunting any signs of mourning, the dominance of the denial of death rather than coming to terms with it through experience, as well as efforts aimed at returning to “normal” as quickly as possible, i.e., life prior to someone’s death. In the contemporary experience of mourning, there is not much space for grieving, mourning and resentment;
- the absence of communication (from direct to mediated forms, broadly understood cultural texts and media images), the lack of conversations about issues relating to death and silence in this regard that leads to the belittlement of death and dying. This fact may be associated with reluctance to cause oneself pain, and in a certain way, is related to and directly engaged in the dying process or the death of a close loved one.

Death and dying are awkward topics. There are euphemisms used that aptly avoid the bluntness of death, i.e., “someone passed away.” People began to hide the dying process from the dying themselves, and reluctance to be in their presence has increased. We avoid visiting them, even if they are our close friends. Often, news of an incurable illness results in the patient’s social isolation precisely because of the inability to address this complicated topic.

New terms emerge, including the death crisis [2], code of silence [18], deconstruction of mortality [2, 3], denial of death [11], sequestration of death [26], dying of death [37], and wish-dream [11].

British sociologist and anthropologist Geoffrey Gorer, considered the pioneer of the sociology of death, was the first to employ the term ‘tabooisation’. Gorer’s text is already a classic. However, the thesis taken from his pioneering speech, in many respects, is still today one of the critical issues of debate in thanatology and the sociology of death. Gorer assumed that specific topics and areas of human experience are treated as being inherently scandalous or offensive. Therefore, they are not to be discussed or mentioned openly; and experiencing

them is done in secret and associated with feelings of guilt or inferiority. According to Gorer, death as a natural process has become gradually unspeakable, and therefore placed in the sphere of taboo as was previously the case with sexuality. While the taboo of sexuality gave way to the spread of perverted sexuality, so taboos on dying have resulted in the eruption of the pornography of death today.

Consequently, natural death is increasingly disguised by prudishness, while violent and unrealistic deaths play a more predominant role in the mass media and pop culture. Death is removed from the horizon of awareness, the sphere of human and emotional experiences, thus allowing the so-called "pornography of death", which means the fashion for ubiquitous and blatant death connected with aggression, slaughter, blood, massacre and violence. In effect, death is trivialized, ridiculed, exaggerated and even treated as amusement. This distorted image of death appears in news broadcasts, pop culture, art, films and advertisements. It could be said that they depict death in the third person – it affects him/her or them. It rarely affects the second person – you (singular), you (plural), and never as me/us.

In this manner, the primal human fear of one's own death is neutralized, displacing traditional customs associated with mourning, which points out the extent that contemporary people are not able to cope with fundamental existential problems.

In conclusion, the crisis of death described as "inverted death" [1] is based on pushing death beyond the boundaries of social awareness and that of the individual, a process that is only deepening in the post-modern era. This process is caused by the following factors:

- the medicalization of death – removing death from social awareness due to medical advancements.
- the secularization of life – reducing the significance of death and religious practises related to death;
- industrialization and urbanization – concentrating social awareness on progress, changes in social structure and environment, and work culture;
- technological progress – associated with medicine and treatment procedures;
- demographic changes – prolonging life, improving its quality, decreasing the number of deaths in children;
- transformations in the hierarchy of social values – in the emerging industrial relations, healthy, non-disabled and productive individuals enjoy greater recognition than the elderly who were once appreciated for their life experience;
- changes in family structures – "branched", multi-generational families have been replaced by nuclear families characteristic for urban life. Family ties have weakened,

and younger generations have started to lose their ties with older family members, who were most often ill and dying.

These tendencies lead to the progressive marginalization of older people and turn society's attention from their problems, illnesses, disabilities and dying process. Consequently, the negation and removal of death from social awareness are deepening, and this phenomenon has dominated people's attitudes towards death since the mid-twentieth century.

Early cultures, more immune to death, created the model of "tamed death". People died at home, surrounded by their close family, reconciled with this fact [1, 34, 35]. Today, significantly more people would rather die quickly, painlessly, under anaesthesia, or when asleep. For this reason, the topic of death is ignored, silenced and uncomfortable. Medical advancements have abolished the clear line between life and death and have led to the institutionalization of death. This has also impacted the way death is perceived.

The Hermeneutics of Dying and Death

The hermeneutics of death, understood as the capability of experiencing and describing the end of one's life, cannot be experienced since the possibility of reflecting on the final moment of one's life ends with death itself. The hermeneutics of death can only be reconstructed indirectly by understanding the death of others, most often that of close friends and family. It is associated with a voluntary and conscious decision to come into contact and in relation with a dying person, which may be difficult due to fear of death.

Since death is inconceivable to human reason, thanatologists have been developing a more accessible version - the hermeneutics of dying, which is emerging as a very "human", and at the same time, humble and curious reaction to the phenomenon of death. Here, hermeneutic thought returns to its sources. In addition to focusing on understanding, it attempts to determine the conditions for understanding it, and – as a manifestation of the human factor – to tear away even a fraction of that which can be grasped by reason, that which cannot or wills not to be understood – i.e., the mystery of death.

That which can be grasped in the hermeneutic perspective is not the state of death but rather the dying process itself. Thus, what is to be understood is never fully comprehended but is constantly being discovered. On the one hand, the subject of hermeneutics is awareness of the inevitability of death as an element of life, a certainty of existence, but also certain paradoxical, and by definition, imperfect anti-experiences of death associated with a lack of experience and knowledge that can only be anticipated as an impression, feeling or

imagination. Thus, this inability to experience "the inability to experience" is absolute philosophically but not existentially.

The hermeneutics of dying concerns situations in which the reality between life and death meet as closely as possible. It is only in this space "in-between", where life has almost come to an end and death has almost occurred, that it is possible to find out about something that resembles death as closely as possible. The hermeneutics of dying possesses yet another feature that the hermeneutics of death does not – namely, the language by which it is possible to describe what can be understood [9].

In the context of dying, language is expressed in the message of the deceased's final will, his/her instructions and desire concerning the future, or as a farewell. These messages are connected with the final moments of life and expressed in the presence of witnesses. Today, wills are drawn up at an earlier time, are anticipatory in nature and may be subject to modification. Although expressed in the broader context of life, the words of the will momentarily bring the person expressing their last will into contact with the awareness of their own dying process. One could speak of the anticipatory dimension of the hermeneutics of dying, which concerns me as "myself" and in the participatory dimension, i.e., concerning my participation in the dying "you". The latter is the only possible situation in which an informed hermeneutic description can be made. Furthermore, "my death" is beyond the scope of leaving an inheritance; however, "your death" is the only area in which dying and death can appear and be constantly described.

Among the authors who have contributed to the hermeneutics of death, predominant hermeneutic thinker Hans-Georg Gadamer should be mentioned. While reflecting on the experience of death, he looked at the accomplishments of technology and pharmacology made for the benefit of not only palliative care but also for supporting human life (or rather the functions of life) beyond its "natural" measure, with slight horror. Thus, death is not only isolated from the public sphere, but it is also "alienated". Gadamer claims that "modern chemistry, equipped with anaesthetics, expropriates the person suffering. (...) At the same time, it also excludes those who have experienced, either by passive or active participation, this event" [9, p. 80-81]. Therefore, it follows that both death and dying are worth (consciously) experiencing and are an integral and key element of human, and therefore – intelligent existence in the world.

Thinkers are surprisingly unanimous in terms of the inability to emotionally or intellectually grasp one's own death. Ludwig Wittenstein claims that "death is not an experience of life. Death is not experienced" [38, p. 81] and therefore, it would be better to remain silent about it. Sigmund Freud expressed a similar view in his text entitled *Our*

Attitude Towards Death when writing that "we cannot, indeed, imagine our own death; whenever we try to do so we find that we survive ourselves as spectators" [7].[4] Martin Heidegger, in turn, wrote that "death, as a possibility, gives Dasein nothing to be 'actualized', nothing which Dasein, as actual, could itself be. It is the possibility of the impossibility of every way of comporting oneself towards..., every way of existing" [13, p. 368]. Zygmunt Bauman claims that "the only thing that thought cannot grasp is its own non-existence" [2, p. 21]. Similarly, the "father of thanatology", Luis-Vincent Thomas, wrote that "as long as we are alive, death exists in the images it suggests, and in the language that we use to describe it" [30, p. 11]. Attempts to describe the experience of dying and death are possible by understanding it in categories of the mutual relation of I and Thou. Thinkers such as Martin Buber, Emanual Lévinas and Józef Tischner wrote about the significance of this relation. The mediation of experience in someone else's dying process causes that I better describe the dying process of Thou than my own, because My process is My drama, from which I distance myself or despair over. The dying of Thou, regardless of how painful it is for me because of the relationship of I and Thou, allows for greater awareness of this process with engagement, but without avoiding it. It could be said that participation in the dying of Thou is the foreground to my own death. Some authors have supplemented this relation with the aspect of the love shown to the dying person [4, 16, 23, 31, 32, 40]. By this love, one experiences his/her own death despite the impassible ontological barrier between Thou and I. To the extent that the love-based subjective I-Thou relationship brings to life the new being "We", "Us" – to that same extent, the death of Thou turns out to be, to some degree, the death of I. Although the I does not die physically, temporarily, it dies as the object of the I-Thou relationship. The death of Thou destroys the I inasmuch as it was engaged in its relationship with Thou, most often by virtue of love [40, p. 118-119].

The dying process is rooted in time. From the perspective of I, it is permanently embedded in the future. However, if the I experiences the death of Thou, understanding this process may refer to the past, present and to the future [15, p. 64].

The knowledge that we obtain thanks to the death of Thou, is a profound, personal existential experience and is something radically new in relation to everything that we had previously known. Before the I was affected by the death of Thou, the I saw only the objective law of nature in human dying, to which we are all subject. However, after

[4] Based on this observation, Freud came to the conclusion that "Our unconscious therefore does not believe in its own death; it acts as though it were immortal. What we call our unconscious, those deepest layers in our psyche which consist of impulses, recognizes no negative or any form of denial and resolves all contradictions, so that it does not acknowledge its own death, to which we can give only a negative content. The idea of death finds absolutely no acceptance in our impulses. (…) The fear of death, which controls us more frequently than we are aware, is comparatively secondary and is usually the outcome of the consciousness of guilt". https://www.gutenberg.org/files/35875/35875-h/35875-h.htm (10.05.2021)

experiencing the death of Thou, an understanding emerges that transcends the ordinary description of nature and now engages not only in academic objectivity but also in subjective emotional, intellectual and often spiritual engagement.

Understanding, language, time and the I-Thou relationship are the elements of the hermeneutics of dying that may be employed when analyzing the impact COVID-19 has on the awareness of dying and social attitudes towards death. Later in the text, they will be used for preliminary analyses of the social reality that has constantly been evolving since the global pandemic outbreak. The main subject of the analyses is that what is currently taking place in the social understanding of death, whose shadow has been the broadest context for all the behaviours, reflections, images and experiences that have organized social life in the COVID-19 era.

The Fear of Death as a Social Force that Builds the Identity of (Im)Mortality

The peculiar marginalization of death has contributed to the social distortion of the image of death, which has changed from so-called "tamed death" into "death gone wild", driven out of everyday life. The extent to which death is feared indicates the scale of taboo, but the main problem is found in using such concepts as denial or the two-dimensional fear: conscious - unconscious.

In attempts to understand how COVID-19 has impacted attitudes towards dying and death, it is crucial to look at the fear that death invokes and the attitudes people may have in reaction. J. Makselon distinguishes three main components of the attitude towards death: (1) thinking about death; (2) fear of death; and (3) defence mechanisms [24]. In turn, A. Ostrowska believes that fear is the most crucial dimension of the attitude towards death [28]. Judging by the amount of academic work devoted to the particular dimensions of the attitudes towards death, this is currently the dominant opinion [6, p. 282-288; 18, pp. 1-25; 33, pp.343-365; 5, pp. 713-733; 39, pp. 83-92; 27, pp. 121–148; 10, pp. 113– 128].

In K. Gebert's opinion, death can be feared only when it is imagined, and since it is a particular negation of existence, one must first be aware of its existence. From this perspective, the fear of death is one of the most fundamental elements of one's self-awareness; to a great extent, it regulates human behaviour and is inseparably associated with the awareness of one's own existence [42].

The fear of death can be viewed in various ways - as the fear of one's own death or the death of loved ones, fear of the moment of death or the dying process, fear of what happens to the body after death, and fear of the way we think about death and negative thinking about it. However, fear always engages one's personality, and everyone experiences it uniquely.

R. Ochsmann distinguished six types of the fear of death:

1. fear of encountering death that manifests itself in fear of direct contact with a dying or deceased person;
2. fear of mortality expressed as the fear that one's plans and intentions will be brought to nought by death and fear of confronting the sufferings experienced by close friends or relatives;
3. fear of the end of one's life expressed in refusal to accept death understood as the definitive end of existence;
4. fear of physical destruction linked with an intense fear of what will happen with the body after death;
5. fear of life after death triggered by the terrifying perspective of the uncertainty of what will take place after death;
6. fear of the dying process and the suffering that accompanies death [43].

The fear of one's own death refers to the feeling of the irreversible passing of time in human life and development and the end of one's own existence, over which we have no influence. This fear may concern various aspects:

1. dying, i.e., approaching death;
2. destruction of the body after death;
3. surviving relatives;
4. the unknown, and the unknown moral judgement of God
5. apparent death, at times the result of stories of burying people still alive;
6. premature death, when one is still fully active;
7. the appearance of the body after death;
8. a specific type of death;
9. social - psychological death - understood as the absence of interpersonal relations [24, pp. 55-58].

Many factors impact one's attitude towards death. Such factors include an individual's propensity to fear, life-threatening situations, experiencing someone else's death, concern for life and its prolongation, religious and cultural factors that shape various interpretations of death and provide it with meaning. Attitudes towards death change throughout one's life, but they always constitute the social context in which death occurs. Social convictions about death are reflected in customary practises, in legally binding legislation and institutional statuses concerning death that regulate the conditions of dying and significantly determine the interaction between the dying and their environment.

The fact of dying is closely related to attitudes towards death. According to E. Kübler-Ross, the dying process includes stages that differ in terms of the essence and intensity of the dying process and one's acceptance of the inevitability of death. She conducted several hundred conversations with the terminally ill, which in turn allowed her to distinguish five reactions to death, also known as stages of dying: (1) denial and isolation, (2) anger, (3) bargaining, (4) depression and (5) acceptance [21, 22].

In another systemization developed by T. Szaniawski, the following attitudes are distinguished depending on our personality:

(1) **ambivalent** - is aware that death is a value but constitutes the greatest uncertainty, a sad necessity, the end of hope and a tragedy. One fears death but also attempts to think about it;

(2) **calm** - accepts death; according to such people, death is not a tragedy, but a mystery, the path to rebirth and cleansing. Thinking about death motivates them to make changes in their life;

(3) **religious** - understands death in the context of faith but does not always live according to it. Such people often think about their own death and that of their close family and friends, but this does not prevent them from having an optimistic outlook on life. Death is understood as unity with the Absolute;

(4) **evasive** - they do not think of their own death, do not consider it to be the most important issue and do not consider it a tragedy. Death does not frighten such people; however, they often think of the death of close family and friends;

(5) **terrified** - death is the main problem in life and the greatest uncertainty. Such people fear death and often think about it; however, their reflection does not help them live a better life [29].

According to A. Kaczmarek, the contemporary attitude to death has at least three aspects that impact people's social activity with regards the dying process: (1) adopting an indifferent attitude, treating death as obliteration and negative; (2) rooting it in a theological horizon that merges dying with the perspective of eternity, the thought of which should guide one's earthly life; (3) the "taming death" effect – hospice movements that are not always related to a particular religious discourse, however, they restore death its social acceptance and reject the indecency of suffering and illness [17].

Summing up these reflections, contemporary social reality in relation to death is characterized by the following phenomena which coincide:

- **the tabooisation of death** - the avoidance of speaking and thinking about death, removing it and dying from daily life; for the majority of people, dying takes place in

hospitals, alone, surrounded by medical specialists; a commercial approach to funeral rites, the family does not participate in preparing the deceased for the funeral;

- **pornography of death** - death becomes the subject of spectacle and fascination. It is shown, e.g., in sudden, violent death scenes in films, computer games, trivializing and ridiculing death, etc.
- **the medialization of death** - together with the development of new technologies, new forms of commemorating and mourning the deceased have emerged – and its promoter and driving force has been the Internet. Increasing more often, people watch funeral ceremonies on the Internet. Virtual cemeteries, monuments and virtual candles, similar to traditional candles or lamps, or are marked with special graphic signs reflecting grave candles, are increasingly more common. In the scope of this phenomenon, the cult of the dead or famous people – religious figures, people of the arts and culture or celebrities – has emerged, taking on a global character, thanks to the community of mourners worldwide. Examples include the global mourning of the deaths of Princess Diana, John Paul II or Michael Jackson.
- The **retabooisation** of death - the dynamic development of academic thanatological reflection and the development of the hospice movement, palliative care, organized social campaigns for a good and dignified death. An element of **retabooisation** is restoring to funeral rituals and the mourning process a form that assists in overcoming the pain experienced after losing a loved one but simultaneously helps in coming to terms with the awareness of one's own passing.

Admittedly, in response to the process of tabooisation, social activities have emerged that are aimed at re-taming death and giving it a humanistic character, including hospice movements, social campaigns (e.g., the "Dying Humanely"), but changes in thinking about dying occur very slowly. In what way does COVID-19 contribute to accelerating changes in the area of understanding death?

COVID and the Social (Mis)Understanding of Death

If we accept Gennys Howarth's argument that the fundamental problem for sociology is the question of how societies can endure in the face of mortality, the concept of death as a taboo can definitely be treated as an attempt to explain this phenomenon in relation to modern societies [14, p. 15].

However, what is COVID-19's role in the development of the social understanding of death? Does it contribute to even greater tabooisation, or does it perhaps introduce a new aspect to the process of de-tabooisation due to its global and long-lasting nature? COVID-19

appeared at a time when the social understanding of death could have been viewed as being subject to tabooisation than to taming. Social actors awaited a medicine for immortality, medical "specialists" (doctors, nurses) made use of cutting-edge technology in treating people and prolonging their lives. Moreover, the pharmaceutical industry has made huge profits on selling medication and supplements to keep people in good health or extend their lives without death. The global economy has generated profits, and sales markets have produced increasingly more needs to keep the economic wheel spinning. The outbreak of the pandemic was a shock world-wide that revealed the unpreparedness of medical, social, academic and political environments in coping with this unknown type of threat. Reactions to the spread of the virus varied, often extreme, resulting in conspiracy theories and explaining the situation with great depopulation narratives.

For the first time in history, a pandemic spread throughout the social life of inhabitants of the Earth to such a great extent. Its emergence revealed people's emotions on a massive scale. The first emotion that guided political, economic and social actions was the fear of death. Although it was not mentioned for months, it was the driving force behind the solutions adopted by specific states. These drastic measures included closing borders, restricting movement, economic lockdown, prohibiting the sale of goods and services unrelated to basic food and medical needs, closing educational institutions (preschools, schools, universities), and socially isolating people infected or suspected of being infected. It can be noted that during the first stage of the pandemic, aside from fear for one's life, feelings of uncertainty, senselessness, crisis, fear of the unknown and the future dominated. For some, this was associated with martial law, only the nature of the opponent was unknown. People employed five basic strategies for social existence:

(1) **disregard** – distancing oneself from the situation, functioning as if nothing had happened, not listening to the news, living one's life and avoiding obstacles that appeared in the social environment as a result of COVID-19; extreme forms of disregard may include misunderstanding what is happening and lack of interest in the situation;

(2) **revolt** – based on breaking restrictions, searching for conspiracy theories to explain events, refusal to comply with recommended precautions (great discussion on wearing masks), using arguments related to civil liberties, freedom of choice, etc.

(3) **resignation** – based on the gradual loss of hope, deteriorating mental health condition, the extreme form of which is panic, nervous breakdown or auto-aggressive behaviours.

(4) **acceptance** - coming to terms with uncertainty and change and creating constructive personal strategies adapting to further life; characterized by calmness, hope for the future, and expecting the situation to improve.

(5) **co-operation** - based on keeping up-to-date about the pandemic and undertaking action to support those in need and those who have experienced difficulties in coping with the pandemic situation. In terms of co-operation, people have engaged themselves in social campaigns by sewing masks, going shopping for the elderly, caring for the ill, etc.

The activities mentioned above may intertwine or transform from one to the other. This list of activities is also the effect of social observations and requires further social research conducted after a certain period and with a particular distance to investigate the dynamics of such changes.

The driving force behind these attitudes was undoubtedly the fear of death - whether conscious or not - driven by the media or political messages. Therefore, the COVID-19 situation has been, in principle, thanatological in nature. Various social actors have been involved in the situation that has arisen as a result of COVID-19. Among other examples of the COVID situation referring to the hermeneutics of dying, various situations that build the thanatological character of social experience can be mentioned:

(1) the ill - "patient" at risk of death;
(2) specialists providing care for those infected with COVID-19 (doctors, nurses, patient services);
(3) the family of "patients" and later the deceased
(4) the elderly, who as an age group were more at risk of contracting COVID-19 other groups;
(5) members of a given local community that are potential participants in funerals.

Each of these situations is extremely rich in terms of research into the impact on individual and social awareness of dying. These situations reveal the social aspect of attitudes (behaviours, emotions and beliefs) towards the dying process and someone else's death. By examining each of them, it is possible to notice new, unknown or more intensified relations, behaviours and experiences related to death. When analysing them in detail, it must be emphasised that the social role of patients is characterized by being isolated from family and staying in a hospital environment where medical professionals surround them. In addition, due to the sanitary rigour, patients have to deal with unusually dressed personnel with whom sensual contact (by means of sight, sound and touch) is extremely limited. The sight of people dressed in special suits, masks and visors may deepen a dying person's feeling of being in an unreal, absurd and uncertain situation dominated by suffering, fear, loneliness and despair.

The accounts given by volunteers who support dying patients bear witness to the enormity of the confusion experienced by those in the dying process. This is undoubtedly an interesting topic for further research since the description of experiencing such dying is certainly more intense and characterized in a way so far unknown.

In turn, the attitudes of the medical personnel towards death are also exceptional and unparalleled in this regard. An element of their profession is the freedom to navigate oneself around the reality of regulations and processes, and having extensive expert knowledge. Their work is performed in hospitals where people fight for their lives, and death is treated as a failure. However, the COVID-19 pandemic has revealed the limitations of the health care system, not only in terms of equipment and capacity but also mental preparation. It has forced medical staff to exert inhumane physical, mental and emotional effort with the burden of the constant threat of their own death (as was the case in every country in which health care workers have died). They have witnessed the multitude of death among their patients and have been faced with the necessity of assessing who should receive their help and who has a greater chance of surviving in the context of limited access to medical equipment. The attitude of medical staff and attitudes towards medical staff on the part of those who witness their work and the local communities in which they have been perceived as a potential threat to the health of others – constitute a rich source of research material that could contribute to a better understanding of death as a social phenomenon.

Another group that has encountered the dying process, whether they like it or not, have been the families of "patients", both those whose access to their loved ones in hospitals has been severed, and those who have lost their loved ones and have had to organize funeral ceremonies in sanitary regimes. Families have not had the possibility of accompanying their loved ones in the dying process, saying goodbye to them, accepting their wills or blessing for the journey ahead. They have also not been able to accompany their dying loved ones to ease their pain. They have been forced to organize modest funerals that could not be attended by all those who desired to pay respects to the deceased. Such families have been witnesses and participants in the "funeral factory" – they have placed the corpse of their deceased in a family grave or mass cemeteries among hundreds of other graves. They have had feelings of complete alienation from the death of their close family members and friends that have left an unspeakable gap between the last time they met and their absence in family life. This situation has also arisen due to quarantine, and families have not been able to participate in a family member's funeral, thus making the gap even greater. Members of a given community in which someone has passed away have also had similar experiences, although to a lesser extent. Fear of infection, epidemic restrictions, and one's own powerlessness have caused the

deceased to disappear from the social horizon in an almost invisible and unknown way, without saying goodbye. In this way, COVID-19 has transformed the character of social mourning. Compared to the pre-covid era, public figures (politicians, actors, singers, artists and celebrities) have also died with reduced social response, mourning and sadness. It is as if the world has grown accustomed to death over time or has at least become immune to it.

An accurate assessment of the impact of COVID-19 on the development of thanatological knowledge will occur in the future, because distance is essential to reach comprehensive conclusions. It goes without saying that in the context of this historical moment, both negative and positive effects can be observed in terms of coping with death. The former may include the intensified isolation of those in the dying process – removed from family, the local environment, loved ones, and entrusted to health care services. As far as medical sector workers are concerned, their exceptional devotion and enormous effort to care for patients, even at the cost of their own health and lives, is evident. Coming into contact with death to such a great extent has renewed their fundamental motivation to practice their profession. It could be said that it has verified their professional vocation, albeit in connection with enormous effort.

Undoubtedly, people have also started to reflect on the end of their lives and search for answers to existential questions to a greater extent than previously. However, attitudes of withdrawal and revolt have been noted, along with ones that feed on conspiracy theories. It could be said that the fear of death has intensified, which, on the one hand, could lead to dissent and social revolt, while on the other hand, to a bolder search for answers to questions that people are unwilling to ask. COVID-19 has also verified the quality of our social relations, revealed areas of longing and essential issues unrelated to consumption. It has become a strong incentive, occasion and pressure to reflect on one's own death. To a larger extent, it has confronted societies with the issue of death, and not necessarily from the point of view of dreamers in search of a medicine for immortality.

Summary and Conclusions for Further Analyses

For ages, the ceremonies of "taming" death have been subject to numerous changes; however, the constant relationship between death and society has never been disturbed.

The paradox of everyday life and death remains essentially an "everyday" topic since it constantly accompanies life changes. However, at the same time, it is denied the most. Although death is a natural stage of human existence, it is simultaneously one of the most unwanted and avoided topics, and a taboo subject.

Almost every discussion on this topic is reserved for philosophers, ethicists, theologians and scholars. On the other hand, open discussions about death are avoided and ignored since they evoke unpleasant emotions in people and are even treated as awkward.

Changes in attitudes and opening society to the problems of death and the conditions in which it takes place is significant for the way death is experienced by the dying themselves, their close family and friends and the medical staff providing care. The way we feel and think about death, what we believe in, and the values we assign to it greatly impact how society, institutions, and families say goodbye to their departed members.

COVID-19's lesson is not a clear-cut thanatological lesson, but it has undoubtedly contributed to the de-tabooisation of dying and death by means of intensifying social emotions around these issues. It has also revealed great constructive and destructive layers in individuals and social groups. Such strong social experiences have made people aware of the need to search for ways of coping with death so that it would bring support and not destruction to one's environment, despite the unrest that COVID-19 has also caused.

It could be said that this is the first in a series of lessons on how to live with death and maintain distance and creativity, being grounded in the present and rooted in relationships, peace, joy and care. This lesson has undoubtedly been different than other pandemic experiences due to its more global character. Thanks to the mass media, social media and other forms of bridging social distance, humanity has experienced and is still experiencing this pandemic situation in a new way. COVID-19 has shown the important aspects of social relations and that what death has taken from people – family, relationships, health, physical fitness, work – while the long-term effects of this virus remain unknown.

While summarizing these reflections on understanding COVID-19, I would like to put forward the following claim – COVID-19 is a shocking phenomenon on a global scale that has mainly contributed to intensifying people's fear of death. In certain situations, it has caused that people have cut themselves off from the awareness of their own death even more and have started to celebrate life. Others, however, have initiated thanatological reflection resulting in changes in their attitude towards death or encouragement to do so. It has also grounded thanatological thought in shaping knowledge about dying. Perhaps, if people (not only thanatologists) seriously worked on building awareness of their own passing, they would confront it and engage in open discourse, make use of their resources more creatively and reduce the fear that could be the source of increasing aggression and competition. Furthermore, they would ground themselves in the present to a greater extent, without expectations and memories that often anchor them and hamper their potential. For this to occur, thanatological education and research on the long-term effects that COVID-19 will

have on family relationships, the social mourning process, and taming death by means of the coronavirus are needed. This topic is certainly a fertile thanatological phenomenon worth further attention.

REFERENCES

1. Aries, P., *Człowiek i śmierć* [Images of Man and Death], PIW, Warszawa 1998.
2. Bauman, Z., *Śmierć i nieśmiertelność, O wielości strategii życia* [Mortality, Immortality, and Other Life Strategies], Wydawnictwo Naukowe PWN, Warszawa 1998.
3. Berger, P., *Święty baldachim. Elementy socjologiczneh teorii religii* [The Sacred Canopy: Elements of a Sociological Theory of Religion], Zakład Wydawniczny Nomos, Kraków 1997.
4. Buber, M., *Ja i Ty* [I and Thou], Instytut Wydawniczy PAX, Warszawa 1992.
5. Cicirelli, V. G. (11/1998). *Personal meanings of death in relation to fear of death.* [in:] Death Studies. 22 (8).
6. Feifel H. i Branscomb A., *Who's afraid of death.* Journal of Abnormal Psychology, 81/1973.
7. Freud, *Our Attitude Towards Death*, [in:] idem, Reflections on War and Death, New York 1918.
8. Gadamer H.-G., *Prawda i metoda. Zarys hermeneutyki filozoficznej* [Truth and Method], trans. B. Baran, Inter Esse, Kraków 1993.
9. Gadamer H. -G., *Doświadczenie śmierci* [The Experience of Death], trans. A. Przyłębski, [in:] idem, O skrytości zdrowia [On the Secretiveness of Health], Poznań 2011.
10. Gesser, G., Wong, Wong P. T. P., Reker, G. T. (03/1988), *Death Attitudes across the Life-Span: The Development and Validation of the Death Attitude Profile (DAP),* OMEGA - Journal of Death and Dying. 18 (2).
11. Gorer G. (1955) 'The Pornography of Death', in (ed.), Death, Grief, and Mourning. New York: Doubleday: 192–9
12. Hayslip, B., *Death denial: hiding and camouflaging death* [in:] Handbook of Death and Dying, Bryant C.D., ed., SAGE 2003.
13. Heidegger, M., *Bycie i czas* [Being and Time], trans. B. Baran, Wydawnictwo Naukowe PWN, Warszawa 1994.
14. Howarth, G., *Death and Dying. A sociological introduction,* Polity Press, Cambridge 2008.

15. Jankélévitch, V., *Tajemnica śmierci i zjawisko śmierci* [The Mystery of Death and the Phenomenon of Death], [in:] Antropologia śmierci. Myśl francuska, selection and trans. S. Cichowicz, J. M. Godzimirski, Wydawnictwo Naukowe PWN, Warszawa 1993.
16. Jankélévitch, V., *To, co nieuchronne. Rozmowy o śmierci* [The Inevitable. Conversations About Death], PIW, Warszawa 2005.
17. Kaczmarek, A., (4/2009) Śmierć. Poszukiwanie znaczenia w kontekstach kulturowych, społecznych i politycznych [Death. The Search for Meaning in Cultural, Social and Political Contexts], [in:] Teka Komisji Politologii i Stosunków Międzynarodowych PAN.
18. Kastenbaum, R., *Śmierć psychologiczna* [Phychological Death], [w:] L. Pearson, ed., Śmierć i umieranie. Postępowanie z człowiekiem umierającym [Death and Dying. Dealing with the Dying], PZWL, Warszawa 1973.
19. Kielanowski, T., *Przedmowa* [Intorduction], [w:] Śmierć i umieranie [Death and Dying], L. Pearson, ed.., PZWL, Warszawa 1975.
20. Kolbuszewski, J., *Kryzys, pornografia i renesans śmierci* [Crisis, Pornography and the Renaissance of Death], [in:] Problemy współczesnej tanatologii [The Problems of Contemporary Thanatology], J. Kolbuszewskiego, ed., vol. I, WTN, Wrocław 1997.
21. Kùbler –Ross E., *Rozmowy o śmierci i umieraniu* [Conversations about Death and Dying], PAX, Warszawa 1979.
22. Kùbler –Ross E., *Życiodajna śmierć* [Life-giving Death], Księgarnia św. Wojciecha, Poznań 2005.
23. Levinas, E., *Całość i nieskończoność, Esej o zewnętrzności* [Totality and Infinity. An Essay on Exteriority] , PWN, Warszawa 2012.
24. Makselon, J., *Struktura wartości a postawa wobec śmierci* [The Structure of Values and Attitudes Towards Death], Katolicki Uniwersytet Lubelski, Lublin 1983.
25. Makselon, J., *Lęk wobec śmierci. Wybrane teorie i badania psychologiczne* [The Fear of Death. Selected Theories and Phychological Research], Polskie Towarzystwo Teologiczne, Kraków 1998.
26. Mellor, P. *Death in high modernity: the contemporary presence and absence of death*, [in:] The Sociology of Death, D. Clark, ed., Oxford 1993.
27. Neimeyer, R. A., ed. *Death Anxiety Handbook: Research, Instrumentation, and Application,* Taylor & Francis 1994.
28. Ostrowska, A., *Śmierć w doświadczeniu jednostki i społeczeństwa* [Death in the Individual and Social Experience], Wydawnictwo IFiS PAN, Warszawa 1997.
29. Szaniawski, T., *Typy postaw wobec śmierci a osobowość* [Types of Attitudes Towards Death and Personality], PAT 1998.

30. Thomas L.-V., *Tworzenie tanatologii* [Creating Thanatology], trans. M.L. Kalinowski [in:] Wymiary śmierci, Słowo/obraz terytoria [Dimensions of Death, Word/image territory], Gdańsk 2002.
31. Tischner J., *Myślenie według wartości* [Thinking in Values], Wydawnictwo Znak, Kraków 2005.
32. Tischner, J., *Filozofia dramatu* [The Philosophy of Drama], Wydawnictwo Znak, Kraków 2006.
33. Tomer, A. and Eliason, G., *Toward a Comprehensive Model of Death Anxiety* [in:] Death Studies, vol. 20, 1996.
34. Vovelle, M., *Historia ludzi w zwierciadle śmierci* [The History of Humanity in the Light of Death], trans. M. Ochab, [in:] Wymiary śmierci [Dimensions of Death], S. Rosiek, ed., Gdańsk 2002.
35. Vovelle, M., *Śmierć w cywilizacji zachodu. Od roku 1300 po współczesność, Słowo/obraz/terytoria* [Death in the Western World. From 1300 to the Contemporary Era, Word/image/territory], Gdańsk 2008.
36. Vuillemin, J., *Śmierć w oczach zwierzęcia* [Death in the Eyes of Animals], [w:] Antropologia śmierci. Myśl francuska [The Anthropology of Death. French Thought], Cichowicz S., Godzimirski J.M., eds., PWN, Warszawa 1993.
37. Walter, T., *The Revival of Death*, Routledge 1994.
38. Wittgenstein L., *Tractatus logico-philosophicus*, trans. And introduction by B. Wolniewicz, Wydawnictwo Naukowe PWN, Warszawa, 2000, p. 81, teza 6.431.
39. Yalom, I.D., *Staring at the Sun: Overcoming the Terror of Death*, Jossey-Bass, San Francisco, CA 2008. Reviewed by Yvonne B. Bregman, M.A., M.S.W., Ridgefield CT
40. Ziemiński, I., *Twoja śmierć. Próba eksplikacji doświadczenia śmierci* [Your Death. An Attempt to Explain the Experience of Death], "Diametros" no. 11, 2007.

Internet Sourecs:

41. Gogacz M. http://katedra.uksw.edu.pl/gogacz/artykuly/028_filozof_ujecie_smierci_wydruk.pdf
42. Gebert K., Jednostka wobec śmierci [The Individual in the Face of Death], http://www.jednota.pl/archiwum/o-smierci/303-jednostka-wobec-mierci.
43. Jastrzębski J., Psychologiczny wymiar lęku przed śmiercią [The Psychological Dimension of the Fear of Death]http://www.psychologia.net.pl/artykul.php?level=209
44. https://www.bloomberg.com/news/articles/2020-04-22/iceland-is-the-perfect-country-for-studying-covid-19

45. https://covid-model.net/
46. https://www.bloomberg.com/graphics/2020-coronavirus-cases-world-map/
47. https://www.npr.org/sections/health-shots/2021/02/06/964527835/why-the-pandemic-is-10-times-worse-than-you-thin

SOCIAL attitudes and strategies

Dobroniega Głębocka, Mariola Racław, Unmasking features of the state of the epidemic: what is the uniqueness of the position of older people in Poland

Introduction

In Poland, the first case of SARS-CoV-2 was confirmed on March 4, 2020. The state of pandemic was declared in mid-March 2020. As in many countries, also in Poland it was a shock event for the society. „We understand shock event as a focusing event (…) that has created considerable stress waves in a society" [10, no page number]. Kaufmann et al. [10] emphasize that these are sudden events, relatively rare, with harmful (or judged as harmful) results for society. Such an event has a social impact, causing a wave of shock among politicians, the media and the public. It focuses attention on the problem, which results in the introduction of specific solutions, often with long-term effects and long duration. Sometimes along with the "turning point", when people feel that the problem has been solved, social tension disappears and the problem is considered historic.

After half a year of the epidemic in Poland, when the country is struggling with growing economic and social problems [7], it is difficult to indicate which solutions introduced during the pandemic will be maintained in social life and what processes will be initiated or strengthened by them. It seems to us that what is visible and will probably leave lasting results is the consolidation and acceleration of the medicalisation process of old age in Poland with its social consequences. From the outset, the narrative in the public and political spheres was about public health. According to the Polish sociologist Jan Domaradzki, health and life gained the status of superior values during the pandemic [37]. As all government actions were accepted as necessary to protect the population and health of individuals this was widespread and unquestioned. Their acceptance was related to the experience of a socio-cultural trauma, as a significant number of Poles lost control over the events in their lives.

The politicisation of the epidemic, understood as its introduction to the political game, was associated with a strong medicalisation of various areas of social life. The epidemic per-se is related to health and medical issues. In the initial stage of the pandemic, a lock-down was introduced in Poland, the wearing of masks, hand hygiene, physical distance were ordered, remote work was introduced and service points were closed. The public was informed and continues to be informed about infections, illnesses and deaths caused by Covid-19. This coronavirus-induced medication of social life also meant medication of old age in Poland. The thesis of the article is that the visible trends in the medicalisation of old age in Poland, which have so far been limited due to the poor condition of public health services and the low income of older Poles, have been significantly reinforced by the emergence of the pandemic. They have also gained strong social legitimacy, stemming from the ideology of protecting older people from the consequences of coronavirus infection. The protection of the elderly has strengthened the tendency towards their social isolation. In our opinion, the experience

of the pandemic will contribute to the repositioning of the elderly, medicalisation of their problems and separating them from other social groups.

Another thesis we put forward relates to the impact of the pandemic on the shaping of a new paradigm of working with and for the elderly. The paradigm of socializing people and places, derived from Simmel's understanding of socialization, makes it possible to see the high-level goals of social work. They are aimed at creating weaker ties of older people in their living environments and changing the stereotypical, negative image of older people in Poland. We believe that in the long run, an unintended result of the pandemic, which should be treated as an anticipated reversal effect, will be: a) the crystallization of the concept of social work with and for the elderly in Poland, which takes into account the effects of the pandemic, b) the development of new social practices, resulting from the involvement of social work in building a moral space in the living environment of older people [28], c) increased interest of representatives of helping professions and social politicians in the concept of the caring potential of the family and community [11;28].

The SARS-CoV-2 epidemic in Poland and the elderly - statistical data

According to official government data in Poland in September 2020. (as of 07.09), since the beginning of the epidemic, over 71 thousand infections, over 55 thousand recoveries and over 2 thousand deaths have been recorded. In September, the current number of patients was almost 14 thousand. According to the data of the Central Sanitary Inspectorate, in mid-April 2020, in the total number of coronavirus deaths, the share of deaths in the 60-69 age group was about 20%, in the 70-79 age group – 33%, and in the 80-89 age group – almost 30%. The percentages in the remaining age groups did not exceed the value of 6 [38]. These data are confirmed by the Polish Ministry of Health. In mid-August 2020. 70% of the coronavirus fatalities were over 70 years old [34]. The co-occurrence of additional diseases such as heart disease, diabetes, hypertension, lung and kidney cancer was not without significance. Patients with reduced immunity and after organ transplants are particularly vulnerable to infection and death.

Over-representation of deaths in older age categories is a phenomenon that occurs in all countries affected by the pandemic [32]. In addition to many important factors influencing population health data (e.g. availability and quality of health care, behaviour limiting morbidity and mortality), the age structure plays an important role in the analysis of information. „Age structure (the share of the total population in each age group) alone cannot tell us which countries will be hardest hit in the pandemic but can provide important context in understanding and responding to the crisis. If two countries have the same age-specific mortality rates from COVID-19, the country with an older population would have more deaths per 1,000 people—a higher crude death rate—from the disease than the country with the younger population" [32, no page number]. This means that Poland, as a country with an advanced ageing process, will have a relatively high mortality rate due to coronavirus, including in the sub population of older people. In 2018, the share of the population aged 60 and over in the total population was 25% [41, p. 13]. Among the sub population of the elderly, about 45% of

people aged 70 and more were recorded. According to the forecasts of the Central Statistical Office, in 2050 the elderly will constitute 40% of society.

Additionally, the health condition of Polish seniors should be taken into account. Unfortunately, it is not good. The results show that Poland ranked 88th out of 195 countries when the age-related disease burden rate was taken into account. The age-related disease burden rate is based on the level of disability adjusted life years (DALYS; healthy years lost) per 1,000 adults ages 25 and older [40]. This is confirmed by Polish epidemiological data, which indicate multiple morbidity in the elderly [7, p. 41]. The results of the self-assessment of health made by Polish seniors in 2018 are not optimistic [41, p. 13]. They rarely indicate good or very good health – only 1.9% of people over 60 considered their health to be very good, while 23.8% of seniors indicated "good" as an answer. 67.0% of people of this age have had long-term health problems or chronic diseases that have (or are expected to continue) for 6 months or more. In 2018, out of 100 seniors, 69 wanted to receive treatment or testing, of which 87.7% of them benefited from the test or treatment each time they needed it Distant appointments, financial difficulties and too long a geographical distance were cited as obstacles to accessing doctors. Additionally, in Poland, we note a low level of development of gerontology in the field of public services. There are 146 geriatric outpatient clinics, with the main locations in three regions: Silesia, Mazovia and Małopolska [41, p. 48]. Older people in Poland also do not have sufficient funds to purchase health services on the private market.

Politicisation of old age in Poland as a precursor to its medicalisation in a pandemic

In Poland, the Statistics Poland systematically collects data on older people, not only in demographic and epidemiological terms, but also in social dimension. Research on the process of population ageing and the situation of older people is undertaken by researchers from various disciplines and has a long tradition. Those developed from the beginning of the 1990s focus on the aspect of demographic imbalance and the process of population ageing. At the same time, the senior citizen related policy was conceptualized and started to be implemented, and ageing became a political problem [6]. The politicization of the ageing process proceeded with variable intensity and in stages: from retirement demography (ageing and the pension system), through apocalyptic demography (the low fertility trap and the ageing of the population) and institutionalization of senior policy (the emergence of appropriate government offices dealing with the issue of ageing and old age) to the intensification of such a policy (reform of the pension system, pronatalist program and changes in long-term care) [6, p. 171-172]. The issues of demographic ageing have become a reference point for many specific policies, including health policy, the labour market and social assistance.

As far as social assistance is concerned, it does not have precisely and clearly defined goals of action towards the elderly. In the Act on social assistance in force in Poland (Journal of Laws of the Republic of Poland) there is no provision on guaranteeing social assistance in the event of old age, loneliness and helplessness, which places the elderly in a negative position in relation to representatives of other groups who have guaranteed rights under certain risks. The income criteria

adopted, setting thresholds for obtaining financial, material and service benefits for older people, result in a reduction in the number of people receiving social assistance which is not justified in view of the scale of the needs of that group [26, p. 153]. The current legal regulations do not clearly define the obligations of social services towards the oldest seniors in their living environment [9, p. 63]. In addition, the specificity of social work with the elderly (and on their behalf) is defined in the course of supporting the elderly in the environment of their residence and / or stay. It is an expression of the adaptation of values and principles to the institutional and organisational requirements of the implemented practices. The problem of instrumentalising the values and principles of social work with the elderly in social assistance is indicated by research results. In our opinion, the problems outlined above strengthen the processes of politicizing old age in the face of many unspecified goals of public tasks. In turn, the politicization of old age makes it possible to make its medicalisation dynamic in the state of epidemics.

The state of the epidemic and legitimizing the medicalisation of old age

When analysing the population ageing process, Polish social researchers focus not only on its scale and pace, but also on the qualitative aspects of its course. There is evidence that the process of medicalisation of ageing has begun in Poland, but it is not as advanced as in other Western European countries and the USA [29]. To medicalise ageing means treating ageing and old age in terms of a disease, not a natural stage in an individual's life [8, p. 588]. It manifests itself in the perception of ageing as a medical problem, which is reflected in various social practices [8, p. 587]. As Michał Nowakowski and Luiza Nowakowska conclude, research on old age and ageing undertaken in this approach aims to identify the aetiology of ageing (at the cellular level), which will allow specialists in the field of medicine and pharmacy to intervene in order to inhibit it in specific individuals [20, p. 2012]. Turning old age into a medical problem has consequences in economic, medical and social terms [29, p. 32]. Wieczorkowska, based on a review of international literature, indicates the consequences of medicalising old age in the social dimension: strengthening stereotypes about old age, secondary deviation, self-marginalization and self-blame, dependence on institutions and learned helplessness, lowering the subjective threshold of old age, new nature of the senior-family relationship, escalation of gerontophobia, negation of the possibility of discovering the meaning of natural ageing, ignoring other dimensions of old age, transforming the technological imperative into a moral one [29, p.32].

The medicalisation process itself is often considered in the context of increasing social control over individuals. It is emphasised that the health care system is intended both to isolate individuals who pose an epidemiological threat and to identify healthy people who are not fulfilling their social roles [37]. Social control is supposed to lead to an increase in the self-control of individuals, because health is not only a right of citizens, but an obligation, especially sanctioned during an epidemic. At present, the obligation to estimate health risks and minimise damage to health has been sharpened by legal regulations and by social pressure and ostracism imposed on those who do not listen to

government recommendations. In Poland, in social media and news portals, there are heated discussions of outraged citizens who point out the irresponsible behaviour of their compatriots (e.g. the lack of masks in public space), especially young people. Importantly, research shows that people over 55 years of age - compared to other age groups - show the highest degree of obedience to government recommendations and introduced restrictions [35, p. 2]. Despite the emergence of groups denying the existence of a pandemic and rejecting government orders, the discourse of protection, which legitimises the suspension of certain civil liberties, seems stronger than the opposite trend.

In times of a declared pandemic, it seems rational to emphasize taking care of one's own and public health as a civic duty. However, it has current and future consequences for the situation of older people and their social position:

1. It seems that focusing the message on the mortality of the elderly as a result of SARS-CoV-2 perpetuates a homogeneous image of the elderly (weak organisms, multiple diseases, low physical and mental capacity), who, as passive and defenceless human beings, must be protected. The homogeneity of the perception of a certain category together with a strong belief in the relationship between health, fitness and age form the basis of ageism. In the last decade in Poland, the established stereotype of elderly people who withdraw from social life with age was slowly being deconstructed. We forecast that in the time of a pandemic, this deconstruction process will stop, or perhaps will even be reversed. There may be a chain of feedback loops that will not only restore the status quo, but also change the wider social structure [cf. 27, p. 427]. It means that not only will the stereotype of a sick and weak senior persist, but there may also be tendencies to isolate the elderly as a method of their effective protection [see recommendations 7, p. 41]. Instead of being included in social life, their institutionalized exclusion will gain social legitimacy.
2. Related to the above process is the shift of the subject of tensions in intergenerational conflict. In Poland, due to strong social expectations concerning the support of the elderly by their relatives, this conflict was not very exposed in the cultural dimension. Rather, possible tensions between the categories of young and elderly people were emphasised against the background of the division of limited public funds allocated to intangible benefits and services. The new dimension of the intergenerational conflict is the biomedical dimension which, along with the strong medicalisation of old age, will point to the social "burden" of old age in the economic dimension (costs of treatment, hospitalization, social benefits) and due to restrictions on civil liberties [see a statement of the Polish influencer: 39]. All manifestations of positive discrimination, e.g. the "hours for seniors" introduced on April 20, 2020 (2 hours in retail outlets dedicated only to people over 65) aroused social irritation related to the need to tolerate the privileges of the elderly-unproductive citizens, despite the generally accepted the ideology of protecting them as vulnerable citizens.

3. Exposing health as a superior value that legitimises the restriction of civil liberties also shows a new aspect of citizenship. So far, debates about seniors in Poland have focused mainly on issues of their social citizenship (social benefits, issues of economic status). Along with advanced medicalisation in Western European countries and the USA, and even the genetisation of social life, biological citizenship is revealed, as "the development of genetics makes biology become political" [5, p. 18]. It is on the basis of biological criteria that new categorisations of risk groups are created. The language, based on biological categories, which speaks about people, at the same time creates an image of self-aware and responsible patients (...). The goal of the state is largely achieved: individuals become active citizens and not just recipients of biomedical services". (ibidem). So far, the issue of biological citizenship has not been addressed in Poland. We forecast a change in this area and the inclusion of health and fitness as a moral imperative and civic duty. This corresponds to the postulates of active ageing, which assume the reduction of dependence of the elderly as a result of an increase in the average life expectancy in health [16, p. 27].

The above directions of change seem to be contradictory. However, this is not necessarily the case. Protection and isolation tendencies can be applied en bloc under the state protectorate At the same time, an alternative image of a healthy elderly citizen will be promoted, which may be difficult to achieve due to the post-covid state of the national economy. Nevertheless, the message about protecting oneself against the risk of losing health and fitness as a citizen's duty will be strengthened [cf.1]. This means that the absence of such actions will be judged as civic negligence and recklessness in relation to the individual regardless of the real possibility of dealing with the risks and uncertainties [cf. 4]. In this aspect, the support received in the local environment and the network of institutions, such as social assistance and social work, will be important.

Social work with and for the elderly in Poland after 1990.

In Poland, professional social work with and on behalf of the elderly is in its infancy. After the introduction of the Social Welfare Act (1990) in Poland, which replaced the Social Welfare Act of 1923, not only has there been a significant change in the position of the elderly as a beneficiary of social welfare benefits, including social work, but also the very concept of social work with the elderly has been disintegrated. The complexity of the elderly population in Poland is not conducive to crystallising this concept. Also the use, in the diagnosis and design of care and assistance activities, and in social assistance and in social work for these people, of the typical criteria: gender, age, income, health condition/ disability level, family situation, place of residence of the elderly (social assistance home, living with the family or alone) limits or even prevents social work from going beyond the objectives of minimising poverty and alleviating selected consequences of old age in the environment where the elderly person lives or stays.

This thesis is illustrated by an attempt to organize and describe social work with the seniors, which takes into account the nature of the space for carrying out social work (home space, living environment, institution of 24-hour care) and the degree of independence of the seniors ("dependent/independent seniors"), by Zofia Szarota [25, p. 54]. Independent seniors can benefit from many community-based social support institutions (social welfare centres, counselling centres, senior citizens' clubs, associations and other social organisations (NGOs), third age universities, senior citizens' academies). A dependent senior citizen can use day care facilities, nursing homes, care and treatment facilities, geriatric wards and hospitals and hospices. Services are provided (care, nursing services, neighbourhood care services in the home space where seniors (dependent and independent) live. The home space may also be a day support centre or assisted housing. Z. Szarota's proposal clearly indicates that the type of space and the state of independence of a senior are decisive determinants for the entire practice of social work with seniors, of an interventionist and preventive nature.

Another proposal for describing social work with seniors relates to the instruments of a social worker. Models of social work and the method of social work set the typical goals of social work with and for seniors [9, p. 73; 17, p. 79]: supporting seniors in their development, activating the elderly, preventing marginalization, improving the quality of life of the elderly, preparation for old age and education for old age. It is assumed that practice patterns in social work, i.e. horizontal models (combining selected, different theoretical approaches in social work) and / or vertical models (combining basic methods of social work) of social work, should serve the achievement of these goals.

After 1990, the belief was systematically expressed that in the Polish context, social work with the elderly and for their benefit should be and is aimed at:

- professional activity based on principles and working methods specific to the profession of social worker [9, p. 82-90],
- a social service integrated with other forms of support for seniors and their families (respite care, neighbourhood care, financial and material benefits, senior citizens' stay at a social welfare home or other 24-hour and day care facilities),
- a social service integrating new and old helping professions that have emerged in the field of assistance, care and activation of the elderly (assistant of an elderly person)
- a social service that integrates informal social support systems and institutionalised systems, which are set as social policy objectives (including social assistance policies) for seniors and their families. On the basis of regional and local diagnoses, these objectives should be achieved by public and non-governmental social assistance and religious organisations, in cooperation with institutions representing health service, education system, cultural institutions and other institutions important for this phase of life.

We believe that the attempts made in the circle of theoreticians and researchers to create models of social work with seniors, based on selected criteria [9, p. 82-90], as well as standards of social work with seniors developed in cooperation with practitioners [2, p. 9-15] sanction the status quo in the

sphere of social practices. They do not lead to fundamental transformations of the existing models of intervention and prevention, and social practices based on these models, in the institutional space, home and living environment. The main priorities of Polish senior policy: changing the image and situation of older people in society, developing social and care services tailored to the needs of older people, developing an educational offer for elderly people in areas that meet their needs, supporting the development of systemic solutions for the organization of various forms of learning for older people, including the movement of the Universities of the Third Age, the development of active citizenship of older people, the development of volunteering among older people [26, p. 333-336], directed the unused potential of "silver social work" in Poland to:

- promoting the issue of the rights of older people and disseminating models of successful ageing in the family and in the institutional space,
- development of new specializations in social work supporting the idea of dignified ageing, such as: oncological social work [22], social work in palliative care, social work with elderly and disabled people and their families,

Analyses of practices present in social work with the elderly indicate differentiated use of basic methods of social work in the living space of older people. The predominant methods of assistance for these people and their families are case work and counselling. Small group work, team work and community work models are most commonly used in institutional settings (senior citizens' clubs, day care centres, community centres) [13, p. 42-47] A challenge for social workers and other representatives of the welfare professions is to take preventive and intervention measures in families where there is no interest in the fate of the elderly and where the matter of care in relation to these people is neglected. An attempt by Zofia Kawczyńska-Butrym to define the family's caring potential [11;12] was aimed at enriching diagnostic tools in social work with the family, which, in the area of assistance and care for the elderly, is only just becoming institutionalised and is, in comparison with other social work models, the least conceptualised. It cannot be replaced by the transfer of care services and forms of neighbourly assistance that should complement social work with the family. Meanwhile, research shows that these forms of care are territorially dispersed, and at the same time often offered on the basis of non-substantive criteria, which means that they do not reach all people and families in need or satisfy these needs only to a certain extent [14; 24].

Could the pandemic help to change the paradigms of social work with and for the elderly?

After 1990, bottom-up social practices were slowly developing in Poland, which in the area of social work with and for the elderly could be seen as an expression of a change in the attitudes of social assistance workers towards the elderly, as well as a readiness to take up an urgent challenge – a change in social attitudes towards the elderly in their living environment and institutional space. In public and media debates, between 1990 and 2013, the ageing of the population as a topic in its own right occupied an increasingly important place [22, pp. 292-321], but particularly in the context of changes in the pension system, discussions about the retirement age, the debate about the birth rate and

the effects of migration. Significant problems: the health of seniors and neglect in the care of the family, institutional care for seniors as well as the inefficiency and ineffectiveness of local support systems for seniors and families [23], have not, in our opinion, been clearly and consistently brought into the public space. They have become the subject of discourse at a lower level. Internal discourse in social work deals with selected problems of the elderly, their families and the issue of effectively limiting some of the consequences of old age, which are acute at the local level, in the paradigms of care, assistance and activation of the elderly that are relatively better established in social assistance and social work.

We believe that the state of the pandemic clearly highlight some, marginalized threads in social assistance, and that are important for the emerging concept of social work with and for seniors. The theme of the state of health of Polish seniors, which was systematically raised during the pandemic, may therefore contribute to revitalising the issue of health in social work with and on behalf of seniors in social support institutions and in institutions that educate people for social work. Due to the scale of family involvement in caring for seniors in Poland, as well as the problem of family support noticed by social assistance due to the deteriorating health condition of family members related to care, it is highly probable that local practices will be intensified (in social work schools, social projects) supporting seniors and families with seniors.

Reports of difficulties in providing services in the living environment of senior citizens [33], as well as concerns about the safety of service providers and restrictions in the contact between service providers and service users, can be a positive reinforcement in the search for solutions in social work, e.g. in long-term care, in palliative care, and with regard to under-utilised tools in social work, e.g. the case management model for the care of people who are both elderly and disabled.

It seems to us that the state of the pandemic may strengthen and even intensify the processes of building the identity of social work in the various social support institutions used by seniors. This should take place in occupational therapy workshops, where research shows that the population of disabled people is clearly ageing [31].

The potential and, at the same time, positive consequences of the pandemic for the development of social work with and for the elderly in Poland, as indicated above, lead us to conclude that this difficult situation may accelerate work on the concept of the caring potential of local communities [28] and the concept of family caring potential [11;12], which has begun. Both of these concepts are the starting point for a paradigm shift in supporting the elderly and their family in the local environment. The new paradigm, which stems from the need for greater socialisation of activities to create a senior-friendly social space based on 'dense' relations with and caring for others, stands in opposition to the current understanding of seniors' socialisation as processes of primary and secondary socialisation to the socially expected roles assumed in the ageing process [19, p. 145].

A factor conducive to the acceleration of work on the changed paradigm and new concept of social work, and in particular social work with the family and with the community experiencing the consequences of old age, may be observed in studies [7] in the trend of increasing trust of Polish

society in institutions at the local level, which include municipal social welfare centres and poviat family welfare centres. They should therefore have a keen interest in the evaluation of social work. Both concepts can be treated as potential standards against which social work practices should be assessed and evaluated.

We forecast the emergence and further development of new social practices, resulting from the involvement of social work in building moral space in the environment where older people live [28]. This direction has already been noticed, as indicated by good practice projects, in which the theme of intergenerational understanding, integration of generations in education, culture, political activity and voluntary activities, counteracting self-exclusion and isolation of older generations is addressed [30].

However, the positive consequences of the pandemic that we have noticed: the development of a clearer identity of social work with and for seniors, a coherent concept of this work based on the new paradigm of socialisation of care in the living environment, may be limited or even inhibited. The tension signalled in the relationship between carers and the cared for can be interpreted as traumatic, for both sides, experience of choosing values in a conflicting situation of opposing obligations (between self-protection of the carer and protection of the "fragile" care receiver). At the micro-social level, in the relationship of help and care, tendencies to control and objectify the charges, especially in the conditions of providing care in institutions, towards elderly seniors and in poor health, may even intensify. Whereas, seniors using the support of centres and groups in the living environment may be encouraged by representatives of helping professions to greater self-discipline and self-control, which may trigger self-isolation mechanisms among seniors.

Summary

Health and taking care of it has become a matter of common concern [1] and has been politicised [4]. In the societies of the 21st century, which are described as societies of global risk [3], international disasters on a large scale are not always easy to predict, but are inscribed in the specificity of the era. Currently, a health shock event is in the process of being reduced to the technical aspect of risk. Risk factors are estimated for specific population groups. Unlike in earlier eras, death ceases to be accidental and becomes a combination of individual properties (resulting, among other things, from previous negligence), forming the individual's biosocial identity [15, p. 111-115] and environmental conditions. The pandemic period reinforces the importance of experts who provide guidance based on scientific evidence. However, in Poland, expert discussions and political debates introduce informational chaos, which increases the sense of uncertainty and fear in society [36].

During a pandemic, old routines must be changed. Polish seniors are recommended to limit social contacts (even with relatives) as much as possible and, in the case of necessary contacts, to observe the sanitary regime [7, p. 41]. As experts from the Polish Academy of Sciences point out, the elderly face a challenge, i.e. ">>inventing<< a new way of functioning in society, mastering new techniques of communicating with family and friends (e.g. social media), developing new interests "[7, p. 41]. The "inventing" of a new lifestyle, called preventive practice, becomes the task of a senior

citizen with a specific bio-social profile. But will the institutions available in local communities support this process?

Meanwhile, the social work with and for seniors that is being created in Poland faces a double challenge. The first relates to direct practice with and for seniors – how the provision of assistance and care should look like in a situation of requirements and restrictions imposed on the elderly, their carers and institutions providing services in a pandemic situation. Relations at the microstructural level are accompanied by fears and concerns of the providers and receivers of assistance.

The second challenge, present at the mesostructural level, concerns developing a new concept of social work with and for the elderly. In its development, we attribute a significant role to the institutions and organisations dealing with the politicised problem of the pandemic and its effects on the population of older people, who receive various forms of care and assistance from these institutions. There are premises [7; 30] that routine social work with and for the elderly will be enriched with projects aimed at new goals, creating a more socialized space of local care for the elderly than before. But we cannot rule out another scenario either. In the coming years, it can be expected that the preventive projects developed by local and regional institutions will "replace" projects developed from the bottom up by seniors themselves.

References

1. Arnoldi J., Risk, Polity Press, Cambridge 2009.
2. Balon K., Rutkiewicz G., Staręga-Piasek J., Stec K., Szmaglińska I., Zielony M., Standard pracy socjalnej z osobą starszą, 2011, s. 9-15, http://www.wrzos.org.pl/projekt1.18/download/SPS_OS2601.pdf.
3. Beck U., Społeczeństwo światowego ryzyka. W poszukiwaniu utraconego bezpieczeństwa, Wydawnictwo Naukowe Scholar, Warszawa 2012.
4. Blaxter M., Health, Polity Press, Cambridge 2004.
5. Domaradzki J., Genetyzacja społeczeństwa. Społeczne konsekwencje nowej genetyki, „Studia Socjologiczne" 2012, Nr 205(2), s.7-26
6. Duszczyk M., Lesińska M., Matuszczyk K., Upolitycznienie problemu starzenie się społeczeństwa w Polsce. Teoria i praktyka, WUW, Warszawa 2019.
7. Duszyński J., Afelt A., Ochab-Marcinek A., Owczuk R., Pyrć K., Rosińska M., Rychard A., Smiatacz T., Zrozumieć COVID-19. Opracowanie zespołu ds. Covid-19 przy Prezesie Polskiej Akademii Nauk, PAN, Warszawa 2020.
8. Estes C. L., Binney E. A., The Biomedicalization of Ageing – Dangers and Dilemmas, „The Gerontologist" 1989, Vol. 29, no. 5, s. 587–596.
9. Kanios A., Postawy pracowników zawodów pomocowych wobec osób starszych, Wydawnictwo Uniwersytetu Marii Curie-Skłodowskiej, Lublin 2018, s. 82-90.
10. Kaufmann, M., J. Lewandowski, A. Choryński, and M. Wiering. Shock events and flood risk management: a media analysis of the institutional long-term effects of flood events in the Netherlands and Poland, "Ecology and Society" 2016, 21(4):51. https://doi.org/10.5751/ES-08764-210451
11. Kawczyńska-Butrym Z., Niepełnosprawność – specyfika pomocy społecznej, Wydawnictwo Interart, Warszawa 1996.
12. Kawczyńska-Butrym Z., Wyzwania rodziny: zdrowie, choroba, niepełnosprawność, starość, Wydawnictwo Makmed, Lublin 2008, s. 165.
13. Kijak R. J., Szarota Z., Starość – między diagnozą a działaniem, Centrum Rozwoju Zasobów Ludzkich, Warszawa 2013, s. 42-47.

14. Krzyszkowski J., Pomoc społeczna wobec starzenia się społeczeństwa polskiego. „Przegląd Socjologiczny" 2013, nr 62 (2), s. 9-31.
15. Lemke T., Biopolityka, Wydawnictwo Sic!, Warszawa 2010.
16. Leon M., Ranci C., Rostgaard T., Pressures towards and within Universalism: Conceptualising Change in Care Policy and Discourse, w: M. Leon (ed.), The Transformation of Care in European Societies, Palgrave Macmillan, New York 2014, s. 11-33.
17. Leszczyńska-Rajchert A., Praca socjalna z seniorami w perspektywie geragogiki, Wydawnictwo Uniwersytetu Warmińsko-Mazurskiego, Olsztyn 2016, s. 79.
18. Maj K., Skarżyńska K., Społeczeństwo wobec epidemii. Raport z badań, Fundacja im. Stefana Batorego Warszawa 2020.
19. Marody M., Formatowanie społeczeństwa – o starych i nowych sposobach uspołeczniania działań, w: M. Flis , K. Frysztacki, G. Skąpska, P. Polak (red.), Co się dzieje ze społeczeństwem?, Wydawnictwo Uniwersytetu Jagiellońskiego, Kraków 2012, s. 145.
20. Nowakowski M., Nowakowska L., Medykalizacja starości: dylematy i zagrożenia, w: D. Kałuża, P. Szukalski (red.), Jakość życia seniorów w XXI wieku. Ku aktywności, Uniwersytet Łódzki, Łódź 2010, s. 206-218
21. Nóżka M., Smagacz-Poziemska M., Srebrna praca socjalna – adekwatność i potencjał usługi, w: M. Nóżka, M. Smagacz-Poziemska (red.), Starzenie się. Problemat społeczno-socjalny i praktyka działań, Wydawnictwo Uniwersytetu Jagiellońskiego, Kraków 2014, s. 39-52.
22. Pawlas-Czyż S., Społeczna rzeczywistość choroby nowotworowej w rodzinie. Profesjonalna praca socjalna w obszarze wsparcia opiekunów nieformalnych osób chorych onkologicznie. Przyczynek do refleksji nad onkologiczną praca socjalną, Wydawnictwo Edukacyjne Akapit, Toruń 2018.
23. Racław M. (red.), Publiczna troska, prywatna opieka. Społeczności lokalne wobec osób starszych, Instytut Spraw Publicznych, Warszawa 2011.
24. Sobiesiak-Penszko P., Koziarek M., Jak dobrze mieć sąsiada. Od pomocy sąsiedzkiej do sąsiedzkich usług opiekuńczych. Instytut Spraw Publicznych, Warszawa 2016.
25. Szarota Z., Uczenie się starości, „Edukacja Dorosłych" nr 1, 2015, s. 54.
26. Szatur-Jaworska B., Polska polityka społeczna wobec starzenia się ludności w latach 1971-2013, Dom Wydawniczy ELIPSA, Warszawa 2016, s. 333-336.
27. Sztompka P., Socjologia. Analiza społeczeństwa, Wydawnictwo Znak, Kraków 2002.
28. Trawkowska D., Potencjał opiekuńczy rodziny – koncepcja i jej konteksty, w: Z. Kawczyńska-Butrym, E. Czapka (red.), Opieka nad dziećmi i starszymi rodzicami w rodzinach migrujących kobiet, Wydawnictwo Polihymnia, Lublin 2016, s. 17-25.
29. Wieczorkowska M., Społeczne i ekonomiczne konsekwencje medykalizacji starości i starzenia się, „Folia Oeconomica" 2018, Nr 2(334) s. 19-37, DOI: http://dx.doi.org/10.18778/0208-6018.334.02
30. Złota Księga Dobrych Praktyk na Rzecz Społecznego Uczestnictwa Osób Starszych - Edycje I-III – Publikacja BRPO, Warszawa 2018.

Links used

31. Analiza działalności warsztatów terapii zajęciowej w 2008 roku. Raport z badania zrealizowanego przez Centrum Badań Marketingowych INDICATOR dla Państwowego Funduszu Rehabilitacji Osób Niepełnosprawnych. Warszawa, maj 2009, https://www.pfron.org.pl/fileadmin/ftp/dokumenty/Badania_i_analizy/Raport_z_badania_-_Analiza_dzialalnosci_wtz_w_2008_roku.pdf.
32. Jarosz B., Keneda T., Oldest Areas May Be Hardest Hit: The Importance of Age Structure In Understanding Mortality During the Coronavirus Pandemic, https://www.prb.org/oldest-areas-may-be-hardest-hit-the-importance-of-age-structure-in-understanding-mortality-during-the-covid-19-pandemic/, accessed September 07, 2020.

33. Kocejko M., Prawa człowieka mieszkańców DPS to zapomniana sprawa (Opinia), https://publicystyka.ngo.pl/magdalena-kocejko-prawa-czlowieka-mieszkancow-dps-to-zapomniana-sprawa-opinia?fbclid=IwAR0CLccASDHEw8s95j0OV83OnMpmyo1qYZP34P2n0wI3lMES_DwmLqI2pNc, accessed September 17, 2020.
34. Krasicka M., Raport Ministerstwa Zdrowia: kto jest najbardziej narażony na COVID-19?, https://portal.abczdrowie.pl/raport-ministerstwa-zdrowia-kto-jest-najbardziej-narazony-na-covid-19, accessed September 17, 2020.
35. Maj K., Skarżyńska K., Społeczeństwo wobec epidemii. Raport z badań, Fundacja im. S. Batorego https://www.batory.org.pl/wp-content/uploads/2020/04/Badanie-spoleczenstwo-wobec-epidemii-fin.pdf, accessed September 18, 2020
36. Mrowiec K., Epidemia jest zjawiskiem miejskim – rozmowy socjologów w czasie epidemii (with prof. zw. dr hab. Bogdan Jałowiecki), https://www.ath.bielsko.pl/epidemia-jest-zjawiskiem-miejskim/, accessed September 10, 2020.
37. Mrowiec K., Społeczeństwo ryzyka – rozmowy socjologów w czasie epidemii (with dr hab. Jan Domaradzki), https://www.ath.bielsko.pl/socjolodzy-o-spoleczenstwie-ryzyka-rozmowy-w-czasie-epidemii/, accessed September 10, 2020.
38. Ofiary koronawirusa w Polsce. Jaka jest średnia wieku? https://www.medonet.pl/koronawirus/koronawirus-w-polsce,ofiary-koronawirusa-w-polsce--jaka-jest-srednia-wieku-,artykul,26466398.html, accessed September 03, 2020.
39. Ossowska A., „Wszyscy mamy już dosyć". Sopocka influencerka zabiera głos ws. żółtej strefy, https://esopot.pl/pl/11_wiadomosci/5975_-wszyscy-mamy-juz-dosyc-sopocka-influencerka-zabiera-glos-ws-zoltej-strefy.html, Accessem Septemper 26, 2020.
40. Scommegna P., Mather M., Kaneda T., United States Ranks 53 Out of 195 Countries on Aging-Health Problems, https://www.prb.org/older-americans-greater-health-problems-may-make-them-more-vulnerable-to-covid-19s-effects/, accessed September 05, 2020.
41. Sytuacja osób starszych w Polsce w 2018 r. (The situation of older people in Poland in 2018), Główny Urząd Statystyczny, Urząd Statystyczny w Białymstoku, Warszawa, Białystok 2020, https://stat.gov.pl/obszary-tematyczne/osoby-starsze/osoby-starsze/sytuacja-osob-starszych-w-polsce-w-2018-roku,2,1.html, accessed September 12, 2020.

Grzegorz Godawa, Ageing and Ageism in CoVID-19 time

Introduction

Brad A. Meisner referred to the difficult determinants of functioning in the time of pandemic and remarked: "Although we cannot control the year we were born, we can control how we think about, treat, respect, and empathize with each other – across generations, in solidarity – especially in a time of crisis" [6, p. 5]. He emphasised that an ability to control and create one's own views and behaviours is key to friendly relationships in society which are based on empathy and solidarity. It is extremely important during the global crisis which humanity is facing as a result of the occurrence of COVID-19.

The pandemic situation has tremendously changed the functioning of individuals and societies. It may even be said that it has strengthened and polarised human attitudes and social phenomena. Unfortunately, they also include negative phenomena which lack mutual intergenerational respect postulated by Meisner. One of them is ageism which is a form of social discrimination by the year of birth. During the pandemic chronological age took on a new meaning as it is older adults who became particularly prone to infection and all its consequences. Consequently, certain words and behaviours which discriminate older adults appeared in different areas of life.

On the other hand, it may also be observed that older adults are perceived and treated in a different, positive way. Care for their safety and health led to numerous initiatives which are not as accessible to the public as the cases of ageism are. The aim of this work is to show the manifestations of ageism and prosocial behaviours in the functioning of global society affected by the coronavirus. In order to achieve it, it will be necessary to outline the issue of older adults facing COVID-19 and the essence of ageism.

Older adults facing COVID-19

The World Health Organization (WHO) declared SARS-CoV-2 as a pandemic on March 11, 2020. It was the beginning of a very difficult time, especially for older adults. According to research, older individuals are more likely to get COVID-19 and have much worse outcomes compared with the general population, in particular with young people. In addition, the level of mortality of the SARS-CoV-2 pandemic in older adults has been striking. If they have certain comorbidities, they may be at a greater risk of infection and suffer worse outcomes. It should be emphasised that many medications and a vaccine are

currently under investigation, but still no approved treatments or vaccines are available for this virus [21, p. 927].

Health risks lead to many other problems because a range of pandemic exceeds the area of medicine. It is important to underline the social context of the epidemic situation. The global recommendation for older populations includes social isolation. It involves staying at home and avoiding contact with other people for some period of time, currently estimated to be between three and four months, depending on the regulations in particular countries. Older adults in need of care are particularly dependent on family and friends. However, social isolation includes avoiding close direct contact with family members and friends if they do not live together. Older adults may also rely on the support of voluntary services and social care. They can organize the delivery of essential items, such as groceries and medications [3, p. 2044].

Some older adults are facing additional difficulties at this time. The spread of COVID-19 in nursing homes is taking a devastating toll on older adult's lives. Some distressing reports indicate instances of neglect or mistreatment. Some older people who are in quarantine or locked down with family members or caregivers may also face higher risks of violence, abuse, and neglect [24, p. 3].

Joanne Brooke and Debra Jackson emphasize the need to recognize that older people who previously had not reported being lonely may disproportionately experience the requirements of social isolation due to COVID-19. It may happen because of the removal of social contacts which normally occur during attending community groups and places of worship and other day-to-day activities. In these circumstances, social isolation and loneliness increase older people's risk of anxiety, cognitive disfunction, depression, heart disease and mortality. In addition, older people may also be affected by ageism which leads to the belief that older life is not as important as loss of life of other age people [3, p. 2044].

Ageism

Robert N. Butler was the first who used the term "ageism" to describe prejudice against older adults, defining it as "a process of systematic stereotyping of and discrimination against people because they are old" [5, p. 12]. Over the next fifty years, this classical definition was coined, modified and completed by adding more well-known forms of prejudice. One of the most complete and up-to-date definitions has been offered by Thomas N. Iversen, Lars Larsen and Per E. Solem, who defined ageism as "negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of) elderly people on the basis of their chronological age or on the basis of a perception of them as being 'old' or

‘elderly’. Ageism can be implicit or explicit and can be expressed on a micro-, meso-, or macrolevel” [11, p. 15]. This definition describes the most important areas of ageism: three classical psychological components of the ageist attitude, conscious and unconscious, positive and negative aspects and the diverse scope of ageism.

Although ageism may relate to the young as well, and in such cases it is called “adultism”, from the perspective of social issues ageism is mainly related to older adults. There are very strong negative attitudes towards older adults, prejudices against them and stereotypes about them in society. They are based on the biological diversity of humans which is connected with the process of aging. Moreover, they are related to the competences and needs of people depending on their chronological age. As a result, the calendar age is used to separate groups whose access to various social resources is subject to systematic control [22, pp. 61-62]. Positive ageism involves attributing certain qualities to older adults. Qualities such as kindness or wisdom result from their lifelong experience. Older age is a factor which may contribute to more lenient treatment in court, deeper understanding when it comes to shortcomings, and organising different forms of support which are available after reaching a certain age. Negative ageism is a form of exclusion and may be expressed in the social rejection of older adults or in self-ageism. It may be observed when older adults start to believe in these negative stereotypes. The internalization of stereotypes contributes to discrimination against older adults in the area of employment, medical care, institutional support and even in the family [18, p. 873].

Ageism may be caused by various determinants of functioning of individuals and society. According to Sagit Lev, Susanne Wurm and Liat Ayalon, the reasons for ageism can be seen in terror management theory, stereotype embodiment theory and social identity theory [14, p. 52]. Terror management theory provides an explanation for the reasons and motives of ageism towards old age groups among the young, middle aged groups and young-old age group. In this case, ageism is connected with the threat of death, the threat of animality, and the threat of insignificance. Prejudice and intolerance are based on the fear of death. An inability to peacefully coexist with others results from an inability to share one’s worldview with those who do not agree with us and do not buffer our anxiety [8, p. 69]. Stereotype embodiment theory explains the roots of ageism among the young-old and old-old age groups. Negative attitudes and stereotypes about older adults which an individual has internalized during their life are often unconsciously embodied during old age, whereas social identity theory is connected with interpersonal and intergroup behaviours. Interpersonal behaviour is determined by individual characteristics and interpersonal relationships. Intergroup behaviour is determined by respective membership in various social groups or categories. The social

behaviour of individuals combines these two aspects. Subordinate and minority groups in society often tend to internalise a social evaluation of themselves as "second class", which leads to self-ageism [14, pp. 58-62].

It seems that the root of ageism should not be searched for only in the psychological and sociological area. Personal dignity plays a particularly important role in this matter. Personal dignity and human rights arising from it were confirmed by the Universal Declaration of Human Rights. The Preamble to the Declaration states: "Recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world" [23]. Unfortunately, there are many factors which may undermine personal dignity of older adults. As a result, they experience exclusion. Pope Francis emphasises the importance of this problem in the following words:

"We have created a 'throw away' culture which is now spreading. It is no longer simply about exploitation and oppression, but something new. Exclusion ultimately has to do with what it means to be a part of the society in which we live; those excluded are no longer society's underside or its fringes or its disenfranchised – they are no longer even a part of it. The excluded are not the 'exploited' but the outcast, the 'leftovers'" [20].

Older adults frequently face such a situation. How and to what extent does their situation change when the circumstances of everyday life change radically?

How ageism affects older adults during the COVID-19 pandemic

Traumatic experiences cause a strong reaction in almost every human being. Tension mounts in extreme situations, which perpetuates traumatic experiences. Such experiences affect the social context of human life, hinder social functioning and increase tension between people. The coronavirus pandemic has intensified some negative social behaviours, e.g. ageism.

"Boomer remover"

One of the manifestations of the influence of the pandemic on daily life are changes in spoken language in which vocabulary related to the pandemic is used. Language is sociable by nature. It is inseparably connected with people who are its creators and users. Language grows and develops together with the development of society. In the social consciousness, the role of language is not limited to being merely a communication tool. Language plays an important role as a concept itself and as a subject of evaluation. Therefore, its quality and level are really crucial. The evaluation of language should not limit its development but

encourage reflection, initiate social debate and implement educational action in areas where controversial, yet popular terms point to deficiencies in language.

Neologisms coined during the pandemic express social moods. They are a form of stress relief and at the same time, they facilitate communication, especially among younger generations. They may have an opinion-forming significance and in this way, they may contribute to the intensification of ageism. They include expressions referring to the coronavirus and older adults who are at risk such as "Boomer Doomer," "Senior Deleter" or "Elder Repeller". However, the best-known expression used in memes is "Boomer Remover" which was a trending topic and hashtag on Twitter in March 2020 [15, p. 3]. The term "Boomer Remover" is a modified form of the expression "Ok, Boomer" which was popular with the members of Y and Z generation in 2019. It was used to refer to the representatives of the generation of Baby Boomers born between 1945-1964. In common usage, this phrase refers to an older adult when one wants to end the conversation with them, expressing a disrespectful attitude towards them.

When referred to the coronavirus which poses a threat mainly to older adults, the expression "Boomer Remover" implies a process of demographic cleansing of society of people above 60 years of age. The term is humorously interpreted as a harmless reaction of the young generation to the oldest members of society. However, a deeper analysis shows that in the media this phrase tends to be used to express hostility towards older adults and disrespect for them [9]. The purpose of using this name is to address global and domestic overpopulation, decrease the burden that older adults put on health care and tax systems, remove older adults from society in order to provide more jobs, opportunities, and resources to younger and healthier people and reduce the number of right-wing conservative voters, too [15, p. 3]. There is no doubt that these expressions can be perceived as a manifestation of ageism. As a result, we may observe a new category of ageism in the mass media which present older adults as "sitting ducks", vulnerable and helpless against COVID-19. High mortality amongst older adults is considered an "inevitable" and "normal" outcome of this pandemic [6, p. 3].

Herd immunity

The idea of herd immunity was presented to the public in the early stage of the development of COVID-19 in Europe. It was related to the fact that the process of adopting a model of combating the coronavirus differed from country to country. Some countries introduced tough restrictions while other ones did not. One of the discussed models assumes that the immunity of a given population may be achieved by infecting around 60% of society.

Therefore, countries where the model was implemented did not decide to severely limit social contacts. The statement that emphasis should be placed on treating the ill rather than on prevention aroused great controversy which has ageist reference in line with the following assumption: „Herd immunity, protect the economy, and if that means some pensioners die, too bad" [4]. The model assumes that older adults are protected, but it does not sufficiently protect them against infection, which is proven by a lot of cases of infection in nursing homes. According to Haley E. Randolph and Luis B. Barreiro, "the consequences of this model are serious and far-reaching – a large fraction of the human population would need to become infected with the virus, and millions would succumb to it. Thus, in the absence of a vaccination program, establishing herd immunity should not be the ultimate goal" [10, p. 741]. At the same time, it is worth highlighting that according to research, the current decline in infections in particular countries should not be attributed to the implementation of the "herd immunity" model, but to the adherence to the rules of social isolation and the introduction of numerous restrictions [17, p. 111].

Is age still the first criterion?

Nowadays, older adults are rarely given a voice and are seldom considered when making decisions. The pandemic creates numerous situations in which making decisions is necessary but extremely difficult, especially in the ethical dimension. It applies to the use of limited sources of support, e.g. respirators. If their number does not satisfy the current need of society, decisions about the priority to use them must be made. The analysis of recommendations and ethical opinions reveals a substantial discrepancy in this matter [19]. There are regulations regarding patients' equality which assumes that race, age, disability, ethnicity, ability to pay or social worth cannot be taken into consideration when making decisions. In this approach, the patient's age cannot become a criterion in the use of limited sources of support, e.g. The New York State guidelines for ventilator allocation rejected the use of advanced age as a criterion as discrimination against older adults [2].

However, there are also opinions that the age criterion is significant. In this case, they refer to the following rule: "Younger individuals should receive priority, not because of any claims about social worth or utility, but because they are the worst off, in the sense that they have had the least opportunity to live through life's stages" [26, p. 1773]. Making the age criterion significant or giving it priority which determines whose life to save first is a manifestation of ageism. Adopting the age criterion as one of the basic determinants of decision making is a risky and medically unjustified proposal in the context of wide diversity of biological potential of people of different chronological age [19].

Overcoming ageism

Despite a lot of examples which indicate that the problem of ageism became more serious during the COVID-19 pandemic, there are also manifestations of deep concern for older adults. The common denominator of these activities is care for the oldest members of society. It is an expression of selfless, emphatic interest in people who need help due to current circumstances. Concern for others may have different reasons, e.g. altruism, solidarity, faith in God and religious beliefs as well as close relationships with other people. Manifestations of care for others may be observed at the microsocial, local and macrosocial level. Numerous initiatives in local communities are a response to the call for society to help older adults. They were promoted by politicians, celebrities and other well-known people. Such initiatives are, first of all, an expression of love and concern for the oldest family members who expect being noticed and need care, kindness and practical help during this special time.

"It is everyone's business"

There are a lot of campaigns aimed at supporting older adults. They show a growing interest in older adults' needs as well as the active involvement in the process of satisfying them. Support offered to older adults by governments has become indispensable and made it possible to introduce regulations which protect older adults at the legislative level.

A growing awareness of older adults' needs may be observed as society is more and more conscious of the fact that older adults are at a high risk of getting infected and at the same time, they constitute an important social group. Consequently, governmental and informal initiatives were launched in the media in order to identify the specific needs of older adults. In this context, on behalf of WHO, Hans Henri P. Kluge emphasised that older adults' life is at risk. He postulated:

"Supporting and protecting older people living alone in the community is everyone's business. I am reminding governments and authorities that all communities must be supported to deliver interventions to ensure older people have what they need. This support includes safe access to nutritious food, basic supplies, money and medicine to support physical health and access to social and mental health support and information to maintaining emotional well-being. All older people should be treated with respect and dignity during these times. Remember, we leave no one behind. (…) 'Physical distancing is not social isolation'" [12].

These words convey a message which highlights not only older adults' specific needs and ways of offering support to them, but it also refers to the social perception of older adults.

The phrase “It is everyone’s business” aims to raise social awareness and calls for a mental change, thanks to which support offered to older adults is perceived as an activity which brings benefits for every member of society.

“We are all in this together”

Care for older adults is expressed in solidarity with them, which is proven by numerous initiatives launched by governmental organizations and other institutions. Funds provided by organisations were given to adults directly or with the help of volunteers. In many cases, contact between donors and older adults would not be possible without the involvement of young volunteers. It is worth noting that their involvement counterbalances ageism: “Despite clear indications of ageism, there are also encouraging signs of intergenerational solidarity during this pandemic. There are myriad examples of younger people supporting older adults during their isolation: dropping off groceries, looking after their garden and working to keep them socially connected” [6, p. 3]. This form of help is most often offered at a local level, without the media.

Adults and young adults have become necessary links in the process of offering support to older adults. First of all, they help their family members, but in many cases they support people who are not their relatives. The involvement of volunteers makes it possible to get to those who need help. Thanks to them, funds provided by governments and non-governmental organisations satisfy the current needs of older adults. It needs emphasising that overcoming the barriers of social isolation which results from social distancing is equally important. It takes place in meetings between those who offer help and those who need it. However, these “meetings” are often limited to knocking at the door and dropping off shopping or initiating contact via communicators. Pope Francis called for young people to overcome older adults’ loneliness by showing them gestures of tenderness directly or with the use of communicators. This initiative was heartily approved of in society [25].

In this respect, the involvement shown by young people is of great significance both at the individual level and at the level of youth organisations. It is confirmed by research conducted by OECD among youth organisations in 48 countries. Research shows that the involvement of young people who belong to various organisations contributes to improving quality of older adults’ life [16, p. 28].

Locked down with seniors

Apart from action taken in families and local communities there are also initiatives which go beyond the scope of support already described in the article. It is worth highlighting

the importance of voluntary work and readiness to assist older adults and other people who stay in nursing homes. During the pandemic nursing homes became places where older adults were at risk of death, and sometimes they suffered from the lack of proper care and attention. It occurred that they were subjected to unacceptable abuse [1]. The difficult situation caused fatigue among staff, and the lack of appropriate equipment aroused the feeling of helplessness. In such a situation, the only solution was to involve volunteers in supporting them. Volunteers showed heroic concern for older adults. They had to make a decision which had long-term consequences, because support offered to nursing home residents was related to an increased risk of infection and the need to stay isolated with them.

Polish nuns and monks showed their readiness to help and responded to the call for support from nursing home directors. During the initial period of the pandemic in Poland, over 3,000 nuns helped those who needed help, e.g. older adults. Some nuns and a group of monks voluntarily "locked themselves" in nursing homes and provided nursing and care services to residents. At the same time, they had to follow the rules of isolation for several weeks. The attitude of volunteers and their help made it possible to support older adults and ill people staying in nursing homes [7].

Seniors' response to the social needs

The pandemic has shown that older adults are not only a group which requires a lot of social support, but they are primarily needed in society. Their contribution to its functioning may be observed on many levels. One of them is their involvement in helping other older adults, firstly their relatives, but also people in a wider social dimension.

According to American Psychological Association, many seniors actively contribute to society as family caregivers, health care providers on the front line of the COVID-19 pandemic by providing essential services in health and long-term care settings or in supportive functions such as housekeeping and food services. If some parents work in essential services or healthcare, grandparents play an equally vital role in facilitating their ability to work. Moreover, retired medical professionals, for example in New York and Florida were called to return to work. In effect, tens of thousands volunteered to do so. Likewise, many older adults are caregivers for family members who are frail. Spouses are the primary caregivers for over a third of seniors. In addition, almost two million older people are caregivers for their grandchildren and 25% of children under five are taken care of by grandparents in place of parents who are working [2]. It shows their great generosity and highlights their role in society.

Similar initiatives were launched in other countries. It is worth noting that the involvement of retired doctors led to consequences. At the beginning of July 2020, the number of doctors who died of COVID-19 in Italy reached 172, including retired doctors [13]. Thanks to their involvement, older adults gained recognition in society. It also made people appreciate their role and reduced the impact of ageism.

Conclusion

The analysis of positive and negative attitudes towards older adults during the pandemic does not provide sufficient quantitative justification of how significant these phenomena are. Only some examples of attitudes towards older adults were chosen and analysed. This analysis is of qualitative significance as although it does not make it possible to exactly determine the scope of the phenomenon, it shows its complexity. It also reveals the complex determinants and mechanisms of ageism as well as the context of adopting prosocial attitudes.

An increase in ageism during the COVID-19 pandemic is easily noticeable, and its manifestations cause well-founded fear. They occur at the level of verbal communication and in the area of healthcare. They are also visible in any other activity which marginalises older adults. The mass media contribute enormously to the problem as it promotes and strengthens ageist attitudes. At the same time, the same mass media provide the opportunity to promote respect for older adults. Therefore, it is important to make use of this potential to defend everyone's rights, regardless of age.

Ageism visible in healthcare is frequently related to the current complex situation of healthcare workers. The need to make decisions about saving patients' lives and about who should receive priority had been quite rare. During the pandemic there was a growing need to make such decisions in hospital teams, which resulted in stress and ethical dilemmas. It seems that in the decision making process there was often not enough reference to the opinions of ethics committees, which together with inevitable haste and stress contributed to adopting solutions which limited the rights of older adults. The presence of such committees in hospitals is a postulate which gained special significance during the pandemic.

Care for older adults, both the close ones and strangers, provides the basis for the prosocial attitude. It was expressed in a variety of ways and was full of empathy, creativity, and even heroism. As a result, the oldest members of society were noticed and their needs received careful attention. The ways of satisfying them were indicated. An interesting manifestation of this attitude is the involvement of older adults in supporting other people in

need. Consequently, society benefited greatly, and older adults showed that they remain an irreplaceable social group.

The way of functioning and the directions of social change remain an open question. An effective vaccine will change a lot. However, in the social dimension of functioning, these changes, in particular the ones in mentality, will supposedly take place at a specific pace. Therefore, it is important to make use of the present time and focus on social education which includes the process of forming attitudes towards older adults. In the near future, the beneficiaries of this kind of education will be people who are currently helping older adults or receiving help from older adults in families. Such an exchange of good is one of the most effective forms of becoming mature both as society and as individuals and rising to modern, difficult challenges.

References

1. AGE Platform Europe, *COVID-19: with great challenge must come great solidarity*, 2020. Available at: https://www.age-platform.eu/special-briefing/covid-19-great-challenge-must-come-great-solidarity [Accessed 7 August 2020].
2. American Psychological Association, *Ageism and COVID-19*, 2020. Available at: https://www.apa.org/topics/covid-19/research-ageism [Accessed 21 July 2020].
3. Brooke, J., Jackson, D., *Older people and COVID-19: Isolation, risk and ageism*, Journal of Clinical Nursing, 29(13-14), pp. 2044-2046, 2020.
4. Bufacchi, V., *How coronavirus exposed our society's inherent ageism*, New Statesman, 2020. Available at: https://www.newstatesman.com/international/2020/05/coronavirus-old-age-over-60s-risk-care-homes-herd-immunity-deaths [Accessed 21 July 2020].
5. Butler, R.N., *Why Survive? Being Old in America*, Harper and Row, New York 1975.
6. Fraser, S., Lagacé, M., Bongué, B. at al., *Ageism and COVID-19: What does our society's response say about us?*, Age and Ageing, pp. 1-4, 2020.
7. Goławski, P., *Wolontariat w DPS-ach, zbiórki pieniędzy, pomoc psychologiczna i modlitwa. Działania Kościoła w walce z COVID-19*, 2020. Available at: https://www.polskieradio24.pl/5/1222/Artykul/2511839,Wolontariat-w-DPSach-zbiorki-pieniedzy-pomoc-psychologiczna-i-modlitwa-Dzialania-Kosciola-w-walce-z-COVID19 [Accessed 15 July 2020].
8. Greenberg, J., Solomon, S., Pyszczynski, T., *Terror Management Theory of Self-Esteem and Cultural Worldviews: Empirical Assessments and Conceptual Refinements*, Advances in Experimental Social Psychology, 29, pp. 61-139, 2020.

9. Haffower, H., *A certain horrible subset of the internet is calling the coronavirus 'boomer remover'*, Business Insider Australia, 2020. Available at: https://www.businessinsider.com/millennials-gen-z-calling-coronavirus-boomer-remover-reddit-2020-3?IR=T [Accessed 2 August 2020].
10. Haley, E.R., Barreiro, L.B., *Herd Immunity: Understanding COVID-19*, Immunity, 52, pp. 737-741, 2020.
11. Iversen, T.N., Larsen, L., Solem, P.E., *A conceptual analysis of ageism*, Nordic Psychology, 61, pp. 4-22, 2009.
12. Kluge, H.H., *Statement – Older people are at highest risk from COVID-19, but all must act to prevent community spread*, Copenhagen 2020. Available at: https://www.euro.who.int/en/health-topics/health-emergencies/coronavirus-covid-19/statements/statement-older-people-are-at-highest-risk-from-covid-19,-but-all-must-act-to-prevent-community-spread [Accessed 3 August 2020].
13. La Repubblica, *Coronavirus, sale a 172 l'elenco dei medici morti da inizio pandemia*, 2020. Available at: https://www.repubblica.it/cronaca/2020/07/06/news/coronavirus_sale_a_172_l_elenco_dei_medici_morti_da_inizio_pandemia-261159772/ [Accessed 3 July 2020].
14. Lev, S., Wurm S., Ayalon, L., *Origins of Ageism at the Individual Level*. In: L. Ayalon, C. Tesch-Römer (eds), *Contemporary Perspectives on Ageism. International Perspectives on Aging*, pp. 51-73, vol. 19, Cham 2018.
15. Meisner, B.A., *Are You OK, Boomer? Intensification of Ageism and Intergenerational Tensions on Social Media Amid COVID-19*, Leisure Sciences, pp. 1-6, 2020.
16. OECD, *Youth and COVID-19: Response, Recovery and Resilience*, 2020. Available at: http://www.oecd.org/coronavirus/policy-responses/youth-and-covid-19-response-recovery-and-resilience-c40e61c6/ [Accessed 15 July 2020].
17. Okell, L.C., Verity, R., Watson, O.J. et al., *Have deaths from COVID-19 in Europe plateaued due to herd immunity?* The Lancet, 395, pp. 110-111, 2020.
18. Palmore, E., *Ageism Comes of Age*, Journals of Gerontology: Social Sciences, 70(6), pp. 873-875, 2015.
19. Pawlikowski, J., *Etyczny wymiar decyzji priorytetyzacyjnych i alokacyjnych dotyczących stosowania zaawansowanych technologii medycznych w kontekście pandemii COVID-19*, Medycyna Praktyczna, 4, 2020.
20. Pope Francis, *Apostolic Exhortation "Evangelii gaudium" on the Proclamation of the Gospel in Today's World*, no 53, Vatican 2013.

21. Shahid, Z., Kalayanamitra, R., McClafferty, B. et al., *COVID-19 and Older Adults: What We Know*, Journal of the American Geriatrics Society, 68(5), pp. 926-929, 2020.
22. Szukalski, P., *Ageizm – przejawy indywidualne i instytucjonalne*. In: M. Halicka, J. Halicki, A. Sidorczyk (eds), *Człowiek dorosły i starszy w sytuacji przemocy*, pp. 59-68, Białystok 2009.
23. United Nations, *Universal Declaration of Human Rights*, Paris 1948. Available at: https://www.un.org/en/universal-declaration-human-rights/ [Accessed 1 August 2020].
24. United Nations, *Policy Brief: The Impact of COVID-19 on older persons*, 2020. Available at: https://unsdg.un.org/sites/default/files/2020-05/Policy-Brief-The-Impact-of-COVID-19-on-Older-Persons.pdf [Accessed 3 August 2020].
25. Watkins, D., *Covid-19: Vatican launches #sendyourhug campaign to support elderly*, 2020. Available at: https://www.vaticannews.va/en/vatican-city/news/2020-07/coronavirus-laity-family-life-campaign-closeness-to-elderly.html [Accessed 10 July 2020].
26. White, D.B., Lo B., *A Framework for Rationing Ventilators and Critical Care Beds During the COVID-19 Pandemic*, JAMA, 323(18), pp. 1773-1774, 2020.

Jaroslava Hasmanova Marhankova, Age-division and ageism in the public debates regarding COVID-19 pandemic. Intergenerational solidarity and antagonisms in the era of the coronavirus pandemic

Introduction

In December 2019, the World Health Organization (WHO) first reported the occurrence of cases of a new form of respiratory disease in the Chinese Wu-Chan area. On the 11th of February, the general director of WHO announced that this disease would be named COVID-19 as an acronym for 'coronavirus disease 2019'. By March 11, reports indicated the disease had already spread to 114 countries across the world, with the number of victims exceeding four thousand. At this point, the WHO classified the outbreak of COVID-19 as a pandemic situation [8]. Current data suggest that approximately 80% of patients have experienced a mild course of the disease, while 20% have required hospitalisation, with approximately 5% of patients requiring hospitalisation in the intensive care unit. Mortality rates are higher for people over 60 and for people with pre-existing health problems [9]. The high infectivity of the disease has been further complicated by a large percentage of people infected with the virus who show no symptoms and the long incubation period of the disease, during which the person does not feel ill but may be capable of transferring the disease to others. Estimates suggest that up to 80% of infections have been diagnosed in individuals who were pre- or asymptomatic [8]. For these reasons, most countries have taken major epidemiological measures aimed primarily at reducing social contact between people, especially in groups that are more at risk of experiencing a serious course of the disease.

The statistically different rates at which serious manifestations of COVID-19 are experienced by different age groups represents one of the most significant features of this pandemic, which also shapes its media image. One of the most widely read national newspapers in the Czech Republic, for example, referred to the coronavirus in one of its headlines as 'the disease of the old, which mercifully omits children'.[5] As Gilleard and Higgs [13] pointed out, our current knowledge regarding the effects of this disease suggest that it does amplify but does not change the chronology of life and death. If this disease were to significantly change the chronology of life and death, its social and psychological effects would probably be fundamentally different and, in many ways, more dramatic. This fact made it possible to symbolically incorporate COVID-19 into the course of life, not necessarily as a natural part of it, but at least as something that does not contradict the order of things. It is,

[5] Baulisová, K.: "Nemoc starých, která děti milosrdně vynechává." MFDnes 11.3.2020.

therefore, not surprising that the emphasis on the fact that the serious progression of the disease mainly affects older people appears as such an essential part of the representation of this pandemic. The reference to chronological age has become an integral component of reports of deaths caused by COVID-19. In the subtext, it is also an essential element of efforts to calm the exaggerated atmosphere of fear. Reference to the fact that the fatal impact of the disease especially affects older people makes constantly visible the evidence that nothing changes significantly in the 'chronology of life and death'. The importance of membership in certain age groups, thus, has become the distinguishing feature of the pandemic. From the beginning, the COVID-19 epidemic has been portrayed primarily as a 'problem of the elderly' [1].

The essentialisation of chronological age as a synonym for risk and definition of health condition in public debates regarding the COVID-19 outbreak has paradoxically led to the invisibility of the essence of vulnerability, which is the greater likelihood of the presence of health problems. However, these health problems are not determined by age, nor are they limited to a group of people above a clearly defined age limit. Homogenisation of age groups obscures this fact and presents all older individuals as automatically vulnerable and all younger people as not at risk. This perception of age groups in relation to the pandemic produces problematic effects. For example, according to this logic, chronological age becomes a relevant criterion for determining access to certain goods that were not previously perceived as being allocated based on age. The Italian Society for Anesthesia, Analgesia, Resuscitation and Intensive Care Medicine (SIAARTI) has issued recommendations in connection with the COVID-19 pandemic for healthcare professionals in intensive care units that explicitly mention the possibility of setting an age limit for access to health care and equipment. The authors of the recommendation mentioned that in a crisis situation when equipment necessary for patient survival is limited, 'criteria for ICU admission (and discharge) may need to be driven not only by the principles of clinical appropriateness and proportionality of care, but also by criteria of distributive justice and appropriate allocation of the healthcare resources, that may be more limited than usual' [18 p. 1]. The patient's age and the estimated number of years the patient's life can be extended by administering treatment are some of the criteria to be considered when deciding who will have access to adequate care (ibid).[6] These recommendations have provoked a wave of critical debates regarding healthcare ethics, the discussion of which is beyond the scope of this paper. Nevertheless, this

[6] In Germany, the Ethics Committee (Deutscher Ethikrat) issued an ad hoc statement for situations involving the lack of resources needed to provide adequate health care. These recommendations explicitly reject the age criterion and emphasise the prospect of the successful treatment of the patient, which depends on the individual's medical condition [11 p. 3].

example illustrates that the need to recognise diversity within age groups, which is one of the pillars of contemporary (social) gerontology, is easily forgotten within specific healthcare policies formulated during a crisis situation. It also indicates that it is still socially accepted to consider chronological age as a fundamental criterion for the distribution of rare social goods.

The way in which the risks surrounding COVID-19 have been portrayed and addressed reflect structural problems related to the perception of the role of older people in society. These problems were not caused by this pandemic. In many cases, however, the coronavirus pandemic has acted as a magnifying glass, making these issues more visible. We believe that critical reflection is needed to analyse what kind of messages are brought to light through this glass concerning old age and the importance of the way chronological age is constructed. Thus, the aim of this paper is to contribute to the discussion regarding the impact of the coronavirus pandemic on intergenerational solidarity and relationships. We argue that the way the pandemic has been framed in public debates and healthcare policies may influence our perception of age groups and possibly lead to intergenerational antagonisms.

The discussion of the (non)existence of intergenerational conflict has a long tradition in gerontological analysis. Such debates have focused mainly on public transfers, suggesting that expenditures related to pensions and health care for the growing number of older people in society may disrupt the social contract between generations [6; 4]. This paper focuses on the assignment of different levels of health risk as a source of potential intergenerational tensions. We argue that the current pandemic may stimulate intergeneration antagonism in a new way. As outlined previously, COVID-19 impacts different age groups differently. This fact may strengthen intergenerational solidarity. (This paper also addresses how the distribution of different risk levels have facilitated solidarity between generations.) However, we argue that the way chronological age has been mobilised in the debates regarding the pandemic may in the long run contribute more to intergeneration antagonism. In this article we outline three processes that have accompanied public discourses on the COVID-19 pandemic and that may significantly shape social perceptions of chronological age and the position of older people in society. Firstly, as already explained, chronological age was established as a significant vector defining human positioning in society during the pandemic. Older age was essentialised as a type of health condition. Age groups, in the public discourse, were constructed as homogenous and united through the idea of (different levels of) risk. Secondly, contact between members of different generations was systematically established as one of the main risks for contracting COVID-19. This situation may further strengthen age segregation and distance between generations. However, the two processes may not necessarily contribute to intergenerational conflict. We argue that it is mainly the way the

nature of risks and the character of the pandemic has been communicated that has led to the paradoxical position of systematically describing the lives of older people as more dispensable while simultaneously highlighting their protection as justification for society-wide measures that have a significant impact on all citizens. This paper suggests that this paradox, together with the essentialisation of chronological age and age segregation, may give rise to new forms of intergenerational antagonism.

AGE SEGREGATION AND THE RISK OF INTERGENERATION CONTACT

We can already find numerous studies addressing the manifestations of ageism aimed mainly at older people that have accompanied public debates regarding the pandemic and the measures that should be followed [2; 5; 11]. We argue that these manifestations need to be interpreted primarily in the context of an age-divided society, which has become part of the communication of the 'fight' against the coronavirus infection. As Hagestad and Uhlenberg [14] noted, we live in a society characterised by institutional, spatial and cultural age segregation. Without personal contact, the members of different age groups easily became 'the others'. Age segregation reproduces ageism and supports the isolation of older people. Institutional arrangements that separate age groups restrict opportunities to form cross-age relationships. In that respect, family represents a crucial context within our age-divided society where people of different generations can gather; indeed, it is becoming one of the last islands where strong relationships are formed across generations [ibid].

Communication on the nature of the risk associated with the pandemic through the language of separate age groups has established relatively impermeable age-group boundaries. Some countries have taken measures that explicitly emphasise the isolation of older people, also because their exclusion from society has been presented as economically viable not only for them but also for society as a whole (because they often do not participate in the labour market) [2]. At the same time, it is intergenerational contact that has often been presented as a real threat to older people. The mild course of the disease is characterised by a relatively high number of people who have the disease but do not have obvious or fundamental symptoms, yet they can still spread the infection to their surroundings. In combination with the older population's higher risk of experiencing a more serious progression of the disease in comparison to younger age groups, the message that intergenerational contact places older people at a higher risk for contracting COVID-19 has become part of the communication of measures aimed at reducing its spread. For example, in the case of the third known victim of the disease in the Czech Republic, the newspapers were filled with headlines pointing to the fact that the woman became infected by her granddaughter (as informed also by the Minister

of Health, who also appealed to citizens on Twitter not to visit their grandparents).[7] Similarly, the Israeli Minister of Defence emphasised that the most important preventative measure for seniors was to separate young from old and described the most dangerous combination as a grandmother meeting and hugging her grandchildren [1 p.1].

The call to reduce contact between extended family members and take precautions in relation to older people who are at greater risk is, of course, not a problem in itself, but rather it is an incentive to think about how intergenerational solidarity can be fulfilled in other ways. As the German Chancellor emphasised in her speech, the emphasis on limiting contact between younger and older family members should be seen primarily as a challenge to look for other, additional forms of intergenerational support inside and outside the family.[8] In this respect, during the initial stages of the pandemic, we also witnessed (especially, but not only) the vast intensity of intergenerational solidarity and the responsibility that many young people felt towards older people. Krastev [15 p.31] observed that the experience of 'staying home' helped younger people to empathise with their parents and grandparents, who may have already spent more of their time at home and may have experienced health-related anxieties before the onset of the pandemic. This shared experienced may, therefore, potentially reinforce the understanding and solidarity between individuals from different age groups. At the same time, the restriction related to the pandemic made us experience what it means when contact between generations is lacking. Thus, it is possible to hope that, among other things, the importance and need for intergenerational ties have become evident through their short-term involuntary (physical) interruption. However, in the next section of this paper, we suggest that the problematic position of chronological age and older people in the debates regarding the COVID-19 pandemic have the potential to alienate the experiences of different age groups and stimulate new forms of intergenerational antagonisms.

NARRATIVES OF A 'STOLEN FUTURE' AND INTERGENERATIONAL ANTAGONISM

The relationship between age and the risk of experiencing a serious progression of COVID-19 has emphasised a key feature of the disease: it significantly affects the dynamics of the relationship between the generations. It has its positive effects that cannot be ignored (whether it is, for example, the activities of young people helping with food delivery or their

[7] Brodcová, D.: "České oběti koronaviru. Koho virus přemohl? " Seznam Zprávy 24.3.2020. Dostupné z: https://www.seznamzpravy.cz/clanek/druha-obet-koronaviru-v-cesku-delali-jsme-vse-ale-byl-oslaben-nadorem-95408.

[8] „Appeal to the people living in Germany: Angela Merkel's speech about the Corona virus in full." Available at: https://ga.de/ga-english/news/angela-merkel-s-speech-about-the-corona-virus-in-full_aid-49639811.

volunteering in healthcare facilities). However, we suggest that with respect to intergenerational dialogue, age segregation and the discourses that accompany (and legitimise) the measures in response to pandemic will, instead, exacerbate antagonisms between the generations. In his essay, Ivan Krastev [15 p. 30-31] predicted that intergenerational conflict will escalate as the duration of the crisis caused by COVID-19 increases. According to Krastev, this conflict is strengthened, on one hand, by different economic effects of the crisis on different generations. At the same time, different levels of risk perception among younger and older people may lead to different patterns of behaviour in response to the pandemic. As a result, older people may feel threatened by young people's reluctance to adapt to rules that may reduce risks [15]. Both moments that Krastev mentioned point to the possible rise of antagonisms between the generations caused by feeling that the other generation may be 'stealing your future'. The COVID-19 pandemic thus mobilises, among other things, the narrative, which is a key part of the debate on the nature of the intergenerational conflict. The idea that the older generation lives on the debt of the younger generation is an essential element of the debate on the risks of an aging population and the sustainability of the pension funding system [6]. Similarly, at the beginning of March in the Czech Republic, economists debated the possibilities of quantifying the value of human life to enable the determination of the limit at which its rescue (at the expense of other societal economic losses) still makes sense.[9] Although the authors of these considerations do not explicitly address the role of chronological age, its implicit presence cannot be avoided. The governor of Texas summed up this reasoning more explicitly in a television interview, mentioning that grandparents would like to sacrifice themselves for the sake of their grandchildren's economic futures.[10] The debates over the approach to dealing with the pandemic, therefore, also include the narrative on 'sacrifice', which places fundamental demands on the older generation hand in hand with the idea of a 'disappearing' future for younger generations, 'stolen' by those who have already lived out most of their lives. Such narratives logically represent an explosive cocktail of intergenerational antagonism. Materialisation of this antagonism is reflected in the hashtags 'Boomer Remover' that appeared in March, referring to the idea of COVID-19 as a tool for effectively relieving society of the burden of older people and for solving problems with the pension and healthcare system or unemployment [16].

[9] Tůma, Z. M, Hampl: "Bývalí šéfové ČNB Tůma a Hampl: necháme v zájmu ochrany života umřít celou českou ekonomiku?" Hospodářské noviny 19.3.2020.

[10] Rodriguez, A.: "Texas' lieutenant governor suggests grandparents are willing to die for US economy." USA Today 24.3.2020. Available at: https://eu.usatoday.com/story/news/nation/2020/03/24/covid-19-texas-official-suggests-elderly-willing-die-economy/2905990001/.

The coronavirus pandemic alone, of course, cannot be considered as the sole and primary source of this intergenerational antagonism. As Ayalon [1 p. 2] asserted, the pandemic entered a society already divided by conflicts, many of which are framed in terms of generational affiliation. The generation of baby boomers (i.e. people born between the mid-1940s and the mid-1960s) is often described as having lived in a time of economic prosperity and at the same time held responsible for a number of environmental challenges facing future generations, the sustainability of pensions or the opportunity for younger generations to reach the same standard of living the boomers enjoyed [7]. Such rhetoric often accompanies youth movements that emphasise the need for changes in environmental policy. Members of student environmental movements often criticise the older generation for not being willing to change the lifestyle they have become accustomed to, at the cost of the consequences that those lifestyles will bear on their children and grandchildren.[11] The idea of a 'stolen future' is certainly not a new narrative. However, the way in which the COVID-19 disease and the policies associated with it are described brings new aspects that change the dynamics of this narrative.

The fact that the fatal progression of the disease mainly affects older people became a key tool mobilised to calm the public and to avoid the panic caused by the emergence of this new disease. Within the discourses on risk, this feature of COVID-19 symbolically differentiated this pandemic from other similar events in the past or expected other (potentially more serious) epidemics in the future. The reference to chronological age was an integral part of the report on victims of COVID-19 (especially) at the beginning of the pandemic, the purpose of which has undoubtedly been to highlight the fact that the vast majority of victims were advanced in age and that the chronology of life and death has not been fundamentally broken. While the reference to the serious progression of the disease affecting older people more often has undoubtedly served as key information to reassure the public, its unintended consequence is that it has reinforced the idea that the lives of certain people have a potentially different value than the lives of others (and this value may be related, among other things, to their age). As explained by Frazer et al. [12 p. 2], in the COVID-19 cases involving the deaths of younger people, the media has provided detailed personal stories, while the deaths of hundreds of thousands of older people have been reported only in the form of statistics.

[11] In this context, it is no coincidence that one of the hoaxes spread in connection with the COVID-19 pandemic in the Czech Republic worked with a fake print screen of the Friday for Future student climate movement Facebook page, where young people praised the benefits of the pandemic for the future well-being of the Earth, as it will enable the next generation to repair the damage done to the environment by the previous ones. The fake contribution sought to exaggerate the degree of intergenerational antagonism that is often present in the narrative of the 'stolen future' that the student movement mobilises in relation to the inability of political representation (recruited from the older generation) to face climate challenges.

Some types of vulnerabilities are influenced or reinforced by social factors. We should keep this in mind even when considering the vulnerability of older people. As noted by Berridge and Hooyman [5 p. 2], although older people are generally more vulnerable to the more serious progression of the disease, the vulnerability of people living in long-term care institutions is further reinforced by the nature of these institutions, where more people live side by side in a small space and are cared for by a small number of carers. Almost half of all COVID-19 deaths involved clients in long-term care facilities. Available statistics indicate that 53% of deaths from COVID-19 in Italy, 57% in Spain and 45% in France involved clients of long-term care facilities [10 p. 5]. In some countries, deaths from COVID-19 that occur in care homes are not recorded in the official statistics. Long term care facilities for older people were deprioritised in terms of interventions at the beginning of the crisis and experienced a lack of personal protective equipment [3]. The protection of the most vulnerable has become the headline of the need to fundamentally interfere with the running of society. However, the places where the most vulnerable are concentrated have paradoxically too often remained on the margins of interest. These moments reflect the structural disadvantages that older people face in society, regardless of the presence of the pandemic. Nevertheless, the way in which the pandemic has been portrayed and how the response to it has been formulated systematically constructed the idea that the value and meaning of human life can be derived from a chronological age. Older people in this context acted as a group that can be 'left' to die.[12]

COVID-19 is presented primarily as a disease that severely affects older people. However, the measures that were supposed to protect the population have an impact on the daily lives of all citizens, probably more fundamentally at the economic level, especially on younger people. In his book, Ivan Krastev [15 p. 31] referred to reports that indicated that up to 52% of people under the age of 45 have either lost their jobs, been forced to go on leave or had their working hours reduced due to policies related to the pandemic. On one hand, older people may feel more endangered by the disease and, therefore, feel the impact of the pandemic more intensively. On the other hand, however, the economic impact of the measures has the potential to have a greater impact on younger and middle-aged people who are in or will be entering the labour market. These measures are taken in the name of a risk that is strongly framed by chronological age and to protect the population (which, given the way in which the risks are presented, mainly involves older people). The way in which the COVID-19 pandemic has affected public policies, thus, sets into motion several processes that

[12] The cases of abandoned residents and elderly patients in retirement homes reported from Spain illustrates this approach in a shocking way (https://www.bbc.com/news/world-europe-52014023).

reinforce intergenerational antagonism. It alienates the experience of this crisis situation between the various generations, who, moreover, are pitted against each other through the narrative of the 'stolen future' - whether within the narrative of young people who endanger older people with their irresponsibility or older ones whose protection costs young people too much. This sentiment is further reinforced by the paradox that all individuals are expected to subordinate their lifestyle and future economic prospects to protection against something that is described as a risk primarily to those who are systematically constructed as more easily dispensable.

CONCLUSION

In the context of the events associated with the COVID-19 pandemic, we have witnessed the expansion of stereotypical depictions of age groups. As noted by Ayalon et al. [1], this pandemic was accompanied by an outbreak of ageism aimed primarily at older people. This paper discusses these forms of ageism. At the same time, it emphasises the role of age division in society as the key to understanding them. As pointed out by of Morrow-Howell, Galucia and Swinford [17 p.4]: 'We will have to regain any hard-won advances in reducing the external and internal ageism exacerbated in this pandemic'. This concerns both the problematic conceptions of chronological age and the stereotypical portrayal of older people, as well as the ideas that people are able to internalise regarding their own aging. Most of us have experienced feelings of helplessness in the face of this pandemic. However, no one should feel hopeless because he/she thinks that based solely on his/her age will he/she not receive adequate health care. Discussions about the need for 'sacrifice' in the case of the older generation or the criterion of chronological age when deciding who will receive what health care can easily evoke in older people a sense of distrust about whether their lives matter to others. The events of the recent months have led not only to the essentialisation of the category of 'old people' but also to the consolidation of the idea age groups as separate. Contact between members of different (homogenous) generations was constructed as one of the fundamental problems in the spread of the disease.

The way in which chronological age and the role of older people have been presented in public debates about COVID-19 not only strengthens the age division of society but also intervenes in intergenerational relations and solidarity. Although we have witnessed (especially at the beginning of the spread of the disease) a rise in solidarity aimed at helping older people, the way in which age is mobilised in public discourses and policies reinforces antagonism between members of different generations. This antagonism stems from both the way age is treated in discussions about COVID-19 and the paradoxical position of older

people in portraying this pandemic. In the public discussions surrounding the COVID-19 pandemic, the lives of older people are systematically described (and perceived) as more dispensable and implicitly less valuable. At the same time, however, the protection of the elderly as a group is becoming a justification for society-wide measures that have a significant impact on all (and often, very painfully on those who do not feel threatened by the disease due to their age). I believe that this paradox gives rise to forms of intergenerational antagonism that further deepen the age division of society.

REFERENCES:

1. Ayalon L. *There is nothing new under the sun: Ageism and intergenerational tension in the age of the COVID-19 outbreak*. International Psychogeriatrics, 1-4. 2020. https://doi.org/10.1017/S1041610220000575.
2. Ayalon L., Chasteen A., Diehl M., Levy B., Neupert S. D., Rothermund K., Tesch-Römer C., Wahl H.-W. *Aging in times of the COVID-19 pandemic: Avoiding ageism and fostering intergenerational solidarity*. The Journals of Gerontology: Series B. 76 (2): e49-e52. 2020. https://doi.org/10.1093/geronb/gbaa051.
3. Age Platform Europe. *COVID-19 and human rights concerns for older persons* (updated version 18 May 2020). . [cit 13.8.2020]. Available at: https://www.age-platform.eu/sites/default/files/Human%20rights%20concerns%20on%20implications%20of%20COVID%2019%20to%20older%20persons_Final_18May2020.pdf.
4. Arber S., Attias-Donfut C. Eds. *The myth of generational conflict: The family and state in ageing societies*. London. Routledge. 2020.
5. Berridge C., Hooyman N. *The Consequences of Ageist Language are upon us*. Journal of Gerontological Social Work 63 (6-7): 508-512. 2020. https://doi.org/10.1080/01634372.2020.1764688.
6. Binstock R. H. *From compassionate ageism to intergenerational conflict?* The Gerontologist 50 (5): 574-585. 2010. https://doi.org/10.1093/geront/gnq056.
7. Bristow J. *Baby boomers and generational conflict*. London: Palgrave MacMillan. 2015.
8. Cascella M., Rajnik M., Cuomo A., Dulebohn S. C., Di Napoli F. *Features, Evaluation and Treatment Coronavirus (COVID-19)* [Updated 2020 Jul 4] [online]. Treasure Island (FL): StatPearls Publishing. 2020. [cit 25.7.2020]. Available at: https://www.ncbi.nlm.nih.gov/books/NBK554776/
9. Cevik M., Bamford C., Ho A. *COVID-19 pandemic-a focused review for clinicians*. Clinical microbiology and infection: the official publication of the European Society of Clinical Microbiology and Infectious Diseases 26 (7): 842–847. 2020. https://doi.org/10.1016/j.cmi.2020.04.023
10. Comas-Herrera A., Zalakain J. X. *Mortality associated with COVID-19 outbreaks in care homes: early international evidence*. [online]. International Long-Term Care Policy Network, CPEC-LSE. 2020. [cit 10.7.2020]. Available at: https://alzheimeriberoamerica.org/wp-content/uploads/2020/04/Mortality-associated-with-COVID-12-April-3.pdf.
11. Ehni H. J., Wahl H. W. *Six Propositions against Ageism in the COVID-19 Pandemic*.. Journal of Aging & Social Policy 32 (4-5): 515-525. 2020. https://doi.org/10.1080/08959420.2020.1770032.
12. Fraser S., Lagacé M., Bongué, B., Ndeye N., Guyot J., Bechard L., Garcia L., Taler V., Adam S., Beaulieu M., Bergeron. C. D. *Ageism and COVID-19: what does our*

society's response say about us? Age and Ageing 49 (5):692-695. 2020. https://doi.org/10.1093/ageing/afaa097.
13. Gilleard C., Higgs P. *COVID-19 amplifies but doesn't alter the chronology of life and death.* [online]. TransformingSociety. 2020. [cit 1.7.2020]. Available at: http://www.transformingsociety.co.uk/2020/05/20/covid-19-amplifies-but-doesnt-alter-the-chronology-of-life-and-death/
14. Hagestad G. O., Uhlenberg P. *Should we be concerned about age segregation? Some theoretical and empirical explorations*. Research on aging 28 (6): 638-653. 2006. https://doi.org/10.1177/0164027506291872.
15. Krastev I. *Už je zítra?: Aneb jak pandemie mění Evropu*. Praha: Nakladatelství Karolinum. 2020.
16. Meisner B. A. Are you OK, Boomer? Intensification of ageism and intergenerational tensions on social media amid COVID-19. *Leisure Sciences*, 1-6. 2020. https://doi.org/10.1080/01490400.2020.1773983
17. Morrow-Howell N., Galucia N., Swinford E. *Recovering from the COVID-19 pandemic: A focus on older adults*. Journal of aging & social policy 32 (4-5): 526-535. 2020. https://doi.org/10.1080/08959420.2020.1759758.
18. Vergano M., Bertolini G., Giannini A., Gristina G. R., Livigni S., Mistraletti G., Riccioni L., Petrini F. *Clinical ethics recommendations for the allocation of intensive care treatments in exceptional, resource-limited circumstances: the Italian perspective during the COVID-19 epidemic*. Critical Care 24 (165). 2020. https://doi.org/10.1186/s13054-020-02891-w.

Beata Bugajska, Celina Timoszyk, Klaudia Piotrowska – Tomczak, Elderly coping strategies in a pandemic situation

Introduction

The beginning of 2020 brought information about the outbreak of an epidemic of the acute infectious respiratory disease COVID-19 caused by SARS-CoV-2 coronavirus. In January this year, the World Health Organization declared a public health emergency of international concern and in March COVID-19 spread to such a scale that the state of pandemic was declared [21]. This created an unprecedented situation. In order to prevent the spread of the disease, governments in many countries decided to introduce lockdown and social distancing. The first case in Poland was recorded on 4 March 2020 and since 20 March, according to the regulation of the Minister of Health, the country is in the state of epidemic.

Metanalyses of psycho-social responses of the general population to stress connected with the previous epidemics such as SARS (Severe Acute Respiratory Syndrome), H1N1 (swine flu) or Ebola indicate that the most common symptoms were anxiety, depression, guilt, regret and loss, posttraumatic stress, stigmatisation but also the sense of strength and compassion towards others [3]. Mental suffering was significantly correlated with age and educational background [18].

During the present COVID-19 pandemic, due to their less efficient immune system and common age-related basic illnesses, older people are considered the group of high risk. Based on the statistics, we know that elderly struggle more with the infection, the mortality rate in this group is also higher and amounts up to 3.6% among people aged 60-67 whereas for people aged 80+ it grows to 18% [7]. This may increase the pandemic-related anxiety and stress among older citizens [15]. Other important issue is the consequences of quarantine; social distancing strengthen by the pandemic may lead to greater loneliness, increased sense of helplessness, anxiety and depression. It may also boost passivity, disturb daily habits and lead to the increase in undesired behaviours, for example medicine or alcohol abuse [7]. Older people who are less familiar with modern digital technologies may struggle with the consequences of the lockdown and experience more negative influence of the pandemic on their mental health than the rest of the population. However, studies conducted in different world regions are not coherent. Some confirm the above mentioned threats, for example residents of retirement homes in France, who suffered from Alzheimer's disease reported higher levels of depression and anxiety during the COVID-19 crisis than before it [4]. A large percentage of Americans reported stress and loneliness, an increased sense of isolation and

change in daily habits during lockdown [5]. In China, senior citizens aged 60 and more had greater problems with depression and anxiety, women more often than men [15]. German studies show that seniors consider the risk of COVID-19 as lower than younger people and use the strategy of focusing on the problem by following expert advices and behaving accordingly to the situation [9]. Reports by German researchers from before the pandemic indicated lower stress level among older rather than younger citizens [12]. Seniors in Spain showed less emotional anxiety in connection with COVID-19 than younger respondents and there were no differences between men and women [7]. In Austrian studies, for every studied aspect of mental health (depression, anxiety, stress, quality of sleep) the younger group of adults (<35 years) yielded the worst results while the elderly, aged 65 and more, obtained the highest results [19]. Older people deal better with the pandemic than younger ones. What is interesting, is that these results are opposite to the ones obtained in Austria before the pandemic, in 2014 when mental health deteriorated with age [19]. Thus, the goal of the research presented herein was to identify emotional responses and strategies of coping with stress among older people.

Stress and coping strategies

The classic concept of stress by R. Lazarus and S. Folkman [13], sees coping as inseparable, together with cognitive appraisal and emotional process, element of a stressful situation. In this concept, coping with stress is connected with cognitive variables and behavioural efforts to manage external and internal demands that are seen as taxing or exceeding the resources of the person. Coping has two functions: instrumental (problem-focused) and emotional self-regulation (emotion-focused). These functions may interfere and influence each other [10]. The classic concept of stress has been referred to, among others, in the concept of coping styles, which identifies task-oriented and emotion-oriented coping, and adds avoidance-oriented style [6]. C.S. Carver, M.F. Scheier and J.K. Weintraub [2], also base on R. Lazarus and S. Folkman's theory and describe ways individuals response to stress. The authors of the COPE scale show similarities and differences as compared to previous tools. The general directions of coping are similar but the opposing tendencies resulting from the structure of motivated action are different (repeated attempts vs. withdrawal). As a result, different responses to stress, even the most effective ones, may have different implications to the person who attempts to deal with it. The data on the functioning of people during previous epidemics indicate that respondents often resorted to problem-focused strategies, support searching, avoidance but also positive assessment of the situation [3]. The longitudinal study conducted during the SARS epidemic show that, compared to younger age groups, older

citizens responded better to the crisis evoked by the epidemic and adapted their strategies better to the situation. They experienced less anger and greater reduction of negative emotions thanks to using both problem-focused and emotion-focused strategy. This study shows that during the peak of the epidemic, the dominating strategy was the problem-focused one whereas several weeks later older people preferred emotion-focused coping [23].

Recognising the emotional responses of seniors and their coping strategies is important in the context of designing support activities for seniors should the pandemic continue. Thus, the following research questions were formulated:

1. What emotional responses occurred among older people during the pandemic?
    a. How was the well-being of older people changing during the pandemic?
    b. What emotions were evoked by the future in the context of the present pandemic?
    c. What difficulties and benefits did older people see during the pandemic?
    d. How did older people see support: who was supporting them and whom did they support?
2. What coping strategies did older people prefer during the pandemic?

Studies [23] allow to formulate the following hypotheses:

H_1 older people prefer active coping strategies and strategies of looking for support and focusing on emotions.

3. What are the relationships between the preferred coping strategies and sociodemographic variables and emotional responses?
4. What are the relationships between the intensity of negative emotions and preferred coping strategies among older people?

H_2 the higher intensity of negative emotions, the greater preference to use strategy of looking for support and emotion-focused strategy.

METHOD

Respondents

The sample consisted of 50 persons: 40 women and 10 men, aged 59-90 (the average age was 72.46). The most numerous group were respondents aged 70-74 (36%), then 65-69 (24%) and 75-79 years (12%). People aged 80 and more were 18% of the sample whereas only 8% were people in their early old age (60-64 years) or pre-old age (2%). As for educational background, 11 (22%) respondents had higher education, 24 (48%) were high school graduates, 9 (18%) graduated vocational school and 6 (12%) finished primary school. There were 21 (24%) married people, 19 (38%) widowed, 7 (14%) divorced and 3 (6%) were

singles. 20 (40%) respondents lived with their spouse, 5 (10%) lived with their families, 21 (42%) lived alone and 4 (%) with another person from outside the family. The vast majority of the respondents rated their health condition as good (46%) or very good (8%). Only 8% declared having poor health and 2% - very poor. 30% of the respondents evaluated their health as "neither good nor bad". 90% of the respondents declared they are believers, while 10% said there were not believers.

Research tools

The research was conducted using a structured interview and a modified COPE questionnaire by Scheier, J.K. Weintraub, adapted to Polish conditions by Z. Juczyński and N. Ogińska-Bulik [11].

The interview consisted of 10 open-ended questions and, where possible, additional 5 or 2 degree scales were used. Questions 1-3 referred to: present well-being (where 1 meant very bad and 5 meant very good), any changes in well-being during the pandemic (where 1=very little and 5=very much) and emotions when thinking about the future (the intensity of the emotions listed was evaluated as 1=very weak and 5=very strong). Question 4 asked was most difficult during the pandemic. The answers were grouped in 5 categories: health (lack of information, more difficult access to medical services etc.), contacts with other people (limited direct interactions), social and living (shopping, finances), activity (recreation, rituals), psychological aspects (loneliness, isolation). The fifth question addressed benefits from this time (where 1=very little and 5=a lot). In question 6 the respondents were asked to relate to some statements (as described below). Question 7 referred to the sources of support for the respondents (family, friends, neighbours, doctor, priest, social assistance centre, senior centre) and question 8 asked whether the respondents provided support for someone else (yes and no answers). In question 9 the respondents were asked to compare their coping with the pandemic situation against other people of similar age (where 1=much worse and 5=much better). Question 10 asked the respondents if other older people use stimulants. The interview ended with demographic questions about age, gender, living situation, attitude towards faith, evaluation of health, education and marital status.

The multi-dimensional COPE Inventory to measure coping with stress, developed by C. Carver, M. Scheier and J. Weintraub and adapted to Polish conditions by Z. Juczyński and N. Ogińska-Bulik [11], consists of 60 statements respondents relate to using a four-degree scale where 1 means "usually do not do this at all" and 4 means "usually do this a lot'". The questionnaire is used to assess the ways of coping with stress and allows to identify 15 response strategies: Active-coping (AC), Planning (P), Instrumental Social Support (ISS),

Emotional Social Support (ESS), Suppression of Competing Activities (SCA), Turning to Religion (TR), Positive Reinterpretation and Growth (PRG), Restraint-coping (RC), Acceptance (A), Focus on and Venting Emotions (FVE), Denial (D), Mental Disengagement (MD), Behavioural Disengagement (BD), Alcohol-drug Disengagement (AD), Humour (H). The reliability of the tool is satisfactory and Cronbach's alpha coefficients for certain scales range between 0.48 and 0.94. Persistency measured in 6 weeks interval in the group of 30 persons ranges between 0.45 and 0.82. Correlations of certain questions with the general result are also sufficient. In the study presented herein, 10 scales were used - AC, ISS, ESS, TR, PRG, A, FVE, D, MD and H. As a result of the discussion and literature analysis, the scales P, SCA, RC, BD and AD were excluded.

Additionally, the factor analysis enabled identification of three main factors like: active coping (P, PRG, AP, SCA), avoidance behaviours (D, BD, H, MD, AD, A) and seeking support and focusing on emotions (ESS, FVE, ISS, TR). These factors explain 77% of variances [11]. For identification purposes, these factors are described as General Active Coping (GAC), General Avoidance (GA) and General Support and Focus on Emotions (GSFE).

Research procedure

The study was conducted via telephone in June and July 2020. The respondents were the beneficiaries of a Senior Centre (institution manged by a non-governmental organisation, as committed by the local government in Szczecin, which has been the coordinator of elderly support during the pandemic). The respondents invited to participate in the study were seniors who previously had asked for a protective mask to be delivered to them. First, the interviewer asked the respondents for their consent, briefly presented the goal of the research and then asked the questions and noted the answers.

Statistical analyses

The statistical analyses were conducted using IBM SPSS Statistics software, v. 24. The data were collected from the structured interview, therefore there were no missing data. Descriptive mean statistics, standard deviations, skewness and kurtosis were calculated without breach to normal distribution projections for the variables. Reliability of all COPE scale indicators was calculated using Cronbach's alpha. The correlation analysis was conducted using Pearson's coefficient. To determine the hierarchy of the strategies used, the t-test was performed for the dependent samples and to compare the differences between the groups, the Mann–Whitney U test was performed.

RESULTS

The descriptive statistics for the certain interview questions were calculated, which allowed to answer to first general research question: What emotional responses occurred among older people during the pandemic? Depending on the scales used, the mean values, the quantity or the percentage indicators were presented.

The research question 1a. referred to the respondents' well-being during the pandemic. The mean value for well-being was 3.61 with SD=1.25 (skewness=-0.88; kurtosis=-0.16). The sense of change in the mental well-being at the beginning of the pandemic was 2.86 on average, SD=1.36 (skewness=-0.09; kurtosis=-1.29). The respondents additionally compared their ability to cope in the pandemic with other people in similar age and the mean value was 3.90, SD=0.86 (skewness=-0.20; kurtosis=-0.85). This means that the respondents described their well-being as good, without significant changes and evaluated their coping abilities as better than the abilities of others.

The research question 1b. referred to emotions evoked when thinking of the future in the context of the pandemic. Only 9 individuals declared having not very positive emotions (hope), others did not list any. In turn, 38 respondents listed negative emotions (uncertainty, anxiety, fear, terror, helplessness) and most often rated them as strong (M=3.16; SD=1.41, skewness=-0.48, kurtosis=-1.04). This indicates that future stimulated mainly negative emotions among the seniors.

The research question 1c. focused on difficulties and benefits of the pandemic. The difficult aspects of the last few months mentioned by the respondents included: health (fear of infection, lack of quick access to medical care, worrying about the health of family members), limited interactions with other people (lack of direct contacts with family and friends) - 17 declarations in each category, reduced activity - 10 respondents (20%) and finally, social and living (bills) and psychological aspects (isolation) - 4 answers in each category (8%). In addition, some persons mentioned wearing masks as a difficulty. 22 respondents (44%) noticed benefits resulting from the pandemic: reflection, time to invest in development, learning new skills (baking, online shopping, coping with the new situation), ability to solve different e.g. administrative issues remotely, realizing there were other sources of support like more distant family or volunteers.

The research question 1d. referred to the support observed: who supported the respondents and whom they helped. In this category, 35 seniors (70%) mentioned family as the source of support, 7 respondents (145%) declared they received help from their friends, 4 people mentioned their doctors, 1 mentioned a priest and 2 a Senior Centre. 38 respondents (76%)

declared that they had supported others, for example their neighbours, friends and spouses. The respondents felt that support was two-way.

Then, the following hypothesis was verified: *H_1 older people prefer active coping strategies and strategies of looking for support and focusing on emotions.* First, skewness and kurtosis of the subscales of the COPE inventory and the three general coping strategies were investigated to assess the normal distribution. Values ± 2 were assumed as acceptable in the normal distribution [8]. Only one variable exceeded this threshold but to the acceptable degree. The reliability indicators were also calculated and they confirmed the validity of the method used and its subscales (Table 1).

Table 1. Descriptive statistics for evaluation of coping strategies - 10 subscales and 3 general scales (COPE) (n=50).

Scales	M	SD	Skewness	Kurtosis	A
I. GAC	2.52	0.64	-0.03	-1.18	0.76
II. GA	2.29	0.34	0.38	-0.17	0.55
III. GSFE	2.60	0.62	-0.10	-1.04	0.86
1. AC	2.53	0.63	0.11	-0.73	0.51
2. ISS	2.26	0.81	0.31	-0.85	0.76
3. ESS	2.65	0.87	-0.14	-0.88	0.82
4. TR	2.85	0.10	-0.45	-1.19	0.94
5. PRG	2.51	0.83	-0.00	-0.98	0.75
6. A	3.38	0.57	-0.77	-0.07	0.65
7. FVE	2.65	0.67	-0.08	-0.29	0.61
8. D	1.76	0.65	0.33	-0.1.12	0.46
9. MD	2.71	0.64	-0.62	0.86	0.36
10. H	1.34	0.61	1.87	2.46	0.84

Legend: General Active-Coping (GAC), General Avoidance (GA), General Support and Focus on Emotions (GSFE), Active-coping (AC), Instrumental Social Support (ISS), Emotional Social Support (ESS), Turning to Religion (TR), Positive Reinterpretation and Growth (PRG), Acceptance (A), Focus on and Venting Emotions (FVE), Denial (D), Mental Disengagement (MD), Humour (H).

Then, in order to study the hierarchy of the preferred coping strategies, the significance tests were performed of differences between the general COPE strategies (Table 2) and between the detailed COPE strategies.

Table 2. T tests for dependent samples between general COPE strategies (N=50, df=49)

Strategy pairs		M	SD	t	P
I	GSFE	2.60	0.62	0.72	0.477
	GAC	2.52	0.64		
II	GSFE	2.60	0.62	2.98	0.004
	GA	2.29	0.34		
III	GAC	2.52	0.64	2.68	0.010
	GA	2.29	0.34		

Legend: General Active Coping (GAC), General Avoidance (GA) and General Support and Focus on Emotions (GSFE).

The results obtained suggest that the most often preferred strategies are General Support and Focus on Emotions (GSFE) and General Active Coping (GAC). General Avoidance (GA) behaviours are significantly less preferred. In order to further specify the preferences, the analysis of differenced between 10 investigated strategies of responding to stressful situations. The analysis showed that the most preferred strategy is acceptance (A), then equally: turning to religion (TR), emotional social support (ESS) and focusing and venting emotions (FVE). The third most often preferred strategy is instrumental social support (ISS) and fourth: active-coping (AC) and positive reinterpretation and growth (PRG). They are followed by denial (D), mental disengagement (MD) and humour (H)[13].

The next step involved answering the third research question about the correlations between the preferred coping strategies and sociodemographic variables and emotional responses. For this purpose, analyses of correlations between the COPE indicators and age (A), gender (G), education (E), subjective evaluation of health (SEH), evaluation of well-being (EW), evaluation of changes in well-being during the pandemic (ECW), evaluation of coping abilities compared to others (ECACO) and intensity of negative emotions (INE). There were no significant correlations between COPE and education so this variable is not presented in Table 3.

Table 3. Correlations between COPE subscales and variables: age (W), gender (G), subjective evaluation of health (SEH), evaluation of well-being (EW), evaluation of changes in well-being during the pandemic (ECW), evaluation of coping abilities compared to others (ECACO), intensity of negative emotions (INE) (N=50).

COPE strategy	Age	Gender	SEH	EW	ECW	ECACO
I. GAC	-0.28*	0.06	-0.13	0.22	-0.09	0.39**
II. GA	-0.31*	-0.13	-0.07	0.17	-0.11	0.46**
III. GSFE	0.11	-13	0.26 ^{t}	-0.33*	0.34*	-0.11
1. AC	-0.09	0.18	-0.03	0.07	0.10	0.40**
2. ISS	-0.01	-0.07	0.31*	-0.36*	0.38**	-0.12
3. ESS	0.16	-0.14	0.16	-0.22	0.18	-0.19
4. TR	0.10	-0.17	0.15	-0.01	0.08	-0.17
5. PRG	-0.37**	-0.05	-0.18	0.28 ^{t}	-0.21	0.29*
6. A	-0.10	-0.04	-0.39**	0.32*	-0.37**	0.25
7. FVE	0.05	0.06	0.14	-0.49**	0.43**	-0.33**
8. D	-0.21	-0.29*	0.15	-0.04	0.02	0.19
9. MD	-0.11	0.06	-0.06	-0.01	0.07	0.26 ^{t}
10. H	-0.27 ^{t}	0.01	0.10	0.13	0.00	0.31*

*p<0.05; **p<0.01; ^{t} p<0.1; General Active-Coping (GAC), General Avoidance (GA), General Support and Focus on Emotions (GSFE), Active-coping (AC), Instrumental Social Support (ISS), Emotional Social Support

13 Due to the volume limitations, data on the t test differences for the dependent samples are not presented. The levels presented are identified based on the analysed significant differences. The detailed data are available in the research report.

(ESS), Turning to Religion (TR), Positive Reinterpretation and Growth (PRG), Acceptance (A), Focus on and Venting Emotions (FVE), Denial (D), Mental Disengagement (MD), Humour (H).

Additionally, to better understand the relationships, correlations between age (A), gender (G), education (E), subjective evaluation of health (SEH), evaluation of well-being (EW), evaluation of changes in well-being during the pandemic (ECW), evaluation of coping abilities compared to others (ECACO) and intensity of negative emotions (INE) were studied (Table 4).

Table 4. Correlations between variables: age (W), gender (G), subjective evaluation of health (SEH), evaluation of well-being (EW), evaluation of changes in well-being during the pandemic (ECW), evaluation of coping abilities compared to others (ECACO), intensity of negative emotions (INE) (N=50).

Variables	**Age**	**Gender**	**SEH**	**EW**	**ECW**	**ECACO**
Age	-					
Gender	-0.01	-				
SEH	0.25^{t}	-0.05	-			
EW	-0.30*	0.07	-0.65***	-		
ECW	0.14	0.09	0.35*	-0.38**	-	
ECACO	0.07	0.18	-0.16	0.44***	-0.24^{t}	-
INE	0.36*	0.12	0.13	-0.25^{t}	0.56***	-0.21

*p<0.05; **p<0.01; ***p<0.001; ^{t}p<0.1;

The data presented in Table 4 indicate that the younger-old persons rated their general well-being (EW) higher and the intensity of negative emotions (INE) lower. Individuals who evaluated their health (SEH) as very good also rated their general well-being (EW) higher and declared less change in general well-being since the outbreak of the pandemic (ECW) (minus results from the reversed scale). The internal correlations suggest that people who rated their well-being (EW) higher also evaluated their health (SEH) as better and saw less changes in their well-being (ECW). They also felt they were coping better than others in the situation of the pandemic (ECACO).

In regards to the variables: living conditions and marital status, the indicators of coping strategies were compared and it resulted from the measuring scales used, Mann-Whitney U test. Within the general strategies, the significant differences were only visible for general avoidance behaviours (GA) U=112.50; p<0.011 (asymptotic, two-way significance); the mean values for ranks show that individuals who live alone (25.64) prefer this type of coping strategy more often than respondents who live with their spouse (16.13). Within the specific strategies, there was a significant difference for humour U=145.00; p<0.040 (asymptotic, two-way significance); again, the mean values for the ranks show that singles (24.10) more often prefer this strategy compared to seniors living with their spouses (17.75). Also, the

differences in coping strategies among the married and widowed respondents were studied. The only significant difference was recorded for general avoidance behaviours (GA) U=121.00; p<0.033 (asymptotic, two-way significance), where the mean value for the ranks shows that married seniors (16.76) prefer suppression strategies less often than widowers (24.63). According to the analyses, the respondents who prefer general, active coping strategies (GAC) and avoidance (GA) are younger (A) and evaluate their coping abilities as higher that those of others (ECACO). Preferring general avoidance strategies (GA) was also connected with living alone and being widowed. Individuals who preferred general support and focus on emotions (GSFE) rated their well-being low (EW) and had noticed greater change in their well-being since the outbreak of the pandemic (ECW); at the tendency level, there was also correlation with evaluating own health (SEH) as poor.

At last, the second hypothesis was verified: *H_2 the higher intensity of negative emotions, the greater preference to use strategy of looking for support and emotion-focused strategy.* For this purpose, the analysis of correlations between the COPE subscales and the intensity of negative emotions (INE) was performed (Table 5).

Table 5. Correlations between COPE subscales and intensity of negative emotions INE (N=50).

COPE	**GAC**	**GA**	**GSFE**	**AC**	**ISS**	**ESS**	**TR**	**PRG**	**A**	**FVE**	**D**	**MD**	**H**
INE	-0.21	-0.29*	-0.21	-0.05	0.26 ^{t}	0.19	-0.16	-0.28*	-0.16	0.48***	-0.22	0.01	-0.27 ^{t}

*p<0.05; **p<0.01; ^{t} p<0.1; General Active-Coping (GAC), General Avoidance (GA), General Support and Focus on Emotions (GSFE), Active-coping (AC), Instrumental Social Support (ISS), Emotional Social Support (ESS), Turning to Religion (TR), Positive Reinterpretation and Growth (PRG), Acceptance (A), Focus on and Venting Emotions (FVE), Denial (D), Mental Disengagement (MD), Humour (H).

The hypothesis was positively verified in terms of the specific strategies - there is a strong correlation between focus on and venting emotions (FVE) and intensity of negative emotions (INE). Within the general coping strategies there was a weak, negative correlation between the general avoidance (GA) and the intensity of negative emotions (INE). There was also a weak correlation between the positive reinterpretation and growth (PRG) and the intensity of negative emotions (INE).

It is worth adding that despite resignation from the COPE subscale measuring substance abuse, the interview had additional question whether the respondents think that other seniors resort to sedatives or alcohol in the present situation. 16 respondents (32%) stated that other seniors use sedatives or alcohol.

DISCUSSION

The goal of the research was to identify emotional responses and coping strategies among older people. The research questions posed referred to emotional responses that occurred during the pandemic and the strategies used by seniors to deal with stress. Two hypotheses were formed: the first addressed coping strategies preferred by older citizens, while the other referred to the relations of these strategies with the intensity of the emotions experienced.

The respondents usually evaluated their well-being as good and noticed only slight changes in it since the outbreak of the pandemic. In the majority of the sample, future evoked negative emotions, mainly fear. A small group declared a positive emotion, namely, hope. When analysing the lives of women sent to Siberia in 1940, Obuchowski [16], points out to the role of hope in sustaining the ability to create future plans and maintain intellectual control over the events. He connects hope with the meaning of life, noticing at the same time that it allows to fight the despair and prevents decision to commit suicide. For the respondents, the most difficult aspect of their daily functioning were issues related with health and interactions with other people. They also notices some benefits like time for reflections and personal development. The most important declared sources of support were family and friends. The respondents also helped other people they felt particularly close to. Despite the disappearing model of multigenerational family, family members are still an important source of support for the elderly, while keeping the so called “distant intimacy” ( ). It can be assumed that, compared to the time before the pandemic, lockdown intensified contacts of seniors with their families (more frequent phone calls, use of other communication tools). More family members, also distant, were involved in supporting seniors (instrumental, emotional, information support). Social distancing management promoted pro-social attitudes and the needs of older people. In general, the respondents preferred strategies of seeking support and focusing on emotions, and active coping, which is coherent with the results of other studies [23]. What needs to be interpreted is the fact that detailed analyses locate acceptance as top preference, while this strategy is one of the avoidance strategies, what slightly modifies the hierarchy. It can be acceptance which is the opposite of denial and is a functional coping response because an individual who accepts the reality of the stressful situation seems to make active attempts to cope with it. Additionally, acceptance influenced two aspects of coping process: acceptance of the stressor and acceptance of the present lack of effective coping strategies [2]. In the present, hardly controllable situation of the pandemic, such acceptance seems to be adequate response [13].

Correlations between the strategies and sociodemographic variables and emotional responses point out to several aspects which are important from the practical point of view.

The general active coping strategies and avoidance behaviours are more often used by younger seniors and individuals who think they are doing better than others in the present situation. General avoidance behaviours were more often declared by the widowed persons and those who lived alone. The respondents who preferred general coping strategies involving seeking support and focus on emotions, declared worse well-being and has noticed greater changes in their frame of mind since the outbreak of the pandemic. The most correlations within the specific strategies were found for acceptance, seeking instrumental support and focus on and venting emotions. Individuals who prefer acceptance feel healthier, experience better mental condition and do not see changes in their well-being since the beginning of the outbreak. Instrumental support strategy is preferred by the seniors who evaluate their health and emotional condition as bad and who notice changes in their well-being. Older people with chronic diseases more often experience fear and depression [17], they are also less independent and rely more on others, which means they require assistance in daily functioning. Preferring the strategy of focus on and venting emotions is correlated with worse mental condition, noticing changes in well-being and sensing that, compared to others, one does not cope well. Younger-old who declared they cope better than others prefer the strategy of positive reinterpretation and growth.

The second hypothesis assuming relationship between the intensity of negative emotions and preferring strategies of seeking support and focusing on emotions was confirmed only regarding specific strategies, that is, individuals who experienced strong negative emotions preferred focusing on and venting emotions. There was no correlation at the level of general support strategies and focus on emotions. An unexpected correlation occurred at the level of general strategies: respondents who preferred general avoidance strategy showed low intensity of negative emotions. Evaluation of own coping abilities compared to those of others turned out to be an interesting variable which is strongly correlated with positive well-being and is the leading variable for the opposite preferences: active coping and avoidance behaviours. It proves that regardless of the preferred, even opposite, coping strategies, they can yield positive results. Most likely, it is the result of individual personality predispositions, experiences and ability to control the situation [13].

The results obtained show that coping strategies used by older people during the pandemic are quite well matched. Young-old prefer to be active or avoid, or more precisely, accept lack of control over the situation. Older seniors who struggle more, seek support and focus on their emotions, trying to vent them. Life experience of older people, connected with previously experienced economic and social difficulties in the post-war period helped them to

cope with stress caused by the pandemic [17]. When facing unfavourable circumstances such as the COVID-19 outbreak, eudaimonic well-being plays a protective role [14].

Conclusion

The results obtained indicate that older persons choose strategies which help them cope quite well with stress during the pandemic. Young-old people choose strategies based on active responses or avoidance which is expressed in accepting the lack of control over the situation. Old-old use strategies focusing on venting emotions and seek support (especially those who struggle more with functioning).

However, the study was limited by the size of the sample and the effectiveness of the strategies used will depend on the duration of the stressful situation. Form the medical point of view, COVID-19 is particularly dangerous for older people and patients with chronic conditions. Due to the greater risk of cardio-vascular, autoimmune, neurocognitive and mental problems, social distancing of seniors is a „serious public health concern" [1]. It is not known who long the pandemic will last and what course it will take. With prolonged isolation, the symptoms of psychical disorders exacerbate [17]. Lockdown measures reimposed in the coming fall/winter season (the Northern Hemisphere) when the infection rates grow, days are shorter and there less sunlight may be another factor with negative impact on the well-being, leading to emotional disorders. Most likely, during exiting the pandemic it will be the oldest citizens who will experience social isolation the longest. In case of removing the lockdown restrictions, every strategy of gradual release should include plans to increase the immunity of people who remain isolated [20].Therefore, it would be beneficial for seniors to:

- strengthen their natural coping tendencies;
- concentrate on "taming" the future to reduce fear related to it.

The reasonable steps to achieve this would be to:

- ensure psychological support for older people to prevent the negative consequences of the lasting pandemic;
- develop remote psychological services adapted to the level of digital literacy of seniors (ability to use electronic devices and applications);
- reduce isolation by learning older people how to use new channels of communication via smartphones;
- reinforce the ability to cope with the consequences of the pandemic in a long-term perspective, by showing in media seniors who cope with everyday struggles despite the pandemic.

References

1. Armitage, R., Nellums, L. B., *COVID-19 and the consequences of isolating the elderly*, The Lancet Public Health, 2020, *5*(5), e256. https://doi.org/10.1016/S2468-2667(20)30061-X
2. Carver, C. S., Scheier, M. F., Weintraub, J. K., *Assessing coping strategies: A theoretically based approach*, *Journal of Personality and Social Psychology*, 1989, *56*(2), 267–283. https://doi.org/10.1037/0022-3514.56.2.267
3. Chew, Q. H., Wei, K. C., Vasoo, S., Chua, H. C., Sim, K., *Narrative synthesis of psychological and coping responses towards emerging infectious disease outbreaks in the general population: practical considerations for the COVID-19 pandemic*, Singapore Medical Journal, 2020, 61(7), 350–356.
4. El Haj, M., Altintas, E., Chapelet, G., Kapogiannis, D., Gallouj, K., High depression and anxiety in people with Alzheimer's disease living in retirement homes during the covid-19 crisis, Psychiatry Research, 2020, 291. https://doi.org/10.1016/j.psychres.2020.113294
5. Emerson, K.G., Coping with being cooped up: Social distancing during COVID-19 among 60+ in the United States, Revista Panamericana de Salud Pública, 2020, 44. e81. https://doi.org/10.26633/RPSP.2020.81
6. Endler, N.S., Parker, J.D.A., Multidimensional Assessment of Coping: A Critical Evaluation, Journal of Personality and Social Psychology, 1990, 58 (5), 844-854.
7. García-Fernández, L., Romero-Ferreiro, V., López-Roldán, P. D., Padilla, S., Rodriguez-Jimenez, R., Mental Health in Elderly Spanish People in Times of COVID-19 Outbreak, The American Journal of Geriatric Psychiatry, 2020, 28(10), 1040-1045. https://doi.org/10.1016/j.jagp.2020.06.027
8. George, D., Mallery, M., SPSS for Windows Step by Step: A Simple Guide and Reference 17.0 Update. 10th Edition, Pearson, Boston, 2010.
9. Gerhold, L., COVID-19: Risk perception and Coping strategies, PsyArXiv, 2020, March 25 https://doi.org/10.31234/osf.io/xmpk4
10. Heszen, I., Psychologia stresu. Korzystne i niekorzystne skutki stresu życiowego. Warszawa: Wydawnictwo Naukowe PWN, 2013.
11. Juczyński Z., Ogińska-Bulik N., Narzędzia pomiaru stresu i radzenia sobie ze stresem. Warszawa: Pracownia Testów Psychologicznych, 2009.
12. Klein E.M., Brähler E., Dreier M., Reinecke L., Müller K.W., Schmutzer G., Wölfling K., Beut M.E., The German version of the Perceived Stress Scale –

psychometric characteristics in a representative German community sample, BMC Psychiatry, 2016, 16, 159. https://doi.org/10.1186/s12888-016-0875-9

13. Lazarus, R. S., Folkman, S., Stress, appraisal, and coping. New York: Springer, 1994.
14. López, J., Perez-Rojo, G., Noriega, C., Carretero, I., Velasco, C., Martinez-Huertas, J., Galarraga, L., Psychological well-being among older adults during the COVID-19 outbreak: A comparative study of the young–old and the old–old adults. International Psychogeriatrics, 2020, 1-6. https://doi.org/10.1017/s1041610220000964
15. Meng, H., Xu, Y., Dai, J., Zhang, Y., Liu, B., Yang, H., Analyze the psychological impact of COVID-19 among the elderly population in China and make corresponding suggestions, Psychiatry Research. 2020, 289, 112983. https://doi.org/10.1016/j.psychres.2020.112983
16. Obuchowski K., Adaptacja twórcza. Warszawa, Książka i Wiedza, 1985.
17. Ozamiz-Etxebarria, N., Idoiaga Mondragon, N., Dosil Santamaría, M., Picaza Gorrotxategi, M., Psychological Symptoms During the Two Stages of Lockdown in Response to the COVID-19 Outbreak: An Investigation in a Sample of Citizens in Northern Spain, Frontiers in Psychology, 2020, 11, 1491. https://doi.org/10.3389/fpsyg.2020.01491
18. Peng, E.Y., Lee, M.B., Tsai, S.T., Yang, C.C., Morisky, D.E., Tsai, L.T., Weng, Y.L., Lyu SY, Population-based post-crisis psychological distress: an example from the SARS outbreak in Taiwan, Journal of the Formosan Medical Association, 2020, 109(7), 524-32. https://dx.doi.org/10.1016%2FS0929-6646(10)60087-3
19. Pieh Ch., Budimir S., Probst T., The effect of age, gender, income, work, and physical activity on mental health during coronavirus disease (COVID-19) lockdown in Austria, Journal of Psychosomatic Research, 2020, Volume 136, September. https://doi.org/10.1016/j.jpsychores.2020.110186.
20. Webb, L., COVID-19 lockdown: A perfect storm for older people's mental health, Journal of Psychiatric and Mental Health Nursing, 2020, doi:10.1111/jpm.12644
21. WHO, Zdrowie psychiczne i funkcjonowanie psychospołeczne podczas pandemii COVID-19, 2020, WHO-2019-nCoV-MentalHealth-2020.1-pol.pdf
22. Xiang, Y. T., Yang, Y., Li, W., Zhang, L., Zhang, Q., Cheung, T., & Ng, C. H. (2020). Timely mental health care for the 2019 novel coronavirus outbreak is urgently needed, The Lancet Psychiatry, 7(3), 228–229. https://doi.org/10.1016/S2215-0366(20)30046-8

23. Yeung, D.Y., Fung, H.H., Age differences in coping and emotional responses toward SARS: a longitudinal study of Hong Kong Chinese, Aging Mental Health, 2007, 11, 579-87.

Anita Richert-Kaźmierska, Support for older adults during covid19 pandemic - how did local authorities in the Pomeranian region respond to the challenge?

Introduction

The older adults' support system in Poland is based on the hierarchical compensation care model, where responsibility regarding seniors' care and meeting seniors' needs is treated as a "family matter": seniors' spouses and /or children are expected to take the full responsibility for providing the support, including long-term care. In small-town and rural societies asking an institution for help to removing a senior to a specialized centre causes family's stigmatization and accusation of soullessness or lack of gratitude.

The older adults' singularization (living alone) requires a review of this approach and more frequent and intensive inclusion of local self-help networks (neighbours and peer groups), NGOs and local authorities in the seniors' support system. The need for cooperation of various entities in providing support for older adults (a complementary care model) was experienced during the social isolation caused by the COVID19. In many cases the assistance received by seniors from their family members proved insufficient.

The purpose of this study is to identify and classify the forms of support that local authorities in the Pomeranian Region offered to older adults during the first stage of lockdown caused by the COVID19 pandemic. Apart from that, based on that experiences, the author intends to develop the concept of effective ways of supporting seniors during future crisis situations.

Local authorities in older adults' support system in Poland

Supporting older people is about providing them with a variety of resources (emotional, informational, material, financial) when they are experiencing difficulties and are unable to cope with them on their own. The insufficient availability of such support results in the needs of the elderly not being met or not sufficiently met [4, p.10]. Ultimately, it leads to the deterioration of their social and living conditions, their health, or even to loss of life. The

organisation of the support system for older people depends on many factors and differs from country to country. The differences concern, among others: the forms of support and their availability [4], the degree of institutionalisation of the system, i.e. the responsibility (formal and customary) of family members and institutions for providing support and care to seniors [7, p. 5-7], the rules of functioning of support providers and the way of financing their activities [12, p.120-127; 22], as well as the supervisory and control bodies of such a system and the scope of their powers[6, p. 93].

The system of support and care for the older adults in Poland is closest to the hierarchical-compensatory model[14]. The family is seen as the most desired, natural environment of emotional functioning and life activity of seniors, guaranteeing the satisfaction of their needs[15]. The responsibility for providing support and care for the older adults rests, in the following hierarchical order, on: their children, spouses, siblings, grandchildren and other relatives [10]. The support and institutional care[16] are treated as complementary to family care and the permanent transfer of a senior citizen to a specialised centre is supposed to be the last resort [5]. As A. Janowicz [11, p. 162] observes, "in smaller environments it happens that giving a loved one up to a specialist centre results in stigmatization of their family and a suspicion of heartlessness or lack of gratitude on the part of their children and grandchildren".

Due to the social changes taking place, including the singularisation of old age[9, p. 40] and the decreasing caring capacity of families [2, p. 446-448], the demand for active participation of non-governmental organisations and public institutions in the system of support for seniors is systematically increasing. Local government, as the "closest to the citizens", has a special responsibility in this respect. It is a provider of statutorily guaranteed social services to seniors, but also an initiator and a coordinator of activities undertaken locally by other entities. According to the provisions of the Polish *Social Welfare Act* [28], the district is obliged to provide assistance to seniors on the same principles as other groups of beneficiaries "in need of support" (people who, due to age, illness or disability, require partial

[14] Z. Szweda-Lewandowska [24] identifies five types of models for the organisation of senior care systems: *the hierarchical compensatory model*, *the substitutional model*, *the specificity model*, *the supplementation model* and *the complementarity model*.

[15] According to EuroCarers statistics, 93.5% of dependent persons in Poland receive care from family carers [30].

[16] The institutional care for older adults in Poland is implemented in two areas: health care and social assistance. The patients who do not require hospital treatment but nevertheless have significant deficits in health and self-care benefit from long-term care in the health care system, i.e. from care, nursing, rehabilitation, palliative and hospice services, in a specialised facility (inpatient care) or at their home (community care). Care services provided within the framework of social assistance are, in turn, available to individuals who, due to age, illness or disability, require the assistance of other people and are deprived of it [28]. The care services in this case mainly include "assistance in meeting daily life needs, hygiene care, doctor-advised care and, where possible, ensuring the possibility of contact with the environment".

care and assistance in meeting their vital needs). However, more and more local governments[17] decide to improve upon the catalogue of compulsory activities related to senior support and implement local old age policies. They include, among others, activities in the field of health prevention, social activation of seniors, increasing the availability of care services for seniors in their place of residence, or supporting family carers – cf. Table 1.

Table 1. The tasks of district self-government in the support system for seniors in Poland

Mandatory*	distribution of cash benefits	• granting and payment of periodic and special purpose allowances, • paying a pension insurance contribution for individuals resigning from employment because of the need to take direct personal care of a long-term or seriously ill family member or their mother, father or siblings who do not live together, • paying for the stay of a district resident in a residential care home
	provision of benefits in kind (social services)	• social work, • in-kind help, • specialist advice and crisis intervention, • providing shelter, food and necessary clothes, • care services in the place of residence, in support centres and in family care homes, • specialist care services in the place of residence and in support, residence and service centres in the residential care home, • assistance in obtaining appropriate housing conditions, • training and family counselling
Optional	preventive healthcare	• implementation of preventive programmes (e.g. vaccination against influenza and pneumococcus, screening) • financing of rehabilitation procedures, including home rehabilitation
	promoting social inclusion and combating discrimination	• implementation of the principles of universal design in investment projects • adapting the existing district infrastructure to the needs of older people with reduced mobility and the disabled • actions aimed at strengthening intergenerational cooperation • developing neighbourhood and intergenerational volunteering • social campaigns for positive ageing and social inclusion of senior citizens • implementing institutionalised advocacy for the interests of older people
	social activation	• investing in infrastructure dedicated to the elderly (meeting places for senior citizens, open gyms) • organizing leisure time (financing the activities of senior citizen clubs and associations) • organization of educational, recreational and sports activities • cultural offer dedicated to seniors • actions for intergenerational integration • support for mobility by providing individual door-to-door transport services
	safety and security	• psychological and legal assistance

[17] The results of the research carried out by the author in the years 2012–2018 indicated that local governments in Poland did not diagnose the demographic changes taking place in their territory, did not recognise the needs of the growing subpopulation of seniors and did not take action to allow for seniors and the ageing of local communities, or such action was insufficient. In recent years, upon participation in multiple research projects and work on local strategies for solving social problems, the author sees a positive change in the attitude of local authorities to the issue of population ageing and actions towards older people.

		• home telecare service, with the support of a telecare assistant • prevention of various forms of violence against older people

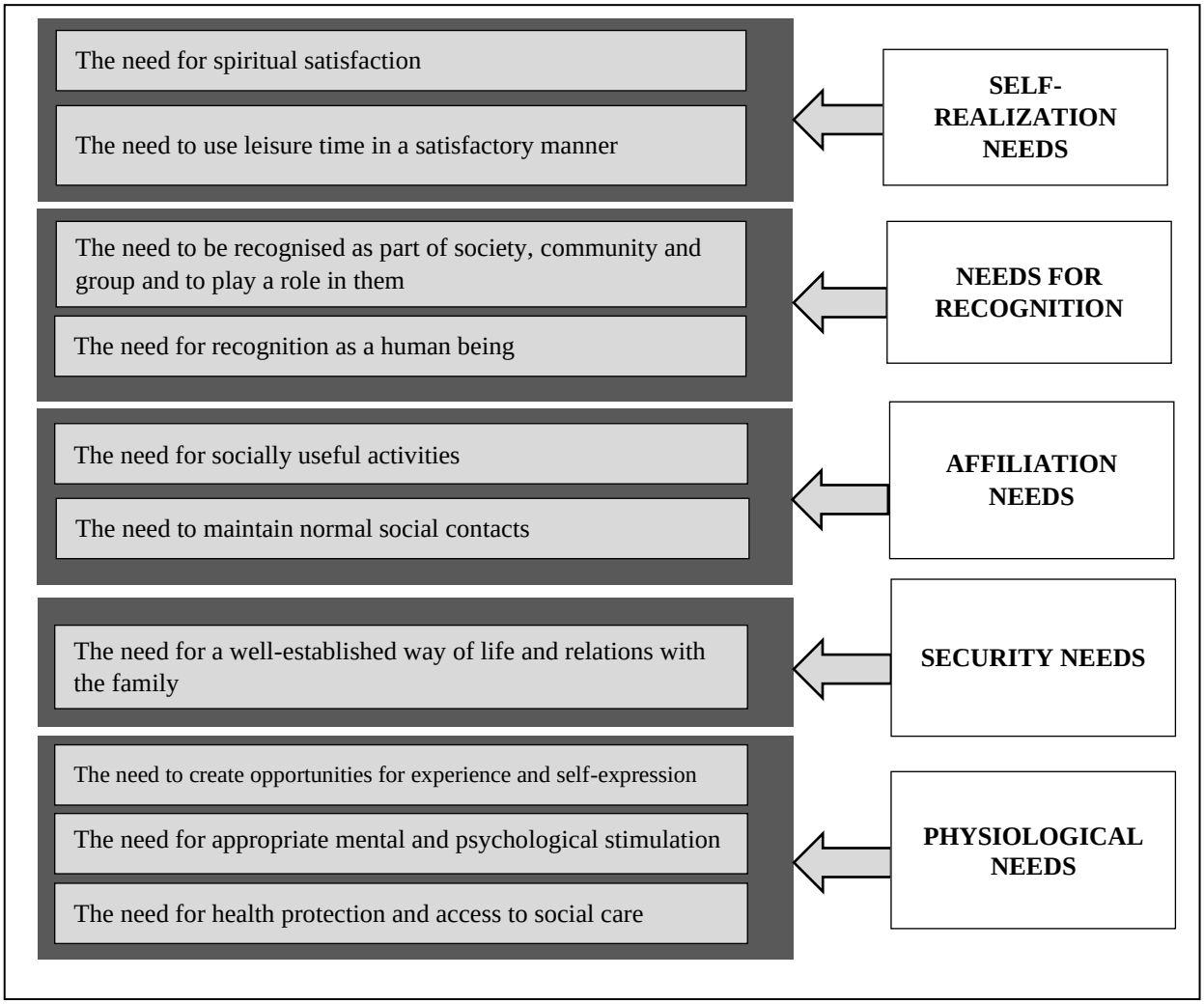
* The forms of support for individuals who, due to age, illness or disability, require partial care and assistance in meeting their necessary life needs, that are obligatory for local government units, are defined in the Polish *Social Welfare Act* [28].

Source: own work.

Senior citizens' needs during the COVID19 pandemic

Due to their heterogeneity (age, health condition, level of independence, family situation, material situation), older people declare different needs which they are able to satisfy on their own or in relation to which they require support from family members, third parties and/or institutions. Both groups of needs can include material, spiritual, emotional and cultural needs, as well as needs related to daily activities or physiological and health needs [3]. C.Tibbitis [25] arranges them into ten groups, which in turn can be arranged according to the hierarchy proposed by A. Maslow [14]. According to Maslow, humans strive to satisfy their needs sequentially, starting from physiological (life, organic) ones and ending with those related to the desire to realize one's potential and personal development — cf. Fig. 1.

Figure 1. The needs of older people in the classification of C. Tibbits hierarchy of A. Maslow



Source: own work.

The needs of older people — as a rule — are not significantly different from those felt at earlier stages of life. However, their hierarchy and intensity may vary. Due to the deteriorating health condition, lower activity and physical fitness, as well as changes in social relations, the need for closeness, acceptance (being needed), support in everyday activities and a sense of security becomes most important in old age [16, p. 162; 26, p. 104].

The COVID-19 pandemic had various social and economic consequences [18]. Its impact on the situation of seniors is intensified by the fact that older age is the main risk factor of death in case of SARS-CoV-2 infection [19]. In the spring of 2020, almost overnight, the seniors became socially isolated as belonging to the highest risk group. For the sake of older people's health, personal contacts between family members were restricted, the activities of institutions organizing leisure time for seniors were suspended, recommendations not to leave home and restrictions on free movement outside the place of residence were introduced, and the availability of various types of social services in a direct personal form (e.g. visits to a doctor, rehabilitation services or participation in religious services) was

limited or suspended. The time of the COVID19 pandemic highlighted — more than ever before — the problems and unmet needs of older people: above all, social isolation and loneliness, age discrimination, insufficient access to health prevention, medical care and care services, as well as lack of or insufficient access to information [21; 31].

For many seniors — despite lack of actual infection with the virus — COVID19 has become the cause of a serious life crisis. It disrupted their earlier, "normal" functioning, caused or deepened the feeling of loneliness, increased the feeling of distrust towards strangers, as well as aroused fear for the health and life of themselves and their loved ones [15; 20; 32]. As with any crisis situation, the reactions of seniors to a new situation are different [17]: concentration on task, concentration on emotions or concentration on avoidance — cf. Table 2.

Table 2. Senior citizens' attitudes and behaviour towards the COVID19 crisis

Attitudes towards a crisis situation	Possible behaviours	Needs affecting the specific behaviours of seniors
FOCUS ON THE TASK	— striving to maintain a positive attitude towards the surrounding reality — continuing previous (routine, customary) activities outside home (e.g. going shopping, participating in senior citizens' clubs) while observing safety recommendations — with restrictions on going outside the place of residence, maintaining remote (telephone, Internet) contact within the network of family and social relations — engaging in various tasks and initiatives (e.g. sewing masks) and participating in online activities dedicated to seniors	— striving for "normality" and functioning at a fixed rhythm of the day — the need for security — the need for affiliation — the need to be useful
FOCUS ON EMOTIONS	— focusing on collecting and analysing (the main topic of the discussions) information on the risks associated with COVID19 and the actions taken by the various institutions in this area — wishful thinking, not taking any action (remaining in a specific state of suspension pending a return to "normality") — catastrophic thinking often leading to mental problems (psychoses, anxiety, depression, aggression)	— a disturbed sense of stability and security — emotional lability — feeling lonely in a crisis situation — the need to relieve emotions and fear, for example by talking to another person — insufficient access to reliable information
FOCUS ON EVASION	— rejection of thoughts about the problem — demonstrating the denial of the existence of a pandemic and its associated dangers (affirmation of a conspiracy theory, ignoring safety rules) — indifference to the problem and dissociating oneself from the information about the pandemic coming from the environment — an "escapist" attitude, expressed as falling into addictions or above-average engagement in substitution activities	— a sense of powerlessness and helplessness — low self-esteem — fatalism — loneliness — lack or inadequacy of mental support, related to missing family, peer and social relations

Source: own work.

Activities for the benefit of seniors undertaken by local governments in the pomorskie province during the COVID19 pandemic — systematics

The COVID19 pandemic forced the whole system of state administration to perform new tasks. Both the central government and the local governments faced the challenge of meeting the security needs of citizens by reducing the level of the epidemic itself on the one hand and supporting those affected on the other.

The local government is the organisational structure of the local community, located closest to the citizens in the hierarchy of power in a state. Therefore, the needs for support in crisis situations are first of all reported by citizens to the district authorities. As regards the fight against the COVID19 epidemic, the activities of local self-government authorities are largely determined by the procedures generated at the government level and should be strictly harmonised with the activities of the government administration and its entities, as well of the local governments at the county and province level. They represent a huge challenge for local authorities — primarily due to the multitude and variety of tasks that fall into the scope of statutory responsibility of districts (own tasks and those commissioned by the government administration), the deficit of local government employees, or the difficult financial situation that had existed in many of them already before the outbreak of the epidemic [1; 8; 23].

According to Polish *Act on special solutions related to preventing, counteracting and combating COVID-19, other infectious diseases and crisis situations caused by them* [29 , art. 10, par.1], the Prime Minister, at the request of the Minister of Health, may impose an obligation on a local government unit to perform a specific task in connection with counteracting the COVID19 epidemic. Moreover, in connection with the counteraction of COVID19, by means of an administrative decision, the territorially competent provincial governor may also issue instructions applicable to all local and regional authorities [29, art. 11, par. 1].

In the classification proposed by M. Klimek, aid activities undertaken by local government units in the fight against SARS-CoV-2 were divided into four areas: support for health care, support for the economy, support for social assistance units and support for residents [13, p. 43]. Activities undertaken by local (district) governments for the benefit of seniors belong mainly to the third and the fourth area — cf. Table 3.

Table 3. Areas of local government support for senior citizens during the COVID19 pandemic

	Recipients (beneficiaries)
AREA 3: SUPPORT FOR SOCIAL ASSISTANCE UNITS PROVIDING SERVICES TO SENIORS	residential care homes day care and 24-hour care facilities for seniors
AREA 4: SUPPORT FOR THE SENIOR RESIDENTS OF THE DISTRICT	seniors residing in their flats/houses — residents of the district seniors residing in residential care homes and other day and day-and-night care institutions

Source: own work.

In order to identify what kind of actions local governments actually took during the pandemic for the benefit of senior residents, the author conducted a survey among the districts of the pomorskie province. Out of 123 districts in the pomorskie province, 10 were selected for the study: 2 urban-rural and 8 rural ones (cf. Table 4). Each of them – in accordance with the Act on Access to Public Information [27] — was asked (by sending an e-mail to the address of the district office's secretariat) for public information in two areas:

a. the forms and methods of support for the senior residents of the district which were implemented in the period from 1 March to 31 July 2020 in response to threats and limitations caused by the COVID19 pandemic,
b. the institutions and organisations (including initiatives of individuals) which joined in providing support to seniors in the district during the pandemic period.

The scope of the questions met the criteria justifying the right of access to public information, as defined in article 6, paragraph 1 of the Act on Access to Public Information. As a result, all the districts to which the inquiry was addressed sent their replies within 21 days from the date of sending the inquiry. The answers, depending on the district, were sent (as confirmed by the signature on the document or in the return e-mail) by the district leaders, the secretaries of the districts, the managers and employees of the district social welfare centres or the head of the village council responsible for senior citizen matters.

Table 4. Pomorskie province districts which were inquired about the support for seniors during the COVID19 pandemic

District	County	Type of district	Total population	Share of individuals aged 60 and more
			Data for 2019	
Bytów	bytowski	urban-rural	25,420	21.7%
Koczała	człuchowski	rural	3,356	26.4%
Kolbudy	gdański	rural	17,839	18.1%
Konarzyny	chojnicki	rural	2,311	17.5%
Kosakowo	pucki	rural	15,589	15.7%
Lipnica	bytowski	rural	5,216	20.8%
Osiek	starogardzki	rural	2,376	27.2%
Smętowo	starogardzki	rural	5 185	21.9%

Graniczne				
Wicko	lęborski	rural	6,019	20.4%
Żukowo	kartuski	urban-rural	40,837	15.2%

Source: own work.

The aim of the study was to diagnose the activities actually undertaken by the pomorskie province districts for the benefit of seniors during the period of social isolation caused by the COVID19 pandemic and to identify organisations, institutions and people with whom they cooperated in this area. The study was of a qualitative nature and therefore the results obtained do not allow for analyses based on statistical methods. On the other hand, the identified solutions may constitute a base of good practices, in the perspective of the so-called second wave of the pandemic and the necessity of the districts' renewed crisis involvement in additional support dedicated to seniors.

Only three of the surveyed districts declared the implementation of tasks in area 3: support for social assistance units dealing with seniors. First of all, these were the districts of Koczała and Kolbudy, in which there are senior citizens' clubs co-financed by the governmental Senior+ programme. Taking into account the needs of these units, both districts:

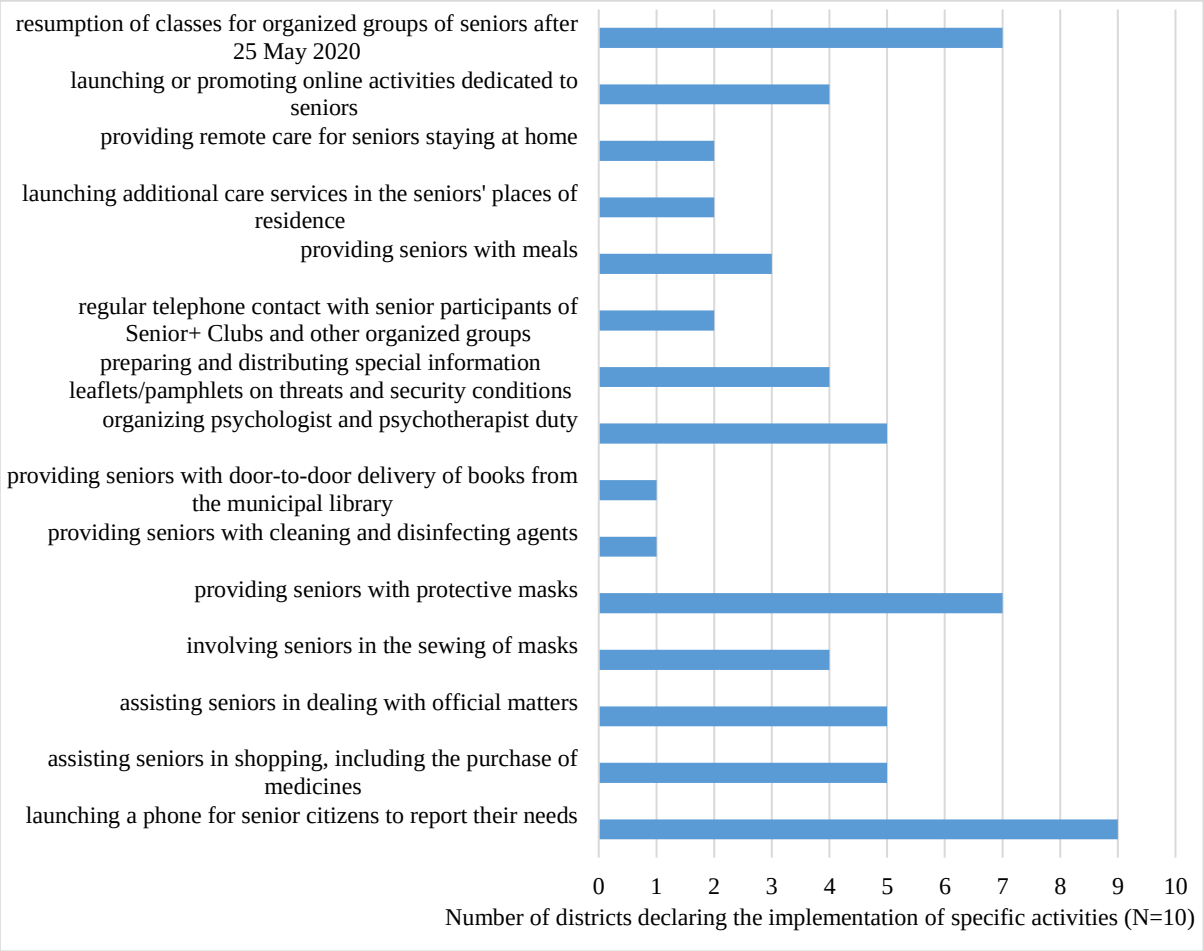
— purchased personal protective equipment (masks, disposable gloves), as well as disinfectants and equipment necessary for their application,
— purchased additional equipment (plastic safety barriers) and appliances (thermometers) necessary to ensure the safe stay of seniors and staff working conditions,
— developed and implemented special security procedures.

In the Koczała district, one of the rooms in the Senior+ Club was additionally arranged to isolate individuals who would show symptoms of disease during classes. The Wicko district, in turn, carried out professional disinfection of all public places where classes dedicated to seniors are held.

Activities in area 4, i.e. support for older residents of the district, were implemented by all districts in the period from 1 March to 31 July 2020 (cf. Fig. 2). All districts declared the uninterrupted operation of their social welfare centres and the provision of social services to individuals requiring support (including seniors), provided for in the Social Welfare Act [28]. Almost all of the surveyed districts have launched a special telephone number which can be used by seniors in need of help, e.g. in shopping, buying medicines, arranging an over-the-phone consultation with a physician, dealing with official matters, etc. In Koczała and Lipnica districts, due to the introduction of such a solution, the working hours of social workers were

extended (the phone number dedicated to seniors was operated by employees of the district social welfare centres). In almost all districts protective masks were provided to seniors.

Figure 2. Activities supporting seniors during the pandemic, undertaken by local governments participating in the survey of districts

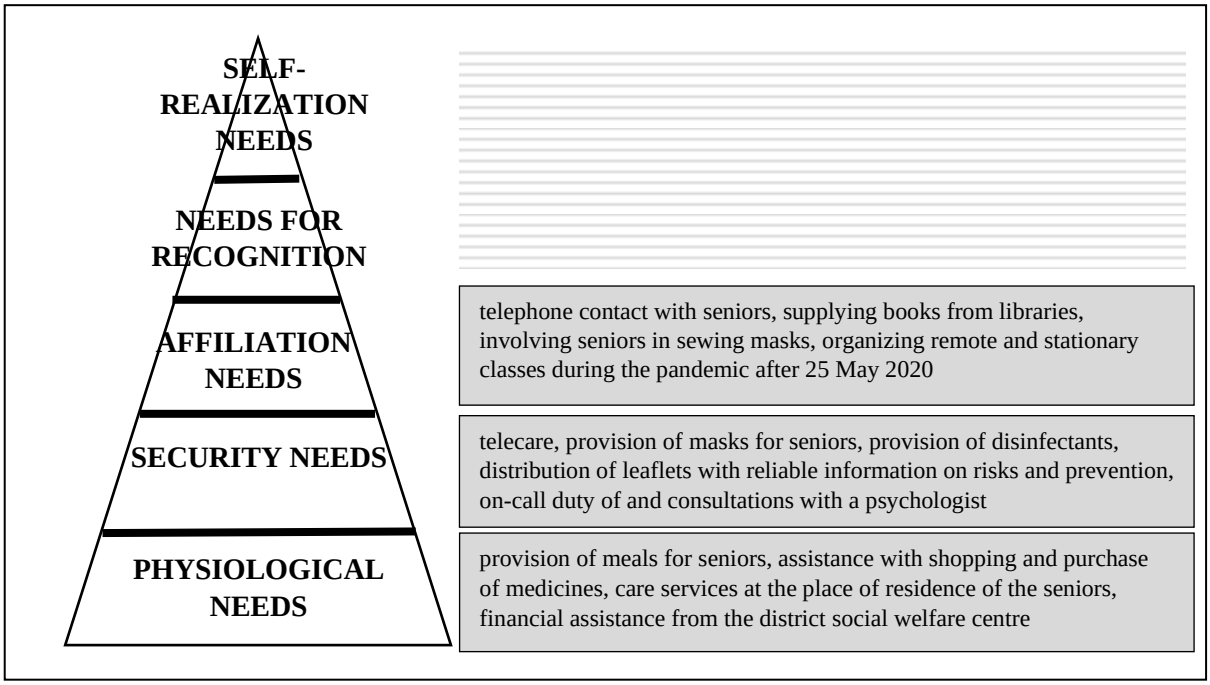


*The stationary classes in Senior+ Clubs and Day Houses were suspended by decision of the Minister of Labour and Social Policy in the period from 13.03.2020 to 25.05.2020. At the same time, all other stationary forms of senior citizen activation were suspended in all districts. As of 25 May 2020, the districts have gradually, at various dates, resumed the classes addressed to seniors.

Source: own work.

The activities undertaken in the period from 1 March to 31 July 2020 by the local governments involved in the study, in relation to seniors, were mainly in line with three groups of needs, i.e. physiological needs, safety needs and affiliation needs – see Figure 3.

Figure 3. Activities supporting seniors during the pandemic, undertaken by local governments participating in the survey of districts, in the context of A. Maslow's hierarchy of needs



Source: own work.

The local governments have undertaken activities to support seniors on the basis of the results of a systematic analysis of the needs of the older adults carried out by the district social welfare centre or the district leaders' proxy for senior citizens (Osiek, Kolbudy), ongoing monitoring of the needs of senior citizens carried out by the village leaders (Konarzyny), a questionnaire sent out to senior citizens (Kosakowo), or in response to specific signals reported by the residents of the district to the district office or the district social welfare centre (Lipnica).

Within activities supporting seniors during a pandemic, local governments performed various functions: they were initiators, coordinators, financing entities or executors. And so, the Żukowo district was i.a. the initiator of the informational and social campaign "Take care of the senior", the aim of which was to encourage the residents to pay more attention to the needs of the elderly in their families, as well as older friends and neighbours, and to offer them help. Konarzyny district (as the District Social Welfare Centre in Konarzyny) coordinated activities supporting seniors carried out in its territory by the Polish Red Cross (acquiring and handing over food parcels), the Association for the Development of the Municipality and District of Debrzno (acquiring and handing over cleaning products to seniors), or the Association for the Support of Children and Youth "Klub Mam" (handing over masks sewn by members of the association to seniors). Kolbudy district funded and purchased protective masks, and the village leaders supplied to the seniors living in their

villages. Kolbudy and Koczała funded and purchased the necessary equipment for the Senior+ Clubs operating on their premises in order to ensure the safety of club participants and staff.

The partners of supporting activities during the COVID19 pandemic were e.g. district organisational units, local non-governmental organisations and entrepreneurs, district volunteer fire brigades, as well as village leaders and volunteers – see Table 6.

Table 5. Partners in the activities of local governments supporting seniors during the pandemic – examples

PARTNERS		DISTRICT	JOINT ACTIONS
District organizational units	**District library**	Wicko	home delivery of books to seniors
	District committee for solving alcohol problems	Wicko	on-duty psychologist and psychotherapist
	District centre of social policy	Wicko	information leaflet
		Konarzyny	delivery of meals and food parcels
		Smętowo Graniczne	care services in the senior citizens' places of residence
Volunteers, village leaders, members of the volunteer fire brigade		Wicko	assistance in shopping and purchasing medicines
		Osiek	
		Konarzyny	monitoring the needs of seniors
Non-governmental organisations		Konarzyny	delivery of cleaning products; sewing and delivering protective masks to seniors
		Kolbudy	psychologist and lawyer on duty; organization of online classes for seniors
Local entrepreneurs		Żukowo	purchase of material for sewing masks; supply of masks and visors for seniors

Source: own work.

References

1. Berenda K., *Alert gospodarczy: Rola jednostek samorządu w powstrzymywaniu zapaści gospodarczej*, (available 6th of May 2020), https://www.rmf24.pl/raporty/raport-koronawirus-z-chin/komentarze-ekspertow/news-alert-gospodarczy-rola-jednostek-samorzadu-w-powstrzymywaniu,nId,4424551
2. Błachnio A., *Starość w rodzinie. Opieka nad seniorem wyzwaniem dla dorosłego dziecka czy państwa?*, Wychowanie w Rodzinie t. XIII (1)/2016, p. 441-453.
3. Błędowski P., *Lokalna polityka społeczna wobec ludzi starych*, Oficyna Wydawnicza Szkoły Głównej Handlowej, Warszawa 2002.
4. Błędowski P., Szatur-Jaworska B., Szweda-Lewandowska Z., Zrałek M., *Model wsparcia społecznego osób starszych w środowisku zamieszkania*, In: B. Szatur-Jaworska, P. Błędowski (ed.), System wsparcia osób starszych w środowisku zamieszkania – przegląd sytuacji, propozycja modelu. Synteza. Raport z prac Komisji Ekspertów ds. Osób Starszych przy Rzeczniku Praw Obywatelskich, Biuro Rzecznika Praw Obywatelskich, Warszawa 2017.
5. Cantor M., *Social Care: Family and Community Support Systems*, The Annals of the American Academy of Political and Social Science 503(1)/1989, p. 99-112.

6. Genet N., Boerma W., Kroneman M., Hutchinson A., Saltman R. (ed.), *Home care across Europe. Current structure and future challenges*, WHO, Copenhagen 2012.
7. Gibson M.J., Gregory S.R., Pandya S.M., *Long-term care in developed nations: a brief overview*, Working papers 2003–13, AARP Public Policy Institute, Washington 2003, p. 5-7.
8. *Gospodarka finansowa jednostek samorządu terytorialnego 2018*, Główny Urząd Statystyczny, Warszawa 2019.
9. Heinze R., Naegele G., *Silver Economy in Germany – More Than Only the Economic Factor: Old Age*, Gerobilim 02/2009, p. 37-52.
10. *Jakiej pomocy potrzebują osoby starsze i kto im jej udziela?*, Komunikat z badań nr 116, CBOS, Warszawa 2019.
11. Janowicz A., *Rola opiekunów nieformalnych w opiece u kresu życia. Przyczynek do badań w ramach projektu European Palliative Care Academy (EUPCA)*, Pielęgniarstwo i Zdrowie Publiczne, 4(2)/2014, p. 161–167.
12. Jurek Ł., *Ekonomia starzejącego się społeczeństwa*, Wydawnictwo Difin, Warszawa 2012.
13. Klimek M., *Działania pomocowe jednostek samorządu terytorialnego wobec epidemii*, In: N. G. Pikuła, M. Grewiński, E. Zdebska, W. Glac (eds.), *Wyzwania dla polityki społecznej w kontekście pandemii koronawirusa*, Biblioteka Instytutu Spraw Społecznych Uniwersytetu Pedagogicznego im. Komisji Edukacji Narodowej w Krakowie 2020, p. 37-51.
14. Maslow A., *Motywacja i osobowość*, PWN, Warszawa 2009, p. 62–76.
15. Morrow-Howell N., Galucia N., Swinford E., *Recovering from the COVID-19 Pandemic: A Focus on Older Adults*, Journal of Aging and Social Policy, 32(4-5)/2020, p. 526-535.
16. Nosek K., *Starość zapomniana, czyli o specyfice funkcjonowaniu osób starszych w nowoczesnym społeczeństwie*, Kwartalnik Naukowy Fides et ratio 2(26)/2016, p. 160-168.
17. Parker J.D.A., Endler N.S., *Coping with coping assessment: A critical review*, European Journal of Personality 6(5)/1992, p. 321–344.
18. Peterson O.K., Thankom A., *Spillover of COVID-19: Impact on the Global Economy* (available 27th of March 2020), https://ssrn.com/abstract=3562570
19. Petretto D.R., Pili R., *Ageing and COVID19: What is the role for elderly people*? Geriatrics 5(25)/2020, p. 1-4.
20. *Prawa człowieka osób starszych podczas pandemii. wspólne stanowisko Niemieckiego Instytutu Praw Człowieka oraz Rzecznika Praw Obywatelskich Rzeczypospolitej Polskiej*, Warszawa 2020, (available 23rd of April 2020), https://www.rpo.gov.pl/sites/default/files/Wsp%C3%B3lne%20o%C5%9Bwiadczenie%20RPO%20i%20DIfMR%20w%20sprawie%20praw%20os%C3%B3b%20starszych%20podczas%20pandemii.pdf
21. Przybył A., Jasiówka M., Gorczyca W., Łukasik M., Tomza P., Raport o samotności – epidemia, która jest naszą wspólną sprawą, Stowarzyszenie Wiosna, Warszawa 2020, (available 10th of April 2020), https://www.szlachetnapaczka.pl/raport-o-samotnosci/

22. Riedel M., Kraus M., *Informal care provision in Europe: regulation and profile of providers*, ENEPRI Research Report 96, 2011.
23. *Samorządy lokalne: pomagamy, ale sami też potrzebujemy wsparcia*, (available 6th of May 2020), https://wspolnota.org.pl/news/samorzady-lokalne-pomagamy-ale-sami-tez-potrzebujemy-wsparcia
24. Szweda-Lewandowska Z., *Modele opieki nad osobami niesamodzielnymi*, Zeszyty Naukowe Wydziałowe Uniwersytetu Ekonomicznego w Katowicach 197/2014, p. 215-224.
25. Tibbitis C. (ed.), *Handbook of social gerontology. Societal Aspects of Aging*, Chicago 1967.
26. Trafiałek E., *Polska starość w dobie przemian*, Wydawnictwo Śląsk, Katowice 2003.
27. Ustawa z dnia 6 września 2001r. o dostępie do informacji publicznej (Dz. U.2014, 782, 1662; Dz.U.2015, 1240).
28. Ustawa z dnia 12 marca 2004 r. o pomocy społecznej (Dz.U.2004, 64:593).
29. Ustawa o szczególnych rozwiązaniach związanych z zapobieganiem, przeciwdziałaniem i zwalczaniem COVID-19, innych chorób zakaźnych oraz wywołanych nimi sytuacji kryzysowych (Dz.U. 2020, 374).
30. *Who cares? Securing support in old age*, Policy Brief 21/2019 (available 27th of May 2019), https://population-europe.eu/policy-briefs
31. *The Impact of COVID-19 on older persons, Policy Brief*, United Nations 2020.
32. Zhang Q., Song W., *The challenges of the COVID-19 pandemic: Approaches for the elderly and those with Alzheimer's disease*, MedComm 1(1)/2020, p. 1-5.

SOCIAL life

Zofia Szarota, Geragogy of everyday life - the COVID 19 perspective

Introduction

In November 2019, information on the new coronavirus SARS-CoV-2 began to appear in the media. The outbreak of the disease was the Chinese town of Wuhan. The virus was spreading fast. The World Health Organization on 29 January 2020 declared a global public health emergency and on 11 March 2020 identified the epidemic COVID-19 as a pandemic. As a preventive measure, social (basically - physical) distancing and a distance of 1.5 - 2 meters between persons was recommended. In the countries affected by the pandemic, there was an appeal to stay at home. An administrative quarantine order was introduced for infected and preventively for people coming from abroad. In Poland, the first COVID-19 infection was registered on March 4, 2020 and immediately after that WHO recommendations were implemented under government regulations. Seniors with the most severe course of the disease, especially those with comorbidities, were considered to be the group at high risk. The time of pandemic confinement, social quarantine, official self-isolation order could increase the feeling of loneliness in the elderly and could result in depressed mood, development of anxiety and even depression. Relationships and perceptions of values may have changed. Has it really happened? The study is an attempt to answer this question. The article takes into account the context of situatedness of human experiences, behaviors, needs and values in everyday life marked by the experience of a pandemic.

Theoretical framework

Social isolation, understood as physical separation from other people, has negative consequences for the well-being of an elderly person. Isolation, sometimes equated with social exclusion, is characterized by a lonely life resulting from the shrinking network of social support resources and rare interpersonal contacts. This is due to the declining interest in maintaining wide social contacts with age, shrinking peer group due to natural causes, deteriorating health condition, which reduces social mobility and is sometimes the cause of institutionalization of the recipient life of care benefits [18]. The negligible resources of social support are a consequence of socio-cultural changes and demographic processes that characterize modern families: low fertility, migrations, disappearance of multi-generational households. The extent of social isolation of older people is influenced by seniority policies,

shaping (or not) environments and support groups, environmental integration facilities and meeting the needs of pensioners [3].

Loneliness can be the result of a subjective sense of social isolation. “The value of loneliness is appreciated in scientific reflection, it is difficult to deny that loneliness is feared in contemporary culture” [6]. Physical (social) solitude “it consists in weakening or breaking the natural bond with other people, a very loose connection with society or living outside it (…) Loneliness is the exclusive communion with oneself and one's inner world, it is a refuge - with life and action - in it [17, p. 47-48]”. At the end of his/her journey through life, the elderly face the necessity to face loneliness (loneliness) and - sometimes awaited - solitude, as new dimensions of spirituality and existential concerns [4], return to “primal loneliness”. According to John Paul II, the term "primary loneliness" means not only the experiences of the first people and their obligation to understand oneself and the world imposed by the Creator, but also filling man with internal dialogue, self-awareness and self-determination in the spiritual sphere: “Solitude also signifies man's subjectivity, which is constituted through selfknowledge”[7]. Meanwhile “… because loneliness is associated with suffering and is a difficult experience to bear, difficulties with accepting it intensify in contemporary culture, where loneliness is perceived negatively, leading individuals to try to avoid it” [6]. Thus, solitude gains two contexts - positive, developing and negative, degrading. The negative aspect brings loneliness closer to social exclusion.

The gerontological theory of activity links the well-being of the old man to his usefulness for himself and society. Senior policies aim at activating older people, involving seniors in society [13]. It is worth noting, however, that experiencing loneliness can become an opportunity to look at reality from a different perspective [see: 6]. Adaptation processes, including learning acts that involve in the process of relieving stress, contribute to the familiarization with loneliness, giving it a dimension of activity, self-creation and transgression. When the external world is a source of tension and the space of activity is significantly narrowing, the spiritual development of an aging person may take place. There is a need to search for internal order, personality integration, self-awareness, integration with the entire life so far, and giving meaning to events. Thought can focus on transcendence, looking for answers to the most important questions in the reflective interior of the old man. Wisdom is then interpreted as orderly experiences, going beyond oneself, emancipation of identity [9].

“Social stress in the aging population, therefore, may be defined in part as a response in older adults to an external challenge or stimuli (i.e., stressors) of social nature that may jeopardize their sense of self or sense of social standing or belonging in a relationship, within a group, or within the larger community” [12].

Routine strategies can be used to solve problems [see: 19, p. 38], which is particularly important for older people. The basic form of collective life and space for the development of older people is the family and the local community. A safe home, a familiar neighborhood, friendly neighborhood build a sense of mental comfort, well-being, good quality of life [1, p. 99-102]. The learning that takes place there is an irregular process situated in everyday life, in relations with other members of the community. It generates experiences that make up unobvious learning. This is my own term, close to informal learning in terms of D. Livingstone [10, p. 4-6, 11, p. 3-6], but not identical. Some interpretative clues can be found in the concept of implicit learning, understood as ways of effectively adapting behaviour to constantly changing environmental conditions [16, p. 281]. Similarities can be found in the concept of learning from experiences that "it is learning during life, in organized or incidental situations, related to the implementation of life tasks and undertaken activities, or their omission. It is learning from experience – in a direct way, i.e. in the course of events happening, in the course of certain life situations. It is learning from one's own experiences and the experiences of Others, who are in direct contact with time and space, which are created by situations" [3, p. 64].

According to its own concept, unobvious education means learning, as it were, on the occasion, in ad hoc situations in which people - through experience and habitus (understood as acquired skills and competences that define individual ways of perceiving the world, rules of conduct and thinking) they adapt, accustom to new conditions and needs, unexpectedly generate new knowledge for themselves and incorporate it into their behavioural mechanisms. Unobvious education environments are social events and interactions, activities and behaviours occurring in everyday life, customs. The subject, internalizing the consequences of self-experience of reality, most often does not give cognitive episodes an educational meaning, does not know that he/she is learning, making this activity an unintentional, hidden, unconscious act. However, it develops new adaptation and coping strategies. Resilient strategies (coping with stressful situations) I classify as an unobvious education area. It should be remembered that the elderly are reluctant to introduce changes in their personal lives. Aging and adaptation are opposite processes, therefore it could be expected that the people participating in the research would have a reduced adaptive ability.

Materials and methods

Research Problems

The aim of the study was to establish individual strategies to minimize the effects of COVID-19 in conditions of compulsory social isolation. The question was to what extent the

drama of closure and isolation changed the perception of central themes and the hierarchy of needs of people aged 60 and over.

The research was conducted in June and July 2020, in the qualitative research stream using semi-structured life-world interview, which allows "to explore the way individuals experience and perceive their world. It allows for a unique insight into the world of respondents' life, who in their own words describe their actions, experiences and views" [9, p. 39]. Such an interview provides an opportunity to obtain answers to specific research questions, but is open enough to give the researched person the chance to make unlimited statements which may give new meanings to the explored problem [5]. Interview instructions focused on experiencing epidemic restrictions. They asked about the reactions triggered by the information about the pandemic (what they felt, what they thought, what they possibly feared); about reactions caused by the need to accept the ban concerning the lockdown and social isolation. An important problem was the scope and type of support received. A significant research issue was the potential changes that took place in their home, family, neighborhood and macrosocial relationships. They were asked about the sources of their knowledge about the potential threat, about the content that contributed to (unobvious, unconscious) learning from the pandemic experience. The preventive measures taken by the respondents against the danger COVID-19 were interesting. Interlocutors were asked to formulate a message, a principle that seemed most important to them after experiencing the effects of the pandemic.

Data analysis

More than 10 hours of recordings were obtained (10:35:14). The recordings were transcribed. Significance-oriented analysis was used [9, p. 171-176]. The transcribed text has been encoded and categorization, then condensation. "Meaning units" were established taking into account the research objective and the rank assigned to them by the interviewee. The description of the results includes information on the main threads of the interview.

Characteristics of the persons interviewed

According to the Older Persons Act [15] in Poland, an elderly person is considered to be a man or woman over 60. Respondents - nine women and three men - they were 60 to 79 years old.

People living in different parts of Poland (between June and July 2020) were invited to the research: four of the respondents lived in a region with a very high COVID-19 incidence

rate, five in voivodships with high incidence rates (5th and 6th position among 16 regions), two people lived in low-disease areas (the last two positions among voivodships).

Informed consent was expected from each of the invited persons to participate in the study [9, p. 64-65]. Some of them refused, arguing that they did not believe in the objectivity of the results, “for sure someone ordered and will publish them for mercantile purposes”. They were afraid that the researcher had been "hired to search for people who would agree to the interview and give their views on this particular matter", they asked annoyed: “What's the best way to upset someone? Conduct the telephone interview”. "They claimed: “I do not believe in the noble and true purpose of such interviews”. Eventually, 12 people took part in the study using phone calls. In one case the interview was given by the couple, the spouses' answers were analyzed separately.

During the research, seven people stayed at home, two on holiday (including one abroad), two were working, and one stayed alone in her home in the countryside. They all had families, no one was alone, although five people lived in widowhood. Apart from one person with German citizenship, the interviewees were Poles. At the time of the research she was in Poland. The interview was conducted in Polish.

Four people managed the household individually, independently, four in one generation in a marriage or relationship, three lived on a two-generation household – two people with their parents (at the age of 95 and 94), and one with her husband and a studying daughter, one person in a multi-generational family - with the husband and the procreative family of one of their own children. Three people lived in houses, the rest in multi-family buildings.

The health status in the self-assessment of seven respondents was good and very good, despite the cases of chronic obstructive pulmonary disease and the state of convalescence after resection of the prostate, three people assessed their health in *so-so* and indicated chronic diseases (pulmonary sarcoidosis, sick thyroid gland, diseased large intestine, convalescence after bone fracture). Two people assessed their well-being as bad and listed a number of comorbid chronic diseases, including diabetes, eye disease, digestive system disease, and cardiovascular disease.

The respondents assessed their own economic situation as good.

The woman who was the only one who considered her finances to be very good, has run her own business in the tourism industry since her retirement. The second woman worked on a contract of employment, the third on a contract of mandate. The man ran a one-man business activity. Five other people volunteered for the universities of the third century (U3A) as their animators, two of whom gave lectures in foreign languages (Russian and French), and

another sang in an amateur vocal ensemble. Three people were active in their own household and hobby activities.

Seven people had higher education, five had secondary.

RESULTS

Pandemic – lockdown

The interlocutors remembered the moment when the first case of COVID-19 was announced in Poland. The day of introducing the isolation regime was also remembered by them. They pointed to events in their daily life that were either interrupted or significantly modified. Thus, they became significant events. Some of them had an individual dimension, others were related to the necessity to abandon the current cultural and educational activity:

- *I was in Poland, my husband and I were going home that day, to Germany. They've announced an epidemic and the barrier has closed behind us* (S f 65); - *I've been in the hospital, I've been getting information that people have a strange kind of flu that goes from China to other countries* (W m 60); - *It happened when my daughter went on a business trip. And I was looking after my grandchildren. Her boss called and said there was a coronavirus and that it was a threat to older people. My son-in-law took me home right away. It was March 13. When he drove me, I was spending five weeks in complete isolation* (T f 70); - *It was March 12, the last Thursday of my freedom away from home, the anniversary of my mother's death* (E f 69).

- *It was after March 9th, after the Monday performance at U3A* (Li f 69); - *They closed our U3A* (A m 76); - *We had to cancel U3A, it was terrible!* (Lu f 63); - *I remember it perfectly. We were with our band at a concert near Rzeszow. People said something bad was happening, everyone started to be afraid […] On Wednesday, they cancelled another concert and the end* (J f 70).

As the own research proves, information about the pandemic caused reactions from "I expected it", through "I had more important problems", to "I was shocked":

- *I predicted what might happen because in Wuhan and Italy… I've been waiting for it to be here. I was buying masks before they introduced the warrant* (A m 76); - *In Europe they already knew in December, and when did they announce? In February! You can draw conclusions from this!* (S f 65).

- *I was getting it, but I didn't care. It might as well be information about Twardowski on the moon* (W m 60)[18]; - *Before that, I was locked in the house for six months because of a broken leg and that was a problem for me. The government reassured us that we were prepared, I believed that the pandemic would not catch us* (K f 75).

- *I broke down. I was crying. I was praying a lot* (Lu f 63); - *I've been thinking about what will happen in the future, how it will mutate, what will happen to children, to grandchildren* (D f 79); - *Those media images were killing me, those mass burials in Italy* (E f 69).

It could be assumed that the elderly would react with fear when they found out they were in a high-risk group. Indeed, some felt existential anxiety. As the research conducted by CBOS [2] showed on a representative group of adult Poles in the second half of June 2020, i.e. at the same time as the reported interviews, 64% of respondents declared fear of contracting the corona virus, and 20% described the level of anxiety as high. The oldest people, over 65 years old (77%), were most afraid of infections. In my own research, the following terms of emotional states were noted: anxiety, fear, fear, horror, panic. The narrators were afraid for their loved ones, for themselves and other people, for health, for life, for lack of ventilators. They were afraid of the plague and its consequences:

– *I was afraid that I would die, for my health, I was afraid of public transport* (E f 69)*; - I didn't realize it was so terrible, this epidemic. I was afraid not to get infected, age is what it is, you can get sick. I was afraid for my children and grandchildren* (T f 70); - *I was afraid for my sister, who was 11 years older. How this situation began in Silesia*[19]*, and my granddaughter's husband works in the mine, I was very scared for them* (A m 76)*; - Fear, panic, loneliness. I understood the danger, I felt anxious for my mother and how I would do outside the home. About not experiencing a respirator* (Li f 69); - *It was shocking, I felt the fear of a terminal illness* (D f 79); - *I was afraid for my son, for myself, I didn't sleep, I assessed the risk* (J f 70); - *When I had , I did not go to the emergency room for fear of getting infected* (M f 67).

But there were also people who - as they claimed - were not afraid of anything:

- *A healthy body is difficult to attack. If you eat healthy, you are well* (S f 65)*; - My main concern was whether after the surgery I would recover that I wouldn't get to the outpatient clinic if they closed the hospital. This concern was more important than COVID. I reminded my mother to wash her hands and wear a mask* (W m 60); - *I wasn't afraid for myself. If it happens - the disease will have to be overcome. After an initial examination of conscience,*

[18] Mr. Twardowski, Master Twardowski, called the Polish Faust - a figure of a Polish nobleman, who, according to the legend, sold his soul to the devil. Legend has it that while escaping from the devil he reached the Moon on a rooster.

[19] An industrial, mining region of Poland with the highest COVID-19 infection rate.

men is prepared to go into the dark. It can come for a man with this scythe. He'll come, hard, we'll go! (A m 76).

An unexpected "addition" to the narrators' accounts became their memories related to the closure of hairdressing salons. Some respondents said they looked "terrible": - *I couldn't look at myself in the mirror* (M f 67); - *Men grew beards and hair, some looked great, others not necessarily - like gorillas* (Lu f 63). Others took matters, or rather scissors, into their own hands: - *I was cutting my hair myself* (Lu f 63); - *I shave every day, but I couldn't look at myself. I have a hair clipper and I got a haircut in front of the mirror. I even tried to go down to the underground barbershop but it failed* (laugh) (A m 76); - *I'm getting a haircut myself, a hairdresser came to my wife, but only in May* (W m 60); - *They opened hairdressing salons so to cheer up my mood I went and cut my hair. I felt better immediately* (E k 69).

The opinion of the interviewees regarding the health service seems important. In many of their conversations, they raised the topic of respect, recognition for courage, for the hard work of the medical staff: - *We started to respect our own health, we treated differently to the doctor, to the medicines* (A m 76); - *Healthcare from the front line deserves medals, applause* (E f 69).

Isolation

The necessity to undergo physical isolation was understood by almost all interviewees. Their first reactions were in contrast, from rebellion and surprise to self-isolation:
- *I was surprised that the world could change so much that we humbly sit at home* (K f 75); - *I accepted the warnings, but some of them I find stupid – no cycling, no entering the forest, no entering the cemetery – That was a stupid order* (D f 79); - *It's stupidity. In Germany, there was no order to sit at home, we went for long walks, because it's healthy and not to go crazy* (S f 65); - *I took the warrant as completely incomprehensible* (J f 70); - *After the surgery, I had to be home anyway. And then I went for walks in the meadows, in the woods, wearing a mask, like an idiot* (W m 60).
- *I spent the first month in complete isolation, at home, as much as for a nearby store, shopping once a week. I took the temperature twice a day, gray soap, I washed my hands often, internal disinfection (laugh), good slivovitz (laugh)* (A m 76); - *Gloves, masks, space. When I came back from shopping, I took all my clothes off and washed myself completely* (Li f 69); - *I locked myself. I did not want to contact either my son or my sister* (E f 69); - *Five weeks I was sitting in total isolation, I just going out on the balcony* (T f 70); - *Three weeks at home. There was such a suspension, such a sad expectation in social silence* (J f 70); - *I understand the idea of isolation, I was just going out of the house to go shopping* (Z m 71); -

I've been disinfecting everything with spirit. When I stood in queue, I was afraid, I kept my distance (M f 67).

Later, a rationalized approach to the problem of isolation prevailed, everyone retained consideration and extreme caution:

- *After two weeks there was no more panic, only depression. I was task-oriented, I have to go shopping, so I go* (Lu f 63); - *I calmed down because I avoided contact, I was safe. I went to the countryside in April and I'll be here until autumn* (T f 70); - *I went to work, but so as not to meet anyone, there were shifts at work, there was no contact with anyone* (M f 67); - *Then came self-control, shopping for five days, cleaning products. I've become familiar with the threat. I was afraid of public transport, but when I had to - I went to my rehabilitation* (Li f 69); - *I tried to be logical, calm and according to the recommendations* (D f 79); - *I tried to follow sanitary regulations so as not to endanger myself and others* (A m 76); - *You have to live… Deal with it somehow. We live with it, with care, with hygiene, without touching our face. I am irritated by people without a mask and without gloves. In the store, they explore and touch… If this grunge was to shine, you could react …* (J f 70); - *In my mask and gloves, I went out for walks, I went to rehabilitation. I avoid huddle of people and obsessive thoughts, which I have listened to especially during sleepless nights. When I left the house, the fear was over* (E f 69); - *We obeyed the recommendations* (M f 67, Z m 71).

The narrators observed the surroundings, implemented preventive strategies which, in their opinion, minimized the risk.

Social support

Support is a process of exchanging information, emotions, care, material goods, services, care and help. It weakens the feeling of danger and uncertainty. The narrators appreciated the efforts of other people:

- *A neighbor asked my wife if we needed anything* (W m 60); - *The younger neighbor offered help with shopping* (K f 75); - *The young boy came twice, asked if I needed anything, brought mineral water, all multi-pack* (Li f 69); - *Support came after two weeks and I felt that I was not alone. There were phone calls, good day wishes, questions about health, messages 30 a day, WhatsApp and Messenger, a lot of cordiality was circulating on the Internet* (Lu f 63).

All interviewees had family support resources, and there were no lonely people among the respondents. The caring function, expressed in providing parents with purchases, turned out to be equally important. The narrators indicated situations that directly concerned them:

- *Daughters called very often, almost every day* (A m 76); - *My son would bring and leave our groceries in front of the door, we talked through the window* (Z m 72)*; - Shopping from my*

family, taking care of my health, God forbid that I would not go anywhere, I had everything brought home (T f 70); - *Support from children, shopping, they take care of me* (J f 70); - *The son tried, but without contact with me* (D f 79); - *Sister and son tried. They brought shopping, there were telephones* (E f 69); - *The son did not want to come because the grandchildren and the daughter-in-law were suffering from flu (maybe it was even COVID), they were afraid for me* (K f 75).

The bottom-up, social initiatives undertaken for aid purposes were remembered:

- *I know from the media that there were initiatives to help with shopping, taking older people's dogs for a walk* (W m 60); - *The young people organized the "Call the Senior" action* (T f 70); - *People were organizing themselves from the bottom up, I had calls from former students that they wanted to sew masks. It grabbed my heart that they came out with such an initiative* (J f 70); - *My sister sewed hand-made masks from canvas. Neighbors were disinfecting the common space. I have heard about shopping, meals, about putting up advertisements with the given contact, about walking the dogs of people in quarantine, about calling lonely seniors, about volunteering in social welfare homes* (E f 69); - *Sewing masks in the library* (A m 76); - *Masks were sewn at the day support center* (K f 75).

Working narrators also indicated protective measures, financial support from the government, the so-called Shield 2.0. They assessed the protective measures directed at private business as efficient and beneficial.

Some interlocutors did not notice the community aid activities:

- *Nobody here* (Z m 72); - *I haven't heard of any support* (Li f 69); - *We heard what they said on television, I was beyond the reach of such actions* (M f 67); - *The society was not involved in helping. I know from TV that my neighbors sometimes helped each other, but in Germany there is no social support, families rely on themselves. You know, it's more about the economy than about human life!* (S f 65).

Several interviewees indicated themselves as the giver of emotional and material support:

- *It was me who supported others, I used my black humor in conversations with my sister* (A m 76); - *As for my friends, I am disappointed, I initiated contacts with those whom I taught French. But they did not express any concern* (E f 69); - *I sewed masks with my neighbor, I gave them to the needy, we sewed from a linen cloth, free of charge, to help those pensioners who cannot afford* (D f 79); - *I am so fit that I was helping and sewing masks. I was involved in the action of reading to children, it was organized by the library, each of us read an excerpt, and the children could watch it on the screen* (Lu f 63).

The narrators rationalized the pandemic tensions by focusing on activities for the benefit of others, on maintaining ties with the outside world.

Changes in relationships - "the shell of fear"

The narrators usually answered the question about the quality of personal relationships between household members - no changes. The spouses participating in the study provided an encouraging answer: - *We are still alive. We never get enough of each other* (laugh) (M f 67 i Z m 72). The narrator, fleeing from stress, stated: - *Since I am alone, I feel fine, I am not afraid that my sister will bring me a plague* (E f 69). Two people in a relationship indicated that frustrating conditions worsened: - *The husband takes care of his business (TV, Internet), and my daughter and I are next door* (Lu f 63); - *Too much being together, sad, nervous, hard, he* [partner] *still has a grudge* (K f 75).

Reflections on family relationships were consistent - emotionally unchanged, but contacts moved to phone lines and communicators. Several narrators sadly remembered Easter, which is one of the most important holidays in Polish culture:

- *The first holidays in life, that neither to church, nor with loved ones, alone. Telephone wishes were, everyone at home. I haven't been going to church since March* (T f 70); - *The holidays were sad, the saddest. The Paschal Triduum is very important to me. I was celebrating the palm tree in front of the screen. The priest blessed the food "travelling", we went out in front of the houses, he blessed and rode on* (Lu f 64); - *Easter was sad, everyone was at home for the first time. Sad experience …* (Li f 69); - *My son came to the balcony, we talked, it was very sad. We spoke to our daughter and grandson via the messenger* (M f 67 i Z m 72); - *Usually, the older daughter would invite her family to her house. This year it was just me and my son-in-law's mother. We kept our distance, no hugging, no physical contact with our loved ones. I fucking miss it* (A m 76).

With regard to relations with neighbours, some interlocutors saw changes:

- *Everyone at home, nobody asks for anything* (M f 67 and Z m 72); - *Emptiness around the block. We walk masked, there is no relationship, we didn't sing on the balconies* (laugh) (A m 76); - *Just "good morning"* (T f 70); - *Relationships have cooled down, everyone is sitting in their nest. It's normal to talk about nothing over a fence. I don't want to talk about lonely people's diseases to lonely people* (J f 70); - *We're next door but not together, the social distance has turned into a reserve* (E f 69).

The social relations shown by the media turned out to be fascinating for the respondents. They were ambivalent in assessing reality:

- *Young people felt they could help and that's a good thing. And the older generation has dressed up in the shell of fear of contact with others* (J f 70)*; - The youth mobilized, there was neighborly support, neighborly help* (D f 79); - *Good committed attitudes have emerged, and, on the other hand, wicked people who wanted to get rich on human harm* (K f 75); - *A scandal connected with masks, even a crime, making money from human suffering is wicked* (E f 69); - *The bad states are revealed, everyone is swept under him* (Z m 72); - *People have become nervous, malicious and aggressive towards other people, fear of getting sick and dying triggers hostility* (Lu f 64); - *There are no people in the streets. The funerals with the participation of only the closest ones were sad, and the dead and their families could not be respected. How little it takes for social life to collapse. We've been split up into countries, regions, atomized into families, into apartments! What a fragile organism is society!* (A m 76).

Sources of knowledge and learning content from pandemic experience

Social quarantine forced a change in the organization of time and daily tasks. People deprived of access to places where they spent their time had to find replacements. The quick response was to move cultural, entertainment and educational activities to the Internet. In this way, everyone who had access to the Internet could read the e-book, read press articles for free, watch selected theater performances, virtually visit the museum, and participate in a concert online. During the isolation, the offer of popularizing and educational activities was expanded. Interesting lectures, discussions, meetings were held live, on the laptop screen, many of them could be played back afterwards.

Most of the narrators were very active people, using the offer of U3A, cinema and theater. For them, lockdown turned out to be a difficult experience: - *I froze my interests. I don't like indirect forms. To survive, I have to go out, be with people. I stood over the cliff. I stepped back, looking for a safe place for my own existence. We can walk safely for a while, but we cannot go forward, because there is an abyss…* (E f 69).

For many, their primary sources of knowledge were television and the Internet, understandable under the pandemic closure: - *I followed what the WHO recommended* (S f 65). For laymen there is a danger here, because the Internet is full of various contents, and expert knowledge is not easy to find and understand [8, p. 8]. Some pointed to preventive information spots, others to interviews with specialists, thematic programs, also on foreign television: - *I am amazed at the irresponsibility of some societies, such as people from the USA, and at the consequences!* (A m 76). They searched the web for content related to health, nutrition, hygiene, and physical condition: - *I am looking for nutritional advice on YouTube,*

in Facebook discussion groups. If I have immunity, no COVID will win against me. The disease can be kicked out of the body (T f 70).

Some people avoided the mass media to minimize stress: - *I couldn't focus on TV, if there is information, it shows the coffins, then why shout "don't panic" later?* (J f 70); - *I watched a movie about China on the Internet, it was very instructive, I experienced it very much. In Italy, the enormity of these coffins, families who could not say goodbye to their loved ones* (Li f 69).

Respondents read a lot and used home resources for entertainment: - *I reduced my anxiety by reading books* (J f 70); - *I read books, I don't fall asleep without reading. I choose literature according to the author, I finish one, I start getting to know the next* (Lu f 63); - *I read, I reached for new literary genres. Crosswords, calling friends in Paris, is a conversation exercise* (E f 69); - *I have a huge collection of books at home, I have plenty to choose from* (A m 76); - *Internet, crosswords, books, I read a lot, I have my own series, I'm not bored* (D f 79); - *I will read something, write something, solitaire games, search on Facebook* (K f 75).

Resilience

The interviewees used various strategies of coping with stress, taming the threat, and reducing anxiety. At first, they isolated themselves, left big cities for the countryside, stocked up disinfectants, practiced almost compulsively hygienically, minimizing the risk, consciously did not meet with their families, and undertook new activities.

Some of the behaviors were barely beyond the usual routine:

- *No changes, except that I did not go outside, I did not change my lifestyle, I only took more care of hygiene. Daily gymnastics, everyday!* (T f 70); - *Morning gymnastics, I have a job at home, I go out to the garden* (J f 70); - *The coronavirus did not harm me, it did not change the quality of life. Gymnastics, a glass of water on an empty stomach, a garden, shopping, neighborhood help. Sometimes I don't have time* (laugh) (D f 79).

Others sought peace in contemplation, prayer, and nature: - *I had my prayer, nordic walking, meetings with deer and a rosary in the forest. The Gospel says: "Shut up in your little room, pray in silence there"*[20]*. When I was denied the opportunity to participate in the sacrament, I felt bad. I returned to the Church on May 10 and cried for the whole mass. I missed it so much* (Lu f 63).

[20] Gospel according to St. Matthew: Mt 6,6: But when you pray, go into your room, close the door and pray to your Father, who is unseen. Then your Father, who sees what is done in secret, will reward you.

Loneliness was sometimes perceived as a negative state: - *I live so many months in emptiness, no one needs me, people don't talk to each other* (E f 69); - *Functioning without social ties is impossible* (A m 76).

All interviewees knew the symptoms of COVID-19. Everyone also remembered and mostly used preventive treatments such as washing hands, maintaining spacing, disinfecting touch surfaces, applying masks, etc. Half of them negatively assessed the so-called "Hours for seniors" (from 10:00 to 12:00 am), considering this innovation "stupid", "sick", "misfire", "stigmatization", "negative stigma". Some criticized the requirement to wear gloves: – *They wore gloves all day and put them everywhere. It made more sense to wash your hands. I also do not trust disinfectants, they dry the epidermis, it is better to wash your hands than to apply the dirt* (W m 60).

Interviewees with a homocentric lifestyle searched for knowledge, remaining in certain television "information bubbles". As a result, mechanisms of assimilating messages and adapting to sanitary recommendations appeared: - *We obeyed* (M f 67 and Z m 72). Some were skeptical about the government's announcements: - *I am negative about the government's information policy. I used my own experience with other types of infections, different types of flu* (W m 60); - *Complete confusion! The health minister spoke mockingly about the masks, and then a 180-degree turn! Suddenly everyone has to!* (D f 9). Others have implemented an avoidance mechanism by displacing incomprehensible and unwanted information: - *I will listen in the morning, get angry and then switch to nature films* (A m 76); - *I explain to myself that it is difficult, I feel sorry, but I do not experience it too deeply. These events are too far away* (D f 79). Not everyone was wary of fake news, crafted news, operating on the principle of a grapevine: - *There is a theory that people vaccinated against tuberculosis endure the crown better or do not get sick. And those who were starving are more resistant. And I had a bad, starving childhood* (A m 76); - *This COVID is a bull. I will refresh in the countryside, the sun, vitamin D3 give me immunity. I will not vaccinate, because it does not help. I eat celery - it's priceless. One day you have to die* (T f 70).

Culturally and socially active people indicated their relationship with U3A:

- *The U3A Management began to publish lectures and proposals for physical activities on the website. It was very good!* (A m 76); - *We call the lonely people, there are duty hours, first we call them, now they call us. There are people who linger over in their homes, lose their condition, fall over, break their hands. We introduced gymnastics via the Internet, lectures, but it's not the same. I miss U3A, education, entertainment, people* (J f 70).

It was not known how long the isolation would take. So there was a need to find new solutions, new resilience strategies (coping). Some people deprived of access to places

where they spent their time found substitutes: - *I don't miss U3A, there are more important things* (Li f 69); *We're fine with each other, we drink coffee in the afternoons (*M f 67 and Z m 72). Others organized their time, providing cultural entertainment other than in the pre-pandemic times: - *On Netflix, my daughter and I used to watch TV series after dinner, legs up high, a laptop between us, home cinema, every night!* (Lu f 63).

In the media space, humorous memes, witty texts, tragicomic jokes and anecdotes appeared. There were also those who undertook new types of activities. When in the Internet appeared the so-called wave of "challenges" #hot16challenge2[21], one of the people I got in touch with. This person, who performed in the vocal group of The Senior Singers, did not agree to the interview, but gave me his own recording. With her consent, I provide the content of the song translated into English by the granddaughter of Ms Maria Kramarczyk:

For three months been sitting in my house
Separated from my culture
The people that surrounded us
Are being distanced from us, too
I'm waiting for it to end
But the view is not comforting
Now it's rapid unfreezing
Because elections are on the horizon
What I dearly love doing
I can't now because of covid
Medicine is powerless
Against the disease bending us over
All the respect to health service
For caring for us in these hard times
We wont surrender to no one
Though they're trying to make fools of us
We'll free ourselves from this violence
Because we're still full of Power Maria Kramarczyk, #hot16challenge2 [20]

Desires, values

In conversations about the new quality of life, the theme of everyday needs and desires was discussed. All the narrators pointed to the need for safety, security of living conditions,

[21] Hot16challenge2 is the challenge of recording 16 rap lines and nominating more people to create their song in 72 hours. Both nominees and fans were able to donate money to help healthcare professionals fight the corona virus.

risk avoidance: - *I'm getting to risk avoidance* (J f 70); - *COVID has not changed anything for me and let it stay that way* (D f 79); - *I have objections about the functioning of the non-COVID health service, you can't find a doctor in the clinic, scandal* (E f 69). Many indicated the need for a bond, belonging to a community: - *People want to meet, they miss social contact, if only to be able to talk* (Li f 69)*;* - *People need closeness, conversation, cooperation, exchange of experience, appreciation* (J f 70). The importance of the family was most strongly emphasized: - *Family above all, their safety above all* (S f 65); - *The family is the most valuable and the surest value* (J f 70).

Several people have indicated their contribution to building social order: - *I have a hobby - work* (S f 65); - *I feel good at work, I love it* (M f 67); - *When there is no goal, when there is nowhere to go out, you don't want to live* (K f 75); - *I prepared materials for U3A students* (J f 70)*;* - *We updated the website of our U3A* (Lu f 63).

Some postponed the realization of plans and dreams for "someday": - *I was thinking of going to Italy for my 70th birthday - but will I live?* (E f 69); - *We had a trip to St. Petersburg and Moscow recorded in U3A, the advances were paid and it didn't work out. But if Allah and health permit, I will go! (*A m 76).

The messages they would like to address to others are simple: - *I'm too small to teach the world. We're running too fast, there came a moment to slow down, to remember, to stop, noticing the things of the closest* (J f 70); - *Nobody will take the knowledge from you* (S f 65)*;* - *What shall I tell the world? To wash his hands?* (W m 60); - *Remember, tomorrow is also a day!* (A m 67); - *People, be kind and sincere to each other* (Lu f 63); - *I would say - be a good person, don't hurt anyone* (M f 67); - *Respect and forbearance are important* (Z m 72); - *My values are constant, the coronavirus has not changed them, you should think about people, about the environment and not about money (*K f 75).

Several people spoke about the need to share with others: - *You have to help each other* (Lu f 63); - *Live in such a way that something remains of you, which is why I wrote my autobiography* (laugh) (A m 76).

Conclusion

Social quarantine forced a change in the organization of time and daily tasks. The pandemic, social isolation and quarantine kept us at home and triggered great emotions. Grocery stores have introduced the so-called "Senior hours". Senior clubs, U3A canceled classes and all events. Trips and events were suspended. Some workplaces, all schools and universities, parks and forests were closed. Health centers, aid institutions, doctors, pharmacies, banks have become like bastions to be conquered. Social life froze. Lockdown

was a critical event, a kind of transition, an experience difficult for the respondents. It could be expected that the elderly would not find the strength to cope with the change. That did not happen. After the initial phase of lowered mood and anxiety attitudes, they found themselves in a modified pandemic of everyday life. Fear-filled expressions characterizing their emotions from the beginning of the pandemic turned into statements reflecting the essence of individual coping strategies. I conclude that it happened because they did not have to significantly change the rhythm of everyday life, they did not have to work remotely, use public transport, or fight for economic survival. They submitted to the sanitary regime, had a sense of community in the sense of threat and a community of stress relief experiences (collective behaviour in store queues, in public transport, in public spaces).

What is encouraging - the families of the narrators proved themselves in the era of coronavirus, none of the interlocutors indicated a negative change in family relations, except for the lack of physical closeness.

The deprivation of their needs has intensified, especially in terms of bonds and belonging, contact with others, and security - avoiding risk. It has become important to be useful, needed, involved in grassroots and spontaneous pro-social activities.

The material of their unobvious learning was content made available by television and searched on the Internet. All the interlocutors were Internet and social networking users. It was a matter of time when their socio-cultural activity would move to electronic media. They were looking for knowledge and entertainment, social contacts, communicating with families and friends. Thus, electronic technology has become a factor that mitigates their physical isolation, social distance. But the pandemic "house arrest" annoyed the majority, it caused intrusive and gloomy thoughts and sleepless nights. The interlocutors wanted to go back to the activity before the epidemic restrictions.

It can be concluded that the experience of pandemic closure did not significantly affect the attitudes and needs of those involved in the study. Resistance strategies proved to be similar, due to sanitary recommendations. However, they had an individualistic trait, especially when it comes to the emotional sphere. The narrator value system has not changed. Conviction of the interviewee: - *For our generation time has stopped, we will not develop, there is no point in waiting!* (E f 69).

There are no patterns or typologies in this research paper. There are examples of individual approaches to the problem of social isolation, extending competences necessary in pandemic (non)daily life.

References

1. Błachnio A., *Potencjał osób w starości. Poczucie jakości życia w procesie starzenia się* [Potential of people in old age. Sense of quality of life in the aging proces]. Wydawnictwo Uniwersytetu Kazimierza Wielkiego, Bydgoszcz 2019.
2. CBOS News, *Poczucie zagrożenia epidemicznego w drugiej połowie czerwca* [The feeling of an epidemic threat in the second half of June], No. 22/2020.
3. Dubas E., Uczenie się z własnej biografii jako egzemplifikacja biograficznego uczenia się [Learning from your own biography as an exemplification of biographical learning], *Nauki o Wychowaniu. Studia Interdyscyplinarne* [Educational Sciences. Interdisciplinary Studies], No. 1(4)/2017, p. 63-87. DOI: 10.18778/2450-4491.04.05
4. Fabiś A., *Troski egzystencjalne w starości. Ujęcie geragogiczne* [Existential worries in old age. Geragogical approach], Wydawnictwo Naukowe Uniwersytetu Pedagogicznego w Krakowie, Kraków 2018.
5. Galetta A., *Mastering the semi-structured interview and beyond. From research design to analysis and publication*, New York, NY: New York University Press, 2013.
6. Horowski J., Education for Loneliness as a Consequence of Moral Decision-Making: An Issue of Moral Virtues, *Studies in Philosophy and Education* 2020. https://doi.org/10.1007/s11217-020-09728-7
7. John Paul II, *General Audience:The Meaning of Man's Original Solitude*, 1979 http://www.vatican.va/content/john-paul-ii/en/audiences/1979/documents/hf_jp-ii_aud_19791010.html
8. Jarynowski A., Wójta-Kempa M., Płatek D., Czopek K., 2020, Attempt to Understand Public-Health Relevant Social Dimensions of COVID-19 Outbreak in Poland, *Society Register* 4(3), p. 7-44. https://www.researchgate.net/publication/340504841_Attempt_to_Understand_Public_Health_Relevant_Social_Dimensions_of_COVID-19_Outbreak_in_Poland
9. Kvale S., *Prowadzenie wywiadów* [Doing Interviews]. Wydawnictwo Naukowe PWN, Warszawa 2010.
10. Livingstone D.W., Adults' informal learning: definitions, findings, gaps and future research, *WALL Working Paper* No. 21, 2001. https://tspace.library.utoronto.ca/bitstream/1807/2735/2/21adultsinformallearning.pdf
11. Livingstone D.W., Exploring the icebergs of adult learning. Findings of the First Canadian Survey of Informal Learning Practices, *WALL Working Paper* No.10/1999. https://tspace.library.utoronto.ca/retrieve/4451

12. Nguyen US.D.T., Quach L., Tran T.V., Social Stress. In: Gu D., Dupre M. (eds) *Encyclopedia of Gerontology and Population Aging*, Springer, Cham. 2020. https://doi.org/10.1007/978-3-319-69892-2_513-1
13. Szarota Z., Senior Policy in Poland: Compensation of Needs and Active Ageing, *EXLIBRIS Biblioteka Gerontologii Społecznej / Polish Social Gerontology Journal*, No. 2(10)/2015, p. 99-112. https://www.researchgate.net/publication/337545594_Senior_Policy_in_Poland_Compensation_of_Needs_and_Active_Ageing
14. Szarota Z., Uczenie się starości [Learning to age], *Edukacja Dorosłych* [Adult Education] Nr 1 (72)/2015, s. 23-36.
15. *Ustawa z 11 września 2015 r. o osobach starszych* [Act of 11 September 2015 on the elderly], Dz. U. 2015 poz. 1705.
16. Virag M., Nemeth D., The negative relationships between executive functions and implicit learning, In: *Starość, jak ją widzi psychologia* [*Old age: The view from psychology*], WAM, Kraków 2016, p. 281-290.
17. Wałejko M., Samotność a osamotnienie - Osobowe stany egzystencjalne człowieka. Analiza etyczno-metafizyczna [Loneliness and Solitude - The Personal Existential States. An Ethical and Metaphysical Analysis], *Roczniki Nauk Społecznych* [Annals of Social Sciences] 2/2007, p. 45–66.
18. Yu J., Lee T.M.C., Social Isolation. In: Gu D., Dupre M. (eds) *Encyclopedia of Gerontology and Population Aging*. Springer, Cham. 2019. https://doi.org/10.1007/978-3-319-69892-2_422-1
19. Drozdowski R., Frąckowiak M., Krajewski M., Kubacka M., Luczys P/, Modrzyk A., Rogowski Ł., Rura P., Stamm A., *Życie codzienne w czasach pandemii. Raport z drugiego etapu badań* [Everyday life in times of a pandemic. Report on the second stage of research], UAM, Poznań 2020. https://www.academia.edu/43755026/%C5%BBYCIE_CODZIENNE_W_CZASACH_PANDEMII_RAPORT_Z_DRUGIEGO_ETAPU_BADA%C5%83_WERSJA_PE%C5%81NA_?email_work_card=abstract-read-more
20. #hot16challenge2 https://www.youtube.com/watch?v=_sAdw0DIw4U&feature=share&fbclid=IwAR1oGplpkjxZm2008SvmrD8nQKN5oPcuDpBVFFV3dJRNcPZNXetqXkH13cc

Marvin Formosa, Online learning for older persons during the COVID-19 pandemic: The good, the bad and the ugly

Introduction

Since the identification of the first COVID-19 case in Wuhan, China, in December 2019, one witnessed a steady output of academic articles on the pandemic's wide-reaching impacts. An area that received much global attention constituted that interface between COVID-19 and later life. This was far from surprising since COVID-19 proved to be a very serious viral infection for persons aged 80 and over. Literature underlined the pandemic's deadly effect among frail older persons, and how nursing homes for older persons became hot incubators for the coronavirus, as more than half of all COVID-19 deaths in many countries occurred amid residents in long-term care facilities [1]. Other research demonstrated how the COVID-19 pandemic accentuated the exclusion of and prejudice against older adults, as the health crisis led to a disturbing public discourse about ageing that questioned the value of older adults' lives and their valuable contributions to society [2]. Moreover, as most governments prohibited older persons from leaving their residences unnecessarily and barred extended family gatherings, much attention was focused on social isolation and loneliness experienced by older adults, and the resulting impact on their emotional wellbeing [3].

The study reported herein seeks to continue contributing to the knowledge relating to the impact of the COVID-19 health emergency situation on the quality of life and wellbeing of older persons by focusing on older adult learning - which refers to the process in which older adults, "individually and in association with others, engage in direct encounter and then purposefully reflect upon, validate, transform, give personal meaning to and seek to integrate their ways of knowing" [4]. Literature on lifelong learning lists a range of motivational factors inducing participation, but in later life most enrolment stems from the meeting of coping and expressive needs, as many older persons seek to adjust to decreasing physical and social capital, retirement, widowhood, pursuing knowledge for its own sake, and personal developments [5]. This article reports on qualitative research study at the University of the Third Age (U3A) in Malta which, on 12 March 2020, was legally mandated to cease all its classroom-based education, and which instantly took the decision to adopt an online learning strategy . It includes five sections. While the next section familiarises the reader with older adult learning and U3As in particular, the third part outlines briefly the study's research design. The fourth section presents the study's results and analytic inferences regarding the

beneficial, negative and discriminatory consequences arising from this change in mode of teaching and learning. The final part highlights recommendations for the good practice of older adult learning during emergency situations that necessitate lockdown and social distancing policies.

The University of the Third Age and e-learning in later life

Universities of the Third Age (U3As) can be loosely defined as learning centres where older persons "may acquire new knowledge of significant issues, or validate the knowledge which they already possess, in an agreeable milieu and in accordance with easy and acceptable methods, with the objective of preserving their vitality and participating in the life of the community" [7]. As its title postulates, the U3A's target audience are people in the third age phase of their life course. Whilst some centres put age 60 and over as a pre-requisite for membership, others allow persons above the age of 50. The U3A movement has not only withstood the test of time but is also marked by an extensive increase of centres and members all over the globe [8].

U3As are no exception to the e-learning revolution. Although the primary scope of initial experimentation with online courses was solely to reach out to older persons who could not join their peers in the classroom-setting, such as those living in remote areas and the homebound, this stance soon changed [9]. As internet connection became a more common feature of daily living in later life (in New Zealand, Canada, Sweden, and the United States almost half the population aged 65-plus go online), and once the coming of the Web 2.0 internet revolution - with its Blogs, Wikis, Moodle, and Podcasts - brought the possibility for interactive learning to previously unimaginable levels, it became evident that virtual learning can provide a reliable and valid learning experience [10]. The first international online U3A, named U3A Online, was set up in 1998 and from the outset it had a global focus by comprising learners from Australia, New Zealand and the United Kingdom who recognised the potential of the internet for harnessing the expertise of a worldwide cadre of volunteers who would provide low cost, intellectually stimulating courses and resources for a world community of learners and other volunteers [9]. Swindell [11, 12] conducted a number of studies on possibilities and limitations of U3A Online. He found that older people, even those who live in large cities, tend to experience a sense of isolation that is often not recognised by the majority of the community. Hence, programmes such as U3A Online have the potential to make an important contribution to the wellbeing of those older persons who experience an increasing sense of isolation with age despite their living in seemingly well serviced and well-resourced communities. This overall feeling was summed up by different learners:

"Many thanks to you for my being able to enjoy what has turned out to be the most pleasurable weeks of my life…Thank you for the opportunity to work through this programme…I have really enjoyed the course and I am sorry it is over. It has inspired me to push on, further afield".

online learners, cited in [13]

Moreover, U3A Online was credited for being a smart application of internet technology for helping to bridge the grey digital divide [14]. Yet, Swindell's (11, 12) research also underlined the mistake of not initially screening participants to determine their levels of digital competencies. Since participants were required to register and e-mail some background detail, it was assumed that they would have the necessary computer skills. This supposition was, nevertheless, incorrect for about half of the registrants - and especially for less educated individuals and older persons with working-class backgrounds who tend to possess lower levels of cultural capital - as during the first few weeks of the course the tutors spent many hours providing telephone and email advice to individuals about matters like saving stories as text files and attaching files to e-mails. Even when instructions were provided some confusion remained. Indeed, four and five weeks down the line a telephone survey found that many were still frustrated about their inability to handle computer-related tasks. This indicated that even older persons who are digitally literate may face serious obstacles in accessing a virtual learning programme.

Recent studies have confirmed Swindell's results as well as highlighting further barriers to virtual learning by older adults [15]. For instance, since declines in reading comprehension among older adults are related to vision problems rather than cognitive decline, e-learning designers must be aware of these sensory changes when designing courses. Guidelines that ensure that websites are age-friendly include using only sans serif fonts (e.g., 'Arial' font), using 12- or 14-point font size, using double spaced text, using left justification, avoiding patterned backgrounds, inserting text alternatives for all graphics, and using a consistent layout throughout the website. Moreover, inappropriate sequencing of courses and course features can frustration since older adults engaged in face-to-face software training generally prefer an informal structure instead of a formalised, linear class structure. Other research has highlighted how games are being used in e-learning programs [16]. However, since users of games are often forced to proceed rapidly, with less time for thought and contemplation, it follows that these types of designs could cause usability obstacles for some older adults given the declines in working memory in later life. Finally, mobile devices and mobile learning

present another set of challenges for older adults since the small displays and tiny keyboards present major usability obstacles for those older persons with dexterity problems in their hands and fingers.

Research Design

This article draws on exploratory research carried out during June 2020 when the U3A in Malta closed its doors and shifted its classroom-based education to an online learning delivery. A qualitative research design was opted for on the basis of its long and rich history in interpretative research by valuing "people's subjective experiences and how people attribute meaning to their own lives and within the broader culture" [17]. The aim of the research investigation consisted in exploring the positive and negative impacts of the change in this mode of teaching and learning on the quality of life and wellbeing of older persons attending a U3A.

The research study employed a purposeful sampling strategy to identify 'information-rich cases' on the basis that seeking the best cases for the study produces the best data. Three questions formed the crux of the interview schedule: What were the benefits and possible detriments of attending the U3A premises to take part in the learning programmes precious to the COVID-19 situation? How did you experience the change from a classroom setting to an online learning strategy? What were the advantages and disadvantages of such a change? The interviews were conducted with ten U3A members, five men and five women, with their ages ranging from 63 to 73. During data analysis, I gave enough time to myself to immerse in the data to get a sense of the information, "to stew in it, and let…ideas develop…to 'feel' the pulse of the data" [17], following which the data was analysed through open, in-vivo and selective coding strategies [18].

Results and discussion

Five days after Malta registered its first case of COVID-19 on 7 March 2020, the government announced an aggressive, 'Asian-style', lockdown [19]. All public servants, teachers and university lecturers, and most employees in the private sector began working 'from home'. All non-essential public gatherings, including church functions and sport events, were cancelled, and passenger flights in and out of the country were suspended so that Malta became totally isolated from the outside world. The only facilities exempted from such a strict lockdown included supermarkets and pharmacies. The country, one of the world's most densely populated, became strangely quiet. Traffic eased, air pollution went gone down by 50%, and public spaces became deserted . It was in such circumstances that the University of

Malta decreed its U3A to close its doors as from 15 March 2020. This did not come as a surprise since in the previous four weeks Malta was characterised by much wide uncertainty and anxiety towards the impending COVID-19 outbreak on the island. Indeed, during the previous week the number of participants had dwindled substantially, and there were constant phone calls asking whether it was safe to turn up for classes.

Following a number of virtual meetings, a decision was taken to shift all teaching and learning through the University's radio and online platforms, as from 20 April 2020. Tutors were asked to choose whether they wished to transmit their lecture via a radio broadcast or as a recorded lecture to be conveyed via an online link. While about one third of facilitators declined to participate in this new format, a decision which was fully respected, the remaining two thirds opted for radio broadcasting and online delivery in relatively equal numbers. Initially, the University asked tutors to conduct the lectures 'live' during the exact scheduling of the actual sessions, but this was found not to be possible due to the closure of primary schools, as this meant that many were suddenly borne with constant parent and grandparent care during mornings. Indeed, it is worth mentioning that even those tutors who opted to transmit their lecture via a radio broadcast had to record their session at home and send to the radio station via email attachment due to the enforced lockdown. All lectures, even the ones broadcasted via the radio, remained available on the U3A's website until the end of July 2020.

The good

Older learners at the U3A had always resisted any attempt by the University to instil a virtual learning environment. In fact, when members were asked what they gain most from their involvement in U3A activities, the first thing that they usually reported was not related to the learning activities per se but the associated social outcomes such as socialising, making new friends, having the opportunity to achieve personal growth, and finding a support group which helps them through difficult periods in their personal life. However, it was positive to note that this time around the U3A members understood fully the necessity and logic for going virtual, and even applauded the U3A for providing them with alternative learning mediums rather than simply closing the classrooms. In their own words,

> *I was never in favour of online learning and never will be. Yet, given the circumstances, this was the right decision. I thank the U3A for having gone into such trouble. I am sure that it was not easy, but it was the right thing to do, and we are benefitting from it.*
>
> male U3A member, 67 years old

Learning via the computer or the radio is not ideal, but it is better than nothing, and the U3A is trying its utmost, we appreciate that, the most important thing is that we are not left idling away, staring aimlessly into space, especially when we are locked down.

female U3A member, 69 years old

Respondents also commented that this new form of teaching and learning regaled them with much needed flexibility. They highlighted how accessing the lectures via either the radio or internet allowed them to participate in high-quality learning opportunities at their convenience which allowed them to juggle jobs, family caregiving, physical activity, and learning schedules without conflicting timings. As they claimed,

This is very convenient. As it stands now, with all the lectures available on the internet, I do not have to plan my life around the opening times of the U3A. Rather, I can now decide which two hours best suit my learning interests.

female U3A member, 71 years old

I admit that there are many advantages of having all the lectures available at a click of the mouse. I wake up very early in the morning and I can now use this time productively. I choose at what time I learn. This is very good. I lead a very busy life.

male U3A member, 65 years old

Many celebrated the fact that now they had the opportunity to reread a lecture or take more time to reflect on some 'difficult' material before moving on to the next lecture. Interestingly, some learners enjoyed the anonymity that online learning provides. They claimed that discriminating factors such as age, physical appearance, disability, and gender became largely absent, and instead, the focus of attention was clearly on the content of the study-unit and the individual's ability to contribute thoughtfully to the material at hand. As some emphasised,

The best thing about all this is that you can listen to the lectures more than once. Sometimes, I do not always understand what the tutor is trying to explain, and need some time for the information to sink in, this is splendid for me.

female U3A member, 73 years old

Listening to the lectures is beneficial because you do not lose time going to the venue. I am also very self-conscious and feel anxious in large groups. I feel much more comfortable learning over the internet. My favourite teacher is youtube [laughing].

female U3A member, 68 years old

Finally, respondents claimed that while at first it was a much tougher challenge accessing the lectures, rather than just turning up in the classroom and sitting passively listening to the tutor, in the long run such an experience enabled them to reach higher levels of digital competence and creativity. This occurred as they mastered the location of the right radio channel and understanding how internet links work, learning how to navigate online platforms, and sending emails to either the U3A's administration, tutors or classroom members:

They say that 'necessity is the mother of invention', and it is true. I could not figure how to use the internet or send an email just a few weeks ago. Now, look at me! I manage to do all that is required from me. I feel good. I feel in touch with [the year] 2020.

male U3A member, 73 years old

It is thus clear that online learning has the potential to boost older persons' self-esteem and locus of control as they mitigate against the old adage that 'old dogs cannot learn new tricks!'.

The bad

Despite the positive responses appraised in the previous section, it was clear that the shift towards embedding the U3A in an online learning programme was, at best, only a 'work-in-progress'. Indeed, older learners highlighted a number of barriers and obstacles that served to hinder an optimal learning experience. The one-way channels of radio and online transmissions resulted in no dynamic interaction between tutors and learners, and among the learners themselves. Within such an online synchronous discussion structure, the learners were not able to reflect and assert themselves on comments made by the tutor, or fellow learners, before the tutor moved on to the next item on the educational agenda. Hence, learners had no opportunity to articulate responses with much as much depth and forethought as in a traditional face-to-face educational situation:

This mode of learning provides you with no opportunity to add to the lecture or to ask a question. We have so many interesting discussions when we meet physically in class but now it is like watching a television programme.

female U3A member, 64 years old

We have always been told that our life experience enables us not only to participate in the learning taking place but also contribute. All tutors tell us how much they not only enjoy this experience but that they also learn a lot from us during the course of the discussion. This is all impossible now.

female U3A member, 68 years old

Moreover, respondents pointed out that at most times they found it difficult to be motivated in checking in, or even to want to switch on the computer or radio to listen to the tutor's presentation. Many found this form of learning artificial, "extremely robotic" to cite one interviewee, devoid of the human contact and social spirit that U3As are so renowned for. While the early sessions were listened to relatively rather attentively, without ever missing a meeting, in due course it became increasingly difficult to maintain such motivation and interest as the novelty wore off and tutor's presentations became more monotonous and predictable:

I must admit that after two or three weeks, I was no longer interested in switching on either the radio or computer. I could not bring myself to listen to the tutors simply describing some subject without any interaction from learners. We have the television for that. This is not how the U3A should be!

male U3A member, 63 years old

The new online learning format also meant that there was less opportunity for learners to get in touch with tutors to either ask questions or deliver comments. Although learners admitted that this could be accomplished by sending an email, such a mode of communication was not face-less and unnatural, but sometimes tutors either took long to reply or never responded at all. This was very wearisome and frustrating for some learners:

Everybody had the same complaint. The availability of tutors! You cannot reach tutors easily over the radio and the internet, especially when the sessions are

recorded. Some of us do not know how to email, and some tutors were not replying to our emails. I know that it was a difficult time for everybody, but if we cannot communicate with tutors, then the whole purpose of the U3A falls apart!

female U3A member, 73 years old

An analogous issue raised by interviewees revolved around the difficulty to interact with fellow learners. Since there was no physical classroom there was no opportunity to greet and catch up with friends in a face-to-face environment, and therefore, extremely problematic to maintain old and build new social relationships. As a result, many claimed that this online learning strategy made them feel isolated from their peers, and that they felt lonely in front of either their radios or computers:

Many U3A members did not even bother to switch on the radio or computer. Many do not attend to simply listen to the lectures. Many attend the U3A to catch up with friends and even make new ones. Many become members because of the social outings. I am not saying that they do not care about the classes but that the U3A is more than an educational organisation. It is a social experience. Remember, older people need social and intellectual stimulation.

female U3A member, 69 years old – emphasis in italics

I am sure that the intentions were good but this is very, extremely, boring. More than boring, one feels isolated in front of computers. It is true that you are given an opportunity to exercise your mind, but the U3A was never invented to exercise minds in isolation, the human touch is necessary, and with online learning this is completely missing.

male U3A member, 69 years old

Finally, it also resulted that many U3A members experienced complications in following online sessions as they had difficulties staying connected at all times, either because their internet was unreliable or slow, or due to outmoded computers. Some also had sudden malfunctions in their computer, and due to the COVID-19 health emergency situation, it was not possible to get it fixed before the finish of the academic year. This meant that when online learning is deployed, older learners may suddenly find themselves cut off from the virtual classrooms due to technological hiccups which may take weeks to be resolved without a solution in sight.

The ugly

This final sub-section focuses on specific negative factors that were relatively discriminatory and biased towards either a particular sector or all U3A members. The first point considers the issue of 'equity and accessibility'. Prior to the commencement of the online learning programme, the U3A neglected to launch an exploratory survey to discern how many members had access to the internet. Consequently, the shift to online learning excluded those members who had no access, whether for economic or logistic reasons, to an online network. As interviewees emphasised, this was especially a concern with respect to older women and other learners living in rural and households experiencing risk-of-poverty lifestyles. The second concern refers to the issue of 'digital illiteracy and incompetency'. Again, no preliminary analyses were conducted by the U3A to ascertain the extent that learners possess the minimum required level of computer knowledge to master successfully an online learning environment. Since a certain degree of technological knowledge is required to follow a virtual learning programme, many learners who did not know how to operate computers or the internet found themselves unable to continue the learning journey. As aptly articulated by three research respondents:

> *There were a lot of assumptions being made. Most importantly, and this is where the U3A got it wrong, that everybody had access to a computer. This is not correct, there are many older persons, especially widows, who do not possess a computer.*
>
> female U3A member, 71 years old

> *It is true that we are living in the year 2020, where the computer and the internet is something that we take for granted. But this is not the case in later life. Many of my friends, I am referring to women here, computers were bought by their husbands, and they do not have access to such machines.*
>
> female U3A member, 73 years old

> *It was a bit too much expecting us to master the computer almost overnight with no training whatsoever. Many could not follow the lectures because they did not know how to use the computer. This highlights the urgent need for further training programmes in information and communication technology for older persons.*
>
> male U3A member, 73 years old

At the same time, the U3A did not ascertain itself whether tutors who opted to transmit their learning via the online medium were knowledgeable in virtual instruction. Since the tutors were not properly trained in online delivery and methodologies, this certainly compromised the success of virtual learning programmes, since one must ensure that tutors are able to communicate well in writing and use language before launching an online learning strategy. Most importantly, an online tutor must be able to compensate for the lack of physical presence by creating a supportive environment where all learners feel comfortable participating. Yet, interviewers stated that this was far from the case, and that a good number of tutors acted no differently than if they were presenting their material in a face-to-face classroom environment:

> *We expected a different teaching format than what we were used in the classroom but it was exactly same, and in some respects, even worse as it was evident that some tutors were not knowledgeable as how to use the virtual environment to their advantage. They just lectured to the camera or their laptop rather than to us. They also need training in the possibilities and limitations of teaching in a virtual learning environment.*
>
> male U3A member, 69 years old

Finally, interviewees noted that as the online learning strategy took its run, it became clear that some subjects are very difficult to be taught online because a virtual medium may not permit the best suited method of instruction. For example, there is no doubt that hands-on subjects such as public speaking and photography, where physical movement and practice contribute to the achievement of the learning objectives, are best taught in a face-to-face traditional learning environment. Just because it may be technologically possible to simulate a physical learning experience in a virtual environment, this does not necessarily mean that the learning objectives and outcomes will be equally achieved. Indeed, one cannot have the same curriculum serving for both physical and virtual learning environments, since what is successful in the former arena will not always translate to a successful online program where learning and instructional paradigms are quite different. Whilst a hybrid teaching and learning programme represents a potential solution to this problem, this was not possible in the midst of the COVID-19 health emergency situation.

Conclusion

Three key deductions may be derived from this study. First, despite the fact that older learners generally resist any attempt by educational providers to shift from a face-to-face classroom environment to a virtual learning setting, in times of crises (such as the COVID-19 pandemic) they do understand and accept the necessity and logic underlying such a change of strategy. Older learners may approach virtual learning with a level of mistrust at the beginning but in due course will experience a number of benefits. This study found that older learners relished a virtual learning environment for its flexibility potential as it allowed them to juggle jobs, family caregiving, physical activity, and learning schedules without conflicting timings, opportunity to reread a lecture or take more time to reflect on some 'difficult' material before moving on to the next lecture, as well as mitigating against discriminating factors such as age, physical appearance, disability, and gender. Virtual learning also has the potential to boost older persons' levels of self-esteem and locus-of-control as they found themselves improving their mastering of the internet, email communication and online learning platforms. As Swindell [11, 12] found out, this research supports the benefits of e-learning environments in later life by making important contributions to the social and emotional wellbeing of older persons as it attributes them with a new sense of purpose and excitement in their lives, and helping to bridge the grey digital divide by motivating older persons to reach better levels of digital competency so as to be able follow the online learning classes with profit.

Secondly, the shift from a face-to-face classroom environment to a virtual learning setting is neither straightforward nor simple. Unless this shift is carried out under the supervision of e-learning specialists, the learning environment may result in no dynamic interaction between tutors and learners, and among learners themselves, so that the latter will have no opportunity to articulate responses with as much depth and forethought as in a traditional face-to-face educational situation. Moreover, it may result in low of levels of motivation for potential learners to participate, especially if the tutors' presentations are no different to those portrayed in face-to-face classrooms, and if there is less opportunity for learners to get in touch with tutors to either ask questions or deliver comments. In the wrong hands, an online learning environment may actually be counterproductive to the initial aims of the U3A Online as the difficulty for learners to maintain old and build new social relationships may make them feel isolated from their peers and lonely in front of either their radios or computers. Moreover, this study showed that despite the two decades of experience in online learning for older persons the same mistakes continue to subsist. For instance, while the Maltese U3A failed to pre-screen participants to determine how many members had access to the internet and the extent that they possess the minimum required level of computer knowledge to master successfully an online learning environment, no attention was made to

the sensory changes when designing courses so that the electronic information being sent and shared uphold the principles of age-friendly digitalisation by using fonts and colours well-defined and sharp enough for older persons.

Finally, one cannot fail to mention that any efforts to implement educational programmes during the COVID-19 pandemic through the online media, included the trial reported herein, met a range of obstacles due to the pressing issue of digital exclusion. Since the very beginning of the lockdown, the gap between those with good and available internet connection, and between those owning electronic devices and others lacking such tools (which have suddenly become essential goods), was apparent. As COVID-19 spurred many more people to use the internet in new ways compared to before the outbreak, it has also further exposed and deepened the divide between the digital haves and have nots [20]. Indeed, many U3A members experienced complications in following online sessions as they had difficulties staying connected at all times, either because their internet was unreliable or slow, or due to outmoded computers. Some also had sudden malfunctions in their computer, and due to the COVID-19 health emergency situation, it was not possible to get it fixed before the finish of the U3a academic year. This meant that when online learning is deployed, older learners can suddenly find themselves cut off from the virtual classrooms due to technological hiccups, that may take weeks to be resolved without a solution in sight. To mitigate against such lacunae, this article recommends the following four principles of good practice for online learning in later life: (a) making provisions for older persons who are not online by ensuring that in the event of future lockdowns one finds ways of directly contacting those individuals who are not able to leave their home; (b) ensuring that technology is accessible so that hardware and software can be used by as many people as possible, regardless of environment, device being used, age, social class, gender, digital competence and/or cultural background; (c) providing equipment and internet access by working to expand access to broadband, data packages, and to computer and ICT packages, in particular for individuals and families on low incomes who are most likely to be digitally excluded; and (d), investing in skilling older persons in digital competencies since simply providing access to equipment and the internet will not be effective if people cannot use the technology or if they see technology as a barrier [20].

References

1. Ayalon, L., Zisberg, A., Cohn-Schwartz, E., Cohen-Mansfield, J., Perel-Levin, S., Bar-Asher Siegal, E., Long-term care settings in the times of COVID-19: Challenges and future directions. International Psychogeriatrics, 32 10/(2020), p. 11239-1243.
2. Previtali, F., Allen, L.D., Varlamova, M., (2020): Not only virus spread: The diffusion of ageism during the outbreak of COVID-19. Journal of Aging & Social Policy, 32 4-5/(2020), 506-514.
3. Berg-Weger, M., Morley, J.E., Loneliness and social isolation in older adults during the covid-19 pandemic: Implications for gerontological social work. The Journal of Nutrition, Health & Aging, 24 (5)/2020, p. 546-58, 2020.
4. Mercken, C., Education in an ageing society. Odyssee, Baarn, Netherlands, 2010.
5. Formosa, M., Third age learning for active ageing: The Maltese experience. In: Formosa M. (ed), The University of the Third Age and active ageing: European and Asian-Pacific perspectives. Springer, Cham, Switzerland, p. 91-93, 2019.
6. National Statistics Office, Regional statistics Malta. National Statistics Office, Malta, 2020.
7. Midwinter, E., Universities of the Third Age: English version. In: Midwinter E. (ed), Mutual Aid Universities, Croom Helm Limited, Kent, United Kingdom, p. 3-19, 1984.
8. Formosa, M., Active ageing through lifelong learning: The University of the Third Age. In: Formosa, M. (ed), The University of the Third Age and active ageing: European and Asian-Pacific perspectives. Springer, Cham, Switzerland, p. 3 -18, 2019.
9. Formosa, M., Four decades of Universities of the Third Age: Past, present, and future. Ageing & Society 34 (1)/(2014), p. 42-66.
10. Moreira, T., Science, technology and the ageing society. Routledge, London, 2016.
11. Swindell, R.F., U3A without walls: Using the internet to reach out isolated people. Education and Ageing. 15 (2)/(2000), p. 251-263
12. Swindell, R.F., U3A Online: a virtual university of the third age for isolated older people. International Journal of Lifelong Education, 21 (5)/(2002), p. 414-429.
13. Swindell, R.F., Vasella, K., Older learners online: An evaluation of Internet courses for isolated older persons. Griffith University, Brisbane, Australia, 1999.
14. Swindell, R.F., Grimbeek, P., Heffernan, J., U3A Online and successful aging: A smart way to help bridge the grey digital divide. In: Soar, J., Swindell, R.F. & Tsang, P. (eds), Intelligent technologies for bridging the grey digital divide. Information Science Reference, New York, p. 122-140, 2011.

15. Formosa, M., Educational gerontology. In: Gu D. & Dupre M. (eds), Encyclopedia of gerontology and population ageing. Springer, Cham, Switzerland, 2019c. https://doi.org/10.1007/978-3-319-69892-2_411-1
16. Formosa, M., University of the Third Age. In: Gu D. & Dupre M. (eds), Encyclopedia of gerontology and population ageing. Springer, Cham, Switzerland, 2019d. https://doi.org/10.1007/978-3-319-69892-2_412-1
17. Leavy, P., Harris, A., Contemporary feminist research from theory to practice. Guilford Press, New York, 2019.
18. Strauss, A., Corbin, J., Basics of qualitative research: Techniques and procedures for developing grounded theory (2nd ed.). Sage, Thousand Oaks, California, 1998.
19. Baldacchino, G., Coronavirus and Malta: Weathering the storm. The Round Table, 109 (3)/2020, p. 322-323.
20. Ipsos MORI, The Centre for Ageing Better. The experience of people approaching later life in lockdown: The impact of COVID-19 on 50-70-year olds in England. Centre for ageing better, London, 2020. https://www.ageing-better.org.uk/publications/experience-people-approachinglater-life-lockdown-impact-covid-19-50-70-year-olds

GRANDPARENTS RAISING GRANDCHILDREN DURING THE CORONAVIRUS PANDEMIC - A CHALLENGE OR A THREAT?

Introduction

Coronavirus, an epidemic that has caused a world of constant change, time pressure, and deepening social diversity to slow down and stop overnight. People began to view the world from the perspective of danger and the accompanying sense of loneliness and disorientation.

Grandparents raising their grandchildren found themselves in a particularly difficult situation. In a period of ongoing social isolation, they struggled with the consequences of being cut off from the surrounding world, but also with fears resulting, among others, from the fact that they, as elderly people, are most at risk from the coronavirus. Various problems arose with the daily changes in their lives: tasks to be carried out and questions about the future and fate of their grandchildren in a situation where their grandparents' health and life were at risk. Under these circumstances the basic human needs of the grandchildren's guardians, such as a sense of stability and security, have been significantly impaired. In the face of an unexpected threat that caused another change in their daily lives (the previous one took place when they took over the care of their grandchildren), problems related to the grandparents' sense of identity intensified. It is clear that in such a situation, the very distinction between roles ("being" both a grandparent and a parent) can result in complex experiences. All the more so because, as Hooyman and Kiyak claim, the role played by adults is "related to a specific age or stage of life" [9 p. 256]. Therefore, it would be worth considering what happens when grandparents engage in educating the young generation and once again take on the roles that are a repetition of earlier stages of their lives. Role identity theory, on the other hand, suggests that having several identities that are related to each other through shared meaning and simultaneous performance may cause some dissonance [2]. In the case of grandparents raising their grandchildren, the dissonance will be created by the question: "who am I actually? A grandparent or a parent again?" How, then, do they perceive their life situation and what difficulties do older people encounter in the context of 'being' a parent again?

One of the key factors contributing to the difficulties grandparents face in raising their grandchildren may be the expectations set for them, because, as Hooyman and Kiyak argue, "age changes not only the roles expected of people, but also the ways in which they are

expected to play them" [9 p. 257, 10]). Therefore, a younger parent has greater social consent for a certain degree of freedom in matters of upbringing, resulting from the social perception of young people as less competent and inexperienced. On the other hand, it is expected of grandparents that, based on their previous experience, they will easily cope with the "new, yet old" role of a parent. Social expectations become especially important when we try to understand the intricacies of having to adapt to new conditions in the context of the challenges and threats that arise from major events we are dealing with at any given time, such as the coronavirus pandemic. From the moment they take over the care of their grandchildren, grandparents are constantly caught up in various problems and tasks to be accomplished. The moment when they became guardians of their grandchildren has changed the course of their lives, causing a profound shift [1, 8, 10, 14], which only intensifies in a situation of forced isolation. The purpose of this article is to present the factors that determine the nature of the living situation of grandparents raising grandchildren during the pandemic. In the context of our research, it was also important to find out whether the situation is perceived as a challenge or threat. The theoretical basis of the study was the concept of social anchoring, which can explain the processes that stabilize the position of people in the face of a change that, in this situation, was brought about by the coronavirus pandemic.

The article consists of three parts. The first presents the theoretical perspective on the concept of social anchoring. The second one presents the research methodology. The main part of the article is a presentation of an analysis of the results of research into the factors determining the nature of the living situation of grandparents raising grandchildren during the coronavirus pandemic.

Theoretical perspective

The concept of social anchoring was used as the theoretical basis for the presented research. In literature, it is most often brought up when discussing issues of migration in relation to the adaptation and integration of migrants. However, in the presented study, the concept of social anchoring refers to the process of grandparents adapting to the changes caused by the appearance of the coronavirus. The factors that emerged in connection with the pandemic and which grandparents raising their grandchildren had to contend with are multi-layered [15]. The described concept, as noted by A. Grzymała-Kazłowska [5, 6], can be helpful in discussing changes related to the issues of identity, social bonds, and looking for points of support in order to achieve stability in life and rebuild a sense of security.

Social anchoring is defined as an individual's search for "points of reference and support that are important to them - anchors that allow them to achieve relative psychosocial

stability in a new situation (...) and form a basis for psychological and social functioning" [7 p. 53].Importantly, according to the author, the search for anchoring is particularly visible in situations of profound change, as well as in the face of crises and limit experiences. Such events include taking over the care of grandchildren by grandparents, which is becoming more and more common all over the world [13], as well as problems that arise from providing care during the coronavirus pandemic.

Among the various types of anchors, we can list those that are subjective and internal, which include, among others: the personality traits of an individual, individually professed ideas and values, as well as objective and external ones, which include legal and institutional (e.g. legal status, using the help of formal institutions), economic (e.g. material resources), and spatial-environmental (eg. place of residence). There are also mixed type anchors related to socio-professional roles (e.g. family roles), ones position in the social structure and group affiliation, as well as anchors embedded in culture (e.g. cultural messages, norms, and values) [7 p. 54].

As Grzymała-Kazłowska [4] points out, anchors are flexible and therefore susceptible to change, which means anchoring is a dynamic process. Therefore, with the passage of time or the appearance of new changes in one's life, some of them may weaken or even be destroyed, while new ones appear in their place. Therefore, the concept of social anchoring seems promising when trying to analyse the factors determining the situation of grandparents raising grandchildren during the coronavirus pandemic. Since the outbreak of the pandemic and the emergence of stay-at-home orders, the situation of children and grandparents caring for them has changed dramatically. The constant need to stay at home together has created new challenges for grandparents who are the primary caretakers of their grandchildren. Moreover, in this situation, it is necessary to identify grandparents' support points, showing the spheres in which they can "cast" their anchors.

Research methodology

This paper focuses on the factors determining the nature of the situation of grandparents raising grandchildren during the coronavirus pandemic. In order to obtain information for the research, the qualitative method of case study analysis was used, involving partially structured individual in-depth interviews. This method makes it possible to obtain in-depth knowledge about the situation of grandparents raising grandchildren during the coronavirus pandemic and to characterize the factors determining its nature. The work is based on 20 partially structured in-depth interviews with grandparents (aged 60 and over) living in the region of Podlasie, in the north-eastern part of Poland, who have been formal guardians of their grandchildren for at

least 3 years. The time spent caring for grandchildren was an important criterion for selecting the research sample, because it determined whether subjects would have obtained the experience which makes an analysis of their personal situation in the context of changes caused by the coronavirus pandemic possible.

As I mentioned earlier, the study involved 20 grandparents raising grandchildren - 14 women and 6 men. The structure of the sample in terms of age, place of origin, education, and time spent caring for grandchildren is presented in Table 1.

Table 1.

Research Sample Characteristics

gender	female N=14	male N=6
grandparents' age	60 - 65 8 subjects 66 – 70 3 subjects 71 – 75 3 subjects	60 – 65 3 subjects 66 – 70 2 subjects 71 – 75 1 subject
place of origin	rural area - 1 town up to 50,000 - 2 city between 50,001 and 200,000 - 3 city between 200,001 and 500,000 - 8	rural area - 0 town up to 50,000 - 2 city between 50,001 and 200,000 - 1 city between 200,001 and 500,000 - 3
education	primary – 1 vocational – 3 secondary – 8 higher - 2	primary – vocational – 2 secondary – 3 higher - 1
average time spent caring for grandchildren	8 years (between 3 and 15 years)	8 years (between 3 and 14 years)

Source: Own work.

The interviews were conducted at the turn of May and June 2020 at the respondents' place of residence and the average interview duration was 1,5 - 2,5 hours. The sample was selected using the snowball method. All interviews were recorded using a dictaphone, with the consent of the people participating in the study, and a review note was also prepared after each meeting. The interviews were then transcribed, which was the basis for the analysis of the collected research material.

Research results

A feeling of insecurity, loneliness, and isolation

The time of a pandemic is a period that contributed to the emergence of many changes in people's lives. In the case of grandparents raising their grandchildren, it turns out that the

period of isolation due to the pandemic was a difficult time, often referred to as a time of solitude and isolation. One of the respondents admits:

“There were times when I really thought that I would not be able to handle it all, that I was left alone with my granddaughter, her education, and all the daily chores. And I would sit down and cry, you know, from helplessness, fear, and from this feeling that I just can't handle it all."

Anna, 68, 5 years bringing up an eleven-year-old grandson, W_11

The respondents also pointed out that the pandemic only increased their anxieties and reduced their sense of security.

“These weeks of isolation have exhausted me, I thought it would all end up in depression. I had the impression that the whole world has fallen on my head in an instant. Well, because when you are left alone with all of this, you start to panic. But I am doing better now, I had to figure it out somehow. "

Krystyna, aged 63, 9 years raising her granddaughter at the age of 14, W_8

It was only in isolation that the grandparents began to wonder about their overall health and realized that they had various medical conditions that put them at greater risk of falling ill with the coronavirus. This, in turn, contributed to the emergence of a heightened sense of anxiety about the future of their grandchildren.

"From the very beginning, when the whole coronavirus began to be talked about, I was terribly afraid of what will happen. What will happen to the grandchildren if I or my wife are gone? Where will they go, who will take care of them? Will they go to some institution? And then I felt a paralysing fear, so my wife and I tried to do everything not to get infected - we disinfected everything, some things even several times, in boiling water, we did bigger shopping to limit leaving the house to a minimum."

Józef aged 72, 7 years bringing up grandchildren aged 11 and 13, W_5

“I cannot describe the horror I felt about the pandemic. My life has been turned upside down and completely changed. All because I am generally a sick person, I have hypertension, diabetes, and Lyme disease. And when I heard that I could get sick and that it was dangerous, even for my life, I didn't know what to do. Cause who would take care of the girls. And they need care and they will need it for a long time."

Jadwiga aged 62, 3 years bringing up granddaughters aged 5 and 9, W_3

People also emphasized the importance of the lack of support experienced during this period by 9 out of 20 respondents, which significantly contributed to difficulties with meeting the daily needs of both grandparents and grandchildren. In addition, many grandparents emphasized that the loss of freedom was the cause of their deteriorating well-being and even though emphasis is put on a clear decline in social contacts, replaced with individually and independently coping with the situation, research shows that the vast majority of respondents stress the role of family or friends as a factor helping them survive this difficult time of isolation.

The importance of a support group in the life of grandparents raising grandchildren is confirmed by research [3, 12], which proves that it is possible to successfully help the elderly cope with new roles and changes in their lives.

Remote education - perceptions and concerns

When analysing the situation of grandparents during the pandemic, it was important to know their feelings about the educational requirements related to remote education. It turns out that most interlocutors believe that they meet the educational needs of their grandchildren on a daily basis, but remote education and spending free time during the coronavirus isolation turned out to be more difficult than they expected and most grandparents looking after grandchildren attending the last years of primary or secondary schools had great difficulty in meeting their educational needs. The respondents claimed that they were not able to successfully help them with their homework. They also had problems with motivating their grandchildren to regularly participate in on-line classes with teachers. The inability to provide effective support in the context of education, but also in coping with the effects of isolation by young people, contributed to the emergence of various fears.

The problems described above increase the stress of grandparents, who were not only struggling with the effects of isolation, but also had to face home education and help their grandchildren survive this difficult time of being cut off from their peers and the realities of life before the pandemic.

"It is a difficult time for all of us, nobody expected it… it was difficult to change everything in your life overnight. It was difficult for me, not to mention the young ones; for them it is as if the whole world was turned upside down. And even though it was hard for me, because this school and these lessons and all the household chores, well you can have enough of it, but I tried not to show it, because I saw that it was also difficult for my granddaughter - all the time she just asked - how long yet, and when will it be normal, and why can't we go out, go somewhere... and what was I supposed to tell her? Yes, it's that… I don't know, you have to be

responsible and manage somehow to… help her somehow. Because I saw how difficult it was for her without girlfriends and ... and in this lockdown and there are so many of these lessons that sometimes you have to spend the whole day on them."

Halina, aged 61, 3 years bringing up her granddaughter at the age of 8, W_10

Barriers related to the use of technology were mentioned by grandparents as another factor hindering them in effectively meeting the educational needs of their grandchildren. The respondents stated that so far they had often felt a lack of trust in learning new technologies and using the Internet. Moreover, until schools began to use computers to record learning outcomes, monitor students' learning, and communicate with teachers, they did not attract much attention from grandparents. Accordingly, during the pandemic, the use of computers and other technologies was a challenge for grandparents. Most of the respondents - 14 out of 20 - had difficulties in accessing their grandchild's profile in the electronic register and using educational platforms, which often prevented them from maintaining appropriate contact with teachers, as well as finding information related to the current curriculum and tasks to be done.

"Until now, everything has been sorted out, and now sometimes it is too much for me. Since the older one went to school, I knew that someday I would have to start learning it ... using a computer, I mean, because so far I had no need for that. You know, if you don't use it, why learn it? But when my older granddaughter went to school, then I started to think that someday she will need help, and all these things that are to be done for school. There comes a time... like now, when you already know that you have to, that you can't move on without it. So I started to do something about it. But now it's a chore ... once we did none of these lessons for a week because I did not know that it was there that I should look ... until the teacher called. And since then I have been learning, I ask others how it is done ... and I hope that soon I will be able to deal with it myself. "

Jadwiga aged 62, 3 years bringing up granddaughters aged 5 and 9, W_3

While grandparents spoke both about the challenges and the fears they faced, when referring to their experience of helping grandchildren learn at school during the pandemic, most of them also spoke about the benefits of the situation. These included the opportunity to get to know their grandchildren better by spending time with them each day. Grandparents also saw themselves as those who help young people survive this difficult period. Analysis of the research results shows that grandparents considered their own personality traits, i.e. patience, support, and willingness to sacrifice, as some of the most important factors ensuring their grandchildren's sense of security and stability.

The situation of grandparents raising grandchildren in the time of a pandemic

The research results show that there are other areas of concern. The first is the economic situation, as the respondents have experienced an unexpected financial burden during the pandemic. Financial issues were of great importance to almost all grandparents, who said how difficult it was for them to meet the needs of their grandchildren. The greatest anxiety is caused by the rise in prices and the resulting burden on the household budget from daily expenses, which have increased since they have come to live together with their grandchildren. It should be added that during their stay in institutions, the children were provided with meals financed from social assistance funds. The respondents who are still professionally active are additionally afraid of losing their job or of professional degradation, which would significantly lower their standard of living. Similar conclusions can also be drawn from other studies concerning this subject, which emphasize that material difficulties are one of the most serious challenges in households run by grandparents during the pandemic [15].

Another issue raised by the respondents, which in their opinion affects their economic situation, is the legally regulated situation of caring for grandchildren. As the respondents themselves admit, they are entitled to various benefits which supplement their salary or pension and significantly improve their financial situation. This is particularly important because, as the respondents themselves claim, during the pandemic the process of regulating legal guardianship is difficult and stretched in time due to changes in the work organisation of various institutions. Others argue that having these formalities settled in advance makes it easier for them to function on a daily basis, not only during a pandemic, but also in everyday life.

Another area of concern that most respondents mentioned involved the mental health of the grandchildren. The interviews revealed a number of concerns grandparents had about prolonged isolation and lack of access to professional help, connected to problems with the children, which, according to their carers, started to increase from the moment they were forced to stay at home. Many grandparents mentioned the increased stress that arose during isolation. Lack of contact with peers and limited ability to regulate stress are, according to grandparents, the main reasons for the deterioration of the well-being of their grandchildren. The grandparents of children who had previously been diagnosed with various developmental deficits faced similar problems. This situation resulted mainly from the fact that most of the institutions providing assistance were closed and the grandparents were left without proper

help. The following statement by one of the respondents illuminates the great difficulty posed by this situation.

"I didn't know what would happen to him. I was really waiting for the worst. Well, what can you expect when the therapy is stopped overnight and at a moment like this. Because he was in really bad shape, he stayed locked in his room all day, he could sleep 24 hours a day, nothing could draw him out. And when he started going to therapy, I saw him change, and now this… this pandemic came, they closed everything and no one thought about what would happen. What would happen to people like me… parents and most of all children. Because nobody cares. And he got worse again. And how am I not to worry? I try to help him somehow myself, but I don't always know how... then at least I go and just sit with him. "

Sławomir, 66, 3 years bringing up a grandson at the age of 13, W_7

The age of the grandchildren is not without significance. It turns out that each development phase brings with it new challenges to be faced by caregivers and isolation and remote education additionally diversified the experiences in this area. The respondents bringing up their grandchildren in preschool and early school age emphasized that the kids being at home was a heavy burden on them. On the one hand, this is due to the need to provide assistance in the performance of educational tasks, which often takes up a whole day. On the other hand, grandparents wanted to make the best use of this time to build relationships with their grandchildren by spending their free time together, being aware of their own limitations, which no longer allow them to undertake some activities. One of the respondents admits:

"It seems to me that there are many more lessons now. I wake up in the morning and every day is basically the same. From the morning we do all the homework with my older granddaughter and then in the afternoon I sit down with the younger one, because she also has to do various things. And before I know, it's evening already… the next day looks the same. Sometimes we don't have time for anything else, but if we do, we do something else together: we cook, we play games. Well, because you want these children to have fun spending all this time at home, so you just come up with something."

Nina, 67, 6 years bringing up granddaughters aged 6 and 9, W_16

In the case of grandparents bringing up older children, especially adolescents, caregivers had other fears, associated with the need to provide psychological support, motivate to work, and alleviate emerging tensions and conflicts.

Summing up the above considerations, it should be emphasized that a better understanding of the situation of grandparents raising grandchildren is needed, especially in the context of situations such as the one caused by the coronavirus pandemic. Knowledge about the areas of support, as well as resources, challenges, and risks, will help ensure high-quality care for children.

Conclusions

Research results indicate that during a pandemic, the number of social anchors is important, as well as their subjective assessment in the context of their importance and usefulness in the coronavirus era. In the case of grandparents bringing up their grandchildren, it turns out that it was a difficult time, often described by them as a time of solitude and isolation.

The anchors belonging to the group of the so-called subjective and internal, which include, among others: personality traits of the individual and individually held ideas and values, turned out to be the most important in facing the changes caused by the coronavirus. Despite the feelings of fear and worry that accompanied the grandparents, they were able to cope with the situation and were a support for their grandchildren. The ability to deal with difficult situations has become a key skill helping people get through these trying times. It is obvious that in the case of the grandparents participating in the study, the importance they assigned to the role of parent to their grandchildren was also important, which was manifested through their involvement in this role.

Issues related to economic, institutional and legal aspects of parenting also turned out to be important anchors. In the case of the former, it can be stated that a fixed income, in the form of a retirement pension, a job that provides a decent standard of living, as well as stability of employment, provide grandparents with a sense of security that allows them to implement plans for both their own and their grandchildren's future. On the other hand, institutional and legal anchors, such as formal foster care, guaranteed benefits related to the care of grandchildren, and institutional assistance provide appropriate support in the event of various problems.

There were also several other factors influencing the perception of their own situation by grandparents raising their grandchildren during the coronavirus, including the age of both grandparents and grandchildren, as well as the time perspective: i.e. the period that has passed since the grandparents took the children into their care, as well as anxiety resulting from fear for their own health and the future of their grandchildren.

In conclusion, the issues related to the situation of grandparents raising grandchildren during a pandemic require further study. Although we are currently dealing with a reduction in

public health restrictions and the opening of educational institutions, we still live in the shadow of the pandemic. It should also be remembered that some of the consequences of isolation will only be noticeable after a certain period of time. It remains to be seen whether the grandparents and grandchildren will manage to rebuild the sense of stability and security, or whether they will need additional measures aimed at regaining psychosocial balance.

References:

1. Backhouse J., Graham A., *Grandparents raising grandchildren: negotiating the complexities of role-identity conflict*, Child and Family Social Work 2012, 17(3), 306–315.
2. Burke P. J., *Identity Change*, Social Psychology Quarterly 2006, Vol. 69, No. 1, 81–96.
3. Cox C., *Why grandchildren are going and staying at grandmother'shouse and what happens when they get there*, In C. Cox (Ed.), Tograndmother's house we go and stay: Perspectives on custodial grand-parents, Springer, New York 2000.
4. Grzymała-Kazłowska A., *From connecting to social anchoring: adaptation and "settlement" of Polish migrants in the UK,* Journal of Ethnic and Migration Studies 2017, 44(2), 252–269.
5. Grzymała-Kazłowska A., *Social Anchoring: Immigrant Identity, Security and Integration Reconnected?,* Sociology 2016, 50 (6), pp. 1123–1139.
6. Grzymała-Kazłowska A., *Od tożsamości i integracji do społecznego zakotwiczenia – propozycja nowej koncepcji teoretycznej,* CMR Working Paper 2013, Nr 64(122).
7. Grzymała–Kazławska A., *Zarys koncepcji społecznego zakotwiczenia. Inne spojrzenie na tożsamość, adaptację i integrację imigrantów*, Kultura i Społeczeństwo 2013, No. 3, 45-60.
8. Hayslip B., Shore J. Henderson C., Lambert P., *Custodial grandparenting and the impact of grandchildren with problems on role satisfaction and role meaning*. Journals of Gerontology 1998, 53b, 164-173.
9. Hooyman N., Kiyak H. A., *Social gerontology: A multridisciplinary perspective* (6th ed.). Allyn & Bacon, Boston 2002.
10. Kornhaber A., *Contemporary Grandparenting*. Sage Publications, Thousand Oaks, CA 1996.
11. Selwyn J.T., Nandy S., *Sibling kinship carers in England: evidence from the 2001 UK Population Census,* Children and Youth Services Review 2012, vol. 34, 194 - 199. https://doi.org/10.1016/j.childyouth.2011.09.015

12. Strom R., Strom S. (2000). *Goals for grandparent caregivers and supportgroups,* In B. Hayslip, R. Goldberg-Glen (Eds.), *Grandparents raising grandchildren: Theoretical, empirical, and clinical perspectives*, Springer, New York 2000.
13. U.S. Census Bureau, *Profile America: Facts for Features. Available at:* http://www.census.gov/newsroom/releases/archives/facts_for_features_special_editions/cb10-ff16.html 2010
14. Whitley D.M, Fuller-Thomson E., Brennenstuhl S., *Health characteristics of solo grandparent caregivers and single parents: A comparative profile using the Behavior Risk Factor Surveillance Survey,* Current gerontology and geriatrics research 2015.
15. Xu Y., Wu Q., Levkoff S. E., Jedwab M., *Material hardship and parenting stress among grandparent kinship providers during the COVID-19 pandemic: The mediating role of grandparents' mental health,* Child Abuse & Neglect 2020.

Helene von Stülpnagel, Astrid Eich-Krohm, Julia Piel, Ambivalence and future perspectives of older people: Critical reflection on the intertwining of diverse life experiences in East Germany during the Corona pandemia

Introduction

The Corona pandemia has its own historical impact. Not only for Germans, but for many societies this is the reason why it seems challenging all over the world to deal with the effects of the Corona pandemia. For many Germans there are only a few historical parallels that can be compared to the current situation. In her television message to the people in Germany chancellor Angela Merkel described the Corona pandemia as the most striking cut in German history "after the Second World War", in which solidarity is a decisive factor to overcome [33]. In addition to her insistent words, she brought the former German Democratic Republic (GDR) into the discussion about the Corona pandemia for the first time: "For someone like me, for whom freedom of travel and movement was a hard-won right, such restrictions can only be justified in absolute necessity. In a democracy they should never be decided lightly and only temporarily - but they are indispensable at the moment in order to save lives" [33]. Her address to the nation on March 18, 2020 was possibly the starting point for the frequently made comparisons between events in context of the GDR and Corona pandemia. With her statement, she brought an interesting aspect into the effective fight against the Corona virus; Angela Merkel's biography as an "East German" person, who already knew of restrictions on freedom rights from her life in the GDR. East Germany became an important structural cate-gory facing the Corona pandemia.

Based on this mention in her address to the national community, a discussion sparked in the media and public on how far the Corona pandemia could now be linked to the GDR. It can be assumed that the regulations and consequences of the "lockdown" evoke memories of the lost GDR in people [14]. The German press took up the topic, reviewed statements and announcements by politicians and wrote about the extent to which the Corona pandemia can be compared to the GDR. The experience of East Germans would therefore enable them to deal with the current situation during the Corona pandemia more effectively. Once described as "pioneers of precarity" [18], who had experiences of state restrictions, (lack of) authority, they were used to dealing with challenging situations. The social psychologist Wolfgang Frindte expressed the suspicion that these experiences in the East were now being recalled during the Corona pandemia and could unconsciously resonate with them [17]. The lessons learned through the unification process of an entire society should inevitably lead to greater resistance. Even during the Corona pandemia, the Governor of Saxony-Anhalt (East German

federal state), Rainer Haseloff, spoke of the “special abilities” of the East Germans in relation with the containment measures [18, p. 3]. What could initially be dismissed as “far-fetched” developed into serious, if controversial, assumptions in German media attention: East Germans would know better how to deal with crises and adhere to the restrictions in an exemplary and disciplined manner [18]. Hence, they are credited with „being better prepared […] for the consequences of the Corona pandemia than the West. Crises are handled differently here because we have already anticipated them differently“ [31].

The experiences with life in the GDR and during the years of unification could help East Germans to better understand and classify the events during the Corona pandemia. They might offer East Germans a frame of reference and orientation during these times. The question of this article is if the categorical classification as “East German experience during the GDR” can explain such a complex challenging phenomenon as the Corona pandemia.

Comparison between two historical processes

The comparison equating a pandemia with the conditions and events in a repressive state based on a socialist system (comparison of a health policy with a political event) can be too short-sighted and too general at this point. However, we believe that the experiences before, during and after German unification can help people to better deal with incisive experiences such as the Corona pandemia and to classify the events.

In the following, we will take a closer look at this comparison and try to derive supporting arguments for our thesis. For this purpose, we integrate empirical data from a research project to reconstruct the plausibility and conclusiveness of this comparison. In order to reflect on the special horizon of experience of East Germans in connection with the Corona pandemia and to make the comparison more explicit, we first present a chronology of the two events GDR development and Corona pandemia. For this purpose, we only describe the historical events that are most important for our questions.

Covid-19 pandemia in Germany - a chronology

In December 2019, there are increasing reports of an unknown lung disease originating in the Chinese city of Wuhan. Finally, in early January, the Chinese authorities report that the un-known lung disease can be attributed to a Coronavirus. The World Health Organization refers to the disease as Covid-19, the virus itself as Sars-CoV-2 [42]. At the end of January, the first case was reported in Germany and other European countries. The Corona virus Sars-CoV-2 reached Europe and developed into a pandemia. The German government reacted with the first cancellations of major events such as the Leipzig Book Fair. In March, all states of

the Federal Republic of Germany show cases of infections. Chancellor Angela Merkel defines the Corona pandemia as a "challenge of historic proportions" and calls for solidarity and discipline in the fight against the virus [33]. The "lockdown" requires the closure of public institutions, catering businesses, extensive contact, entry and exit restrictions and increased controls among the German population. The measures are initially called for until the end of April. Then, a cautious loosening of the regulations starts with the introduction of voluntarily wearing masks. However, the federal states proceed differently [29].

With the start of the measures to contain the Corona virus, a discussion ensues about risk groups during the pandemia. The age group of older persons is identified by experts as a risk group and is therefore considered in need for special protection very early on [8 p. 1]. In fact, older and very old people in particular are at increased risk of Covid-19, as both the severity of the course and the mortality risk increase with older age [8 p. 1; 35]. However, the role of general health and previous diseases of a person and its impact on the severity of the infection is often ignored. These risks apply equally to older and younger people and cannot be limited to older people [8, p. 1]. In April, Kessler and Gellert of the German Society for Gerontology and Geriatrics (DGGG) are the first to give recommendations for public communication and reporting on „Corona and Aging". They criticize the representation of older people as weak and as a group that has to be protected by society. The general reporting reinforces the perception of a savior-versus-victim narrative, which is reflected in the logic of "we as young and healthy versus you as old and sick" [16 p. 1]. In addition to the classification of risk groups by age limit, we also want to discuss the special attribution as "East Germans" as well as the inter-twining of these two categories ("age" and "East German") in this aticle. For this purpose, we present the development and later dissolution of the GDR in the following.

The formation and development of the GDR - a chronology

The GDR lasted for four decades and starts emerged out of the Soviet occupation zone in 1945 after WWII. The zone included the present-day federal states of Mecklenburg-Vorpommern, Brandenburg, Saxony-Anhalt, Saxony and Thuringia. In 1949, the GDR was founded after political agreements between the Western powers and the Soviet Union failed [24]. The "Volkskammer" (former East German parliament) announced the Constitution of the GDR.

Instead of a separation of powers, as provided for in a democratic legal system, a concentration of powers was envisaged and basic democratic rights such as freedom of opinion were accepted as long as they did not compromise the SED's claim to power [25].

The Socialist Unity Party of Germany (SED), which became the leading state party, saw "building socialism" as its fundamental task [25].

This included the transformation of capitalist into socialist production of goods, economic disempowerment of still existing private industry, the collectivization of agriculture and the suppression of all those areas that could not be reconciled with a Marxist-Leninist doctrine [25]. With the first five-year plan (1951-1955), the GDR paved the way for its economic development towards a planned economy based on the Soviet model, according to which the production and consumption of goods, their prices and wages were set by a central authority [25].

In 1953, the population reacted with strikes after the "campaign for the strictest austerity" enacted by the government. As a result, between 1950 and 1961, around 1.3 million people between 20 and 50 years left the GDR for the Federal Republic of Germany (FRG). Emigration to the West was still legal until 1957 [25]. In December 1957, the GDR government defined it a "republic escape" and to be punishable because the GDR lost important workers for its country. Thus, a so-called restricted area was build and finalized with the construction of the Wall in August 1961 [25]. The political direction of the GDR changed with the aim of raising the standard of living of the population when Erich Honecker became head of government in 1971. For example, social benefits and policy measures were increasingly enacted. Prefabricated housing became the dominant architecture of the cities, as it was hoped that this would ease the continuing shortage of housing for the population [26]. Erich Honecker also established the Ministry for State Security that grew as a power apparatus of the SED, which had the primary task of identifying and suppressing political opponents. Responsible for this development was the secret state police ("Stasi"), which used various methods to try to control and monitor all areas of society [26].

In the 80s, more and more GDR citizens demanded the right to freedom of movement and the number of people applying to the Foreign Office for permanent emigration grew steadily. In particular, the limited participation and choice in one's own career path and the lack of professional prospects broke their way into open conflict in autumn 1989. On October 16, 1989, with the slogan "Wir sind das Volk" (translated by the authors: "We are the people") the largest demonstration for reforms and democratic renewal in the GDR to date took place in Leipzig [24]. Only a short time later Erich Honecker resigned. On November 3, for-mer Czechoslovakia opened its border with the FRG and immediately more than 23,500 GDR citizens emigrated within the period from November 4 to 6 [24].

November 9, 1989 is finally the historic day when the Berlin Wall, that for years separated the Western and Eastern parts of Berlin and with it an entire country, fell. As a

result, freedom of travelling and opinion, the press and assembly in the GDR, free elections to the "Volkskammer" on March 18, 1990 and finally economic, monetary and social union between the FRG and the GDR came about. On October 3, 1990, German unification took place [24].

While the peaceful revolution was a broad social movement of a relative short duration the unification is a process that lasts until today. After 30 years the standard of living between East and West Germany is still not equal [5]. After the unification, most GDR state businesses had to close or were bought by other companies located in West Germany. East Germans experienced a high percentage of unemployment and economic difficulties [28]. As Mau explains "a society of workers became a society of people" [28 p. 168]. Whereas the lives of West Germans did not change with the unification East Germans lost what they had known for many years and had to find strategies to readjust to this new life. The assumption is that the strategies learned after unification and experiences from the former GDR prepared East Germans better to handle the social impact of the Corona pandemia.

First, we want to offer the concept of transformation competence presented by Lettrari as a theoretical basis and use it as an explanatory approach to present the GDR/Corona comparison in a more differentiated way. Thus, we want to examine the patterns underlying the assumption that dealing with the situation in times of the corona pandemia in East Germany is related to the structural category „East German identity/origin".

Concept of transformation competence

The concept of transformation competence was coined by one of the founding members of the network "3te Generation Ost", Adriana Lettrari. Lettrari, Nestler, and Porath [22] define transformation competence as "a reaction to an individual perturbation due to a change situation, which is detectable with a case-dependent variance. The subsequent process of dealing with this situation possibly creates an accumulation of dispositions, which, due to their comparable origin, may lead to similar behaviour. From the targeted creation of a space for reflection, a subsequent penetration of the experienced transformation events can take place. This creates an awareness of the personal actions for shaping the new situation and the competencies on which they are based. The reflective awareness (learning) of one's own transformation experience and competence thus possibly promotes a more targeted handling of future change situations." [22]. It refers to the ability to cope with an abrupt change in the individual or societal situation (for example, a sudden and unexpected system change) [2 p. 255].

The concept of transformation competence is very close to the psychological concept of resilience [3 p. 186]. In contrast to resilience, which is viewed and used primarily in health science and psychology at an individual level, transformation competence aims at social applicability [3 p. 186]. On a meta-level, the social framework is examined and how it is transformed in dealing with socio-structural changes.

Transformation competence can develop when change is experienced by people on a societal level, for example during the German unification process. This experience of the transition from the GDR to the West-German state regulations, economic, societal and moral norms and values serves as the basis for the development of transformation competence. The experiences and coping with the events of unification can form a wealth of insights with so-called upheavals in general [2 p. 255]. Lettrari, Nestler, and Troi-Boeck [3], for example, represent the assumption that transformation competence is especially developed in the generation of the children of the "Wende" (persons born in East Germany between 1973 and 1985) (in general, the term "Wende" refers to a far-reaching historical, world-historical, political or ecological event. In this article, the term "Wende" refers to the major political and social upheaval of 1989 in the GDR [9] due to the experience and coping with a transformation event such as the unification process. In contrast to aforementioned authors we apply the concept to the older generation of East Germans.

Additionally, transformation competence is not automatically set by the experience of the unification process. Rather, it arises from the interaction of personal prerequisites with external factors as, for example, situations that people have experienced in overcoming crises. Hence, transformation competence is also based on personality traits and acquired through the repeat-ed experience of positive outcomes of critical situations as a matter of learned "openness" and flexibility [3, pp. 186–187].

Based on this approach, managing change can be considered a crisis experience and a trigger for building and expanding transformation competence, but the concept can also be traced back to other stressful or resilient life situations. Lettrari [21] assumes that transformation competence could be relevant in the future for shaping certain areas, such as politics, economy or civil society in accelerated times. It may be possible to apply transformation competence to personal, private, civil and entrepreneurial action and at the same time, can be interpreted as forward-looking for dealing with challenges in other areas, for example with regard to being confronted with the challenges associated with the Corona pandemia [20, p.206f.; 32 p. 14]. We like to make an attempt to apply transformation competence to future generations.

Intertwining of diverse life experiences

The comparison between GDR and pandemia must not be too generalized and simplified. A broader perspective is needed to show the interdependence of the differential categories “Corona pandemia”, “GDR” and “age”. With the concept of transformation competence, we want to introduce an alternative conceptual model into the discourse to explain phenomena in old age across life spans. We empirically trace facets of transformation competence as a specific ability for the generation of children of the “Wende” using data of a participative research project with people who were born in East Germany between 1935 and 1959.

Therefore, we describe the background of the research project for a better understanding of the data collected in the project and the continuation of it under pandemia conditions. We will go into more detail about the method of fanzines and describe how the implementation in the scientific context of the research project was possible.

Background to the Research Project STARK

The research project “Social participation and self-determined aging through participatively developed social and digital offerings in the Kannenstieg neighborhood“ (STARK) is being conducted in a city in Saxony-Anhalt in cooperation with a service centre for older citizens (ASZ) in the district’s community centre. The district is populated by one of the highest pro-portions of older people in the city and dominated by prefabricated slabs [1]. Due to the high average age and the anonymous residential structures, it can be assumed that a proportion of older people cannot be reached by the health and consulting services offered in the district. Interviews with social practitioners who work with the elderly in the district report problems with reaching older and socially isolated people. However, participation in societal life into old age can be considered an important factor in promoting well-being and health. Social isolation and loneliness can increase the risk of developing certain diseases [6; 7; 12; 34; 43]. The Euro-pean Union states that “physical and social environments are key determinants of whether people can remain healthy, independent and autonomous long into their old age” [10, p. 29]. Age-friendly environments have an impact on old people to stay physically healthy and feel more socially included and at the same time contributing to a good quality of life [10].

STARK is developed on the research approach of community-based participatory research (CBPR) by involving members of the community as co-researchers and conducting joint re-search practice on the health-related topic social isolation [40 p. 30]. The aims of the project are to get new routes of access to isolated older people, to identify reasons for

isolation and loneliness, and to initiate of appropriate offers to promote social participation in the community. In January 2020, the project group started and met for the first time as a discussion group in February.

Research with fanzines

In the course of the "lockdown", the facility of the ASZ was closed. In order to enable con-tact and to carry and accompany the people during the period of contact restrictions to avoid isolation, the telephone was the primary tool of communication. This proved to be significant in terms of building and maintaining trust with the co-researchers, especially at the beginning of the Corona pandemia. In order to keep the project group able to work and motivated during the period of contact restrictions and not being able to continue the project at a distance, we needed an exchange medium. It was a challenge to develop and test a uniform format in which all co-researchers could participate and contribute on an equal level. At this point, the project group consists of three male and seven female co-researchers (age range 65 to 80 years). The majority of the participants come from the periphery of town. Starting from this initial situation, the idea was born to create a fanzine together with the older co-researchers.

The term "fanzine" is a suitcase word made up of the words "fan" and "magazine" [39, p. 5]. It can be understood as a "product of cultural practices from juvenile scenes - self-designed and self-distributed media (mostly printed documents) that are written within a special context, reproduced, distributed and circulated within communities by mail" [39, 4f]. In zines a polyphony is laid out, that takes up the participatory basic idea in an ad-vantageous way. The authors see themselves as a medium of digital self-empowerment, as they are located exactly where a change from consumer to producer takes place [38, p. 41]. As a kind of "network medium" they further have an important function for community building within a milieu [38, p. 14]. Therefore, fanzines fulfill in many ways the demands for an exchange format in the participatory research project STARK:

- With their form of asynchronous transfer of information and experience, they reach all older co-researchers on a low-threshold and equal basis and give everyone a voice.
- They offer the opportunity to express and communicate in writing or in the form of pictures, articles or other forms of contributions to create something yourself from a distance.
- They can also be used to maintain and strengthen identification with the project and cohesion within the project during the contact ban.

However, the process to create the “STARK-zine” differs from the original idea of a fanzine, as the magazine was not intended to be created as part of a leisure activity, but as part of a research project. The guiding questions were intended to illustrate the topic of the pandemia and at the same time to build a bridge to the project’s topic “social isolation and loneliness in old age”. We formulated seven largely open questions and gave the co-researchers sufficient space and opportunity to contribute their own thoughts and ideas creatively and openly. For example, questions were asked about activities, thoughts, and ways of contact during the period of contact restrictions.

With regard to digital readiness and skills, there is a “digital divide” [4 p. 283] and a certain heterogeneity in the project group. Thus, the questionnaire had to be distributed to the co-researchers in different ways: By mail, by e-mail and in some cases by personal delivery. In view of the continuous change in the situation, there was a processing and return period of approximately one week. We, as a team of academic researchers, finally began to sift through and sort the answers and contributions. This was followed by an interpretative content analysis of the answers.

Similar to a presentation of results in a scientific context, we summarized the categories, prepared them and presented each category in individual articles in the style of a newspaper magazine. It was important to us that every participant finds his or her way into the magazine and feels represented himself or herself in the articles with his or her statements.

Findings

In the following considered categories of the analysis of the zine entries and the telephone calls with the co-researchers are presented. We will limit ourselves to the statements of the co-researchers that are relevant for the exploration of our research question.

The entries clearly point to a major dilemma: The conflicting values of freedom versus protection. This discrepancy about the contradiction and compatibility of freedom rights and the protection of (older) people is not a new discussion, but it became existential during the Corona pandemia.

The answers to one of the questions (what are you most looking forward to after easing the measures) present an inner conflict. Some of the coresearchers describe longing to be able to leave their home without restrictions. A significant demand is to have the choice meeting with anyone at any time and in any place, to enjoy restaurant visits and to shop carelessly. Nevertheless, they seem to take for granted the incongruity between the desire for freedom and compliance with the measures. Although the overall wish is to regain some of the former normality. Many express their displeasure with the behaviour of the people around them. The

longing for freedom and a considerate and protective behaviour in relation to other people seems difficult to reconcile. The fanzine entries of several seniors underline this dilemma. A particular point of contention and criticism related to demonstrations during the pandemia. The number of protest demonstrations against infection protection measures in Saxony-Anhalt in-creased in the course of May. The people and their motives for participating in the demonstrations were heterogeneous. A large number of them questioned measures such as the wearing of masks and contact restrictions. Still others questioned the restriction of their basic rights and thus also their fundamentally regulated right to freedom of assembly (Merkel, 2020). The co-researchers refer to these motives in their statements:

"Some parts of the population see the restrictions as an attack on their freedoms and rights enshrined in the Basic Law. They immediately start swaggering and de-scribe the consequences of the "lockdown" as excessive and inappropriate." (Bm3)

"I am annoyed at the infinite stupidity of people who take to the streets for freedom of demonstration and talk about "Corona invention" and "misleading conspiracy theories"!" (Bm3)

"The demonstrators insist on the fundamental right to demonstrate, even though among them may be Corona virus infected and the pandemia, which is already reaching all continents, is getting worse. They reject the precautionary measures (wearing mouth-nose masks, keeping their distance, avoiding the formation of large groups of people, etc.) as it restricts their "freedom". Do these stupid people prefer to accept illness and death? Is this freedom?" (Bw4)

The author does not only discuss the meaning of freedom in generally. It also raises the question of what freedom still means when the consequences of these demanded rights to freedom have include illness and in the worst-case death of other people. This process of weighing up the alternatives reaches a dimension that, from the perspective of the contributers, has a special dramaturgy.

They apparently do not see any restrictions of fundamental rights in the protective measures, but a necessary, albeit annoying evil, which however serves "the collective protection" of fellow woman/men and must therefore be accepted.

In particular, the demonstrative disregard for protective measures causes a high degree of incomprehension and displeasure among some co-researchers. Some participants of STARK consider it a reckless and thoughtless action questions the solidarity with one another.

However, the disapproval of the demonstrators seems to be an indicator of an assumed lack of solidarity in the population, a much more existential concern of the participants. It is

viewed as a personal affront that solidarity is not understood in the sense of mutual cohesion and sharing of common values and goals. This assumption is substantiated in statements such as:

"What annoyed me was that many people do not take the mutual protection by mouth/nose/masks seriously." (Bm3)

"This also has consequences for the handling of the mouth and nose protection. From the statements of the Federal Government and the RKI [addition by the authors: Robert Koch institute] we have learned that wearing masks is an expression of solidarity and protection for our fellow human beings. Rejecting it can endanger others." (Bm3)

Older people seem to be particularly affected when rules are ignored, i.e. deliberately and intentionally bypassed or simply not taken seriously. This would counteract a national effort to ensure, together and with the participation of all, comprehensive protection, the common good of the entire population, to which each individual contributes. In this way, however, it is consciously accepted that other people can be infected. This would be a mockery of the fear and anxiety of citizens, who see the measures as important and unavoidable, the older project participants consider such violations as personal insults.

This fact becomes particularly clear in the context of spreading conspiracy myths. Some co-researchers perceive the spreading of untruths or misleading non-scientific assumptions as a lack of solidarity, because there are people for whom this would have far-reaching consequences. For example, an older participant writes about a case in which an elderly man would not even receive telephone calls. His friends wrongly assumed that Corona could spread over the phone. This lack of solidarity and the selfishness of some people causes incomprehension and anger among the elderly and is sharply condemned by some participants.

The blame is not exclusively attributed to those who deliberately act against the guidelines, but also to the control authorities. For example, there seems to be a perception that it is the task "from above" to control the applicable regulations and to react with appropriate regulations in case of disregard and missteps. Some would even argue in favour of stronger surveillance and more controls to ensure consistent and collective compliance and implementation of measures.

"State regulation on the wearing of masks in public transport, I, but also other people observe that all people without masks are sitting in the tram. I called the MVB [addition by the authors: Magdeburger Verkehrsbetriebe] and reminded them of this. The answer was: It is better not to take the tram. I go by car. We can-not expel a passenger from the tram, the mask obligation is a recommendation. The Public Order Office is responsible for this. Answer from

the public order office: The MVB is responsible for its trams. In certain West German federal states you pay a fine. In our own federal state it has no consequences [text passage pseudonymized by authors].” (Bw7)

In addition to the inadequacy of the controls, a co-researcher also points to the inconsistency of the measures, which leads to irritation and confusion among people. He questions the sense of allowing cake or coffee to be collected from the buffet counter in catering services, but leaving the outside area with tables and chairs closed to guests. Because a few meters away from the café, people would sit close together on a wall and eat what they picked up. The statements of this elderly man also reveal the ambivalence that many people perceive with regard to infection control measures during the corona pandemia.

When asked about possible benefits or learning effects of the pandemia for the future, some interesting opinions and above all a clear picture emerge. During the “lockdown”, the seniors see this as a chance to get back to essential things. One co-researcher states: “I appreciate health and the small, everyday things that seemed so taken for granted before Corona even more […]” (Bm1).

Some call the “lockdown” a time of deceleration. This deceleration is even perceived as beneficial. “Everything had to be shut down. Peace has returned to society.” (Bw7)

“There is the aspect of deceleration that is worth taking from the Corona period into the future.” (Bm3) “The rush in the stores has also eased. More distance was kept in the stores.” (Bw7)

Occasionally, these positions are developed in relation to the current situation, but also in relation to the future. Thoughts about future development tend to have a thoughtful, questionable connotation. They refer to the personal, individual, as well as to the overall societal level.

One senior asks herself of how society will develop once the Corona pandemia is over or a vaccine for everyone has been developed.

Another senior's contribution can be considered as an answer to this question: “I don't believe that the majority of people will change voluntarily - most will return to their usual self-indulgence.” (Bm3)

Based on these considerations, a date in the future (autumn 2020) is set as scenario and a look back at the past months is asked for. The project members had to think about what might have changed socially during this time - both positively and negatively.

One senior formulates very precisely the striving for maximization and constant growth in Western societies:

“It has to be questioned, whether there has to be the oversized supply in certain areas, just because we can. This ever more, ever further was put to the test with this crisis.” (Bm3)

Finally, these statements stand for a positive evaluation of the participants and their concern returning to the value of the “small”, “everyday” things, which has been lost over the years and are brought back to light by Corona. In this way, the seniors consciously question the prosperity in which they live and question the extent to which lasting maximization and enhancement in all areas of life is meaningful.

This awareness to the “little things in life” is reflected in almost all the contributions of the seniors, in which they express their enthusiasm for nature and their garden. “I observe nature, the birds, […]” (Bw7) or “I go for a walk and see so many things I did not notice before.” (Bw5) are phrases that have often been uttered in the context of deceleration and discontinuation of activities. For most of the older participants, a temporary phase of slowing down everyday life in nature does not seem to be a problematic issue. They note that they enjoy spending their time in the garden, on the balcony or taking walks in the park. These activities turn out to be very beneficial, as they make it possible to combine exercise in the fresh air with something meaningful and practical. In addition, gardening or work on the house prove to be time filling and it replaces the activities that the seniors have previously done when they come to the ASZ group activities. At the same time, Corona seems to be seen as a kind of legitimation to finally give the raised beds in the garden, the fruit trees or the lawn the care they de-serve. Progress and the state of the garden are reported with pride. Those who did not own a garden use their time instead for creative handicrafts or for further training, for example in the form of online courses. An older woman from the project demonstrates her talent for improvisation:

“I didn't grow up in the throwaway society and make a lot out of old things (e.g. pillowcases and patchwork quilts from colourful clothes that are no longer modern, but whose fabric quality is impeccable).” (Bw4)

Others use the time to carry out long-delayed repairs or projects, such as cleaning out the wardrobe, files or garage. All these different works offer distraction and employment.

But in other areas of life, too, some older people have shown great ingenuity and astonishing frugality.

Regardless of age or gender, it seems to be possible to deal with the restrictions quickly and, above all, to reorient the activities of daily life. Complaints are hardly exposed in the contributions. Only a slight regret is expressed when usual offers such as sports, card games or long planned trips cannot be realized.

The co-researchers find it much more difficult to accept the restrictions on contact with close relatives. They describe the fact that they cannot see their children and grandchildren for an indefinite period of time, or only see them from a distance, as a stressful situation. There is a great longing for and hope of seeing them again soon, and at the same time there is a fear that they will live apart and be strangers during the contact restrictions. This can be supported by the statement of a co-researcher who says:

"When Corona no longer troubles us, I would like to go to B. and L. to see my children and grandchildren again. I have a great longing and almost the impression that we are drifting apart and do not recognize each other. The voice on the phone is only a consolation." (Bw4)

It should be emphasized that the statements of the co-researchers on the soon reunion of relatives are formulated more as hope than as demands or reproaches. In addition to their wishes, the co-researchers also consider the ambiguity of the situation, according to which they always adapt and subordinate wishes to the circumstances of the pandemia restrictions.

Besides the appreciation and awareness of the "little things in life", high level of gratitude is expressed especially for the own health condition during the Corona period. At the same time, the participants show concern for their own (mental) health and the health of their relatives. Some of the older people, for example, look at ways of getting physically and mentally fit again after the Corona pandemia. For others, the focus is on caring for relatives:

"I think of my children and grandchildren, who are currently worried about their jobs, postponing their studies and having to cope with other difficulties, without me being able to help them financially, for example, because I draw a small pension. The main thing in the Corona crisis is to stay healthy and not to get infected." (Bw4)

"I also worry about my children that everything is all right. My children all work in the nursing home." (Bw5)

This concern for personal well-being and the well-being of others is also reflected in self-identification as a risk group:

"I avoid contact with former colleagues or handwork friends, because it is said that 60 to 80 year olds can quickly become infected and ill, as the immune system weakens at that age." (Bw4)

"All senior citizens belong to the particularly endangered population group even without previous illnesses." (Bm3)

Of great importance are symbols and gestures that are interpreted as testimonies that their generation is not forgotten or invisible in the social context:

“I received a greeting from the Bürgerhaus [addition by the authors: “Bürgerhaus” as synonym for ASZ] in the form of a piece of cake in my mailbox - for me this was a sign that our generation will not be forgotten.” (Bw4)

Whether the generation of the “older generation” has not only not been forgotten, but whether transformation competence can also be derived from the results presented, will be summarized and discussed in the following chapter.

Discussion

Along the development process of transformation competence, the comparability and parallelism of GDR and Corona pandemia events was explored. A critical discussion of the extent to which the data used above indicate that transformation competence is involved and the extent to which a correlation with East German experiences can be identified follows now.

If we have sought clear references to transformation competence in the contributions of the co-researchers, we have not found them. A possible historical influence of GDR experiences and the experiences of unification during the pandemia remains largely unspecified and unreflected in the statements of the co-researchers. They do not make the GDR the subject of their narratives. At the same time, it must be remembered that many former GDR citizens do not or only rarely make life in the GDR the subject of their stories. One reason why transformation competence is not explicitly reflected in the statements of the co-researchers can be traced back to the fact that our questions to the co-researchers were not originally aimed at examining transformation competence. Another explanatory approach, however, would be the following: Mau describes it as a “devaluation of the accumulated wealth of experience” and “re-setting the East Germans' culture of origin”, which was not available as a source of recognition. Thus, East German socioculture was considered deficient and contaminated by the old GDR regime [28 p. 205]. It is therefore possible that they do not see their own wealth of experience as a direct resource that they can use to deal with the restrictions imposed by the pandemia. Only allusions in the statements of the co-researchers allow conclusions to be drawn about signs of transformation competence.

For example, this becomes clear in the statements of the co-researchers on the behavior of their fellow human beings with regard to demonstrations, handling and compliance with protective measures in the course of corona-related restrictions.

This attitude can possibly be traced back to the assumption that state authority was more pronounced in the East than in the West [31]. Because of their experience with state restrictions and (lack of) authority, East Germans are said to have been particularly exemplary during the pandemia. This applies to their ability to comply with restrictions during

the pandemia and their willingness to act in solidarity [18; 31]. However, this assumption is controversial. Contrary, it is claimed that Corona measures such as contact restrictions are more difficult to enforce in East Germany [15]. The argument is that people in East Germany once fought for a freedom that they now have to defend even more strongly. As a result, some would not understand the obligation to wear masks or the restrictions on crossing boarders [15]. Mutual solidarity can be seen as key to hu-man togetherness, to which many of the co-researchers refer again when it comes to the non-compliance with Corona measures. This is indeed a point that became a key concept during the GDR and the process of unification as well as during the Corona pandemia. “We had to learn that we can do without many things, but not without solidarity and humanity” [13]. An article on the mdr channel, for example, raised the question of whether there are values that have proven themselves historically to overcome crises. In the article, it is mentioned that it is solidarity that should be made sustainable for the future. In the East of Germany individuality would have been more willingly subordinated to the common good [31]. One of the specific East German values would be to help and support one another more strongly. That people did not only pay attention to what was good for them-selves [41]. Mau, on the other hand, argues that experimental studies have not shown a “community advantage of East Germans over West Germans” [28]. In fact, a rapid desolidarization can be assumed [28 p. 219]. This assumption would require a great deal more space to discuss. In fact, the myth of social cohesion still clings to the former GDR today, according to which capitalism is eating away at this sense of community. For a long time, the myth that “moral collectivism” prevailed in the East persisted. Before 1989, there had been more social cohesion, more togetherness. Mau assumes that moving closer together in a gap society created a kind of closeness that allowed humanity and mutual help to flourish and founded the community myth of the GDR [28, pp. 219–220]. Similar to the unification, the pandemia also affects the country and society as a whole and it is important to work together to counteract it. It is a national effort for the common good in which everyone should participate [31].

Another interesting factor, which is also expressed in the statements of the co-researchers, is the criticism of consumer behaviour and permanent consumer maximization. This is particularly evident in the fact that a return to the “small and really important things in life” is taking place and some of the co-researchers find that it is often such “insignificant” things in life as blossoming in spring or hatching young birds that contribute to their happiness.

Even during the pandemia, people withdraw more strongly into their private surroundings - and even have to do so. This could be seen as a return to proven patterns of

behaviour, because even in GDR times, social cohesion in families and neighbourhoods acted as a protective shield [36]. Many people withdrew into privacy and created their secret free spaces. They adapted themselves to the objective possibilities and settled down there [28]. They enjoyed a "building pleasure on a small scale" [37 p. 78]. The commitment and the lived solidarity in the closer circle of family and friends were meaningful. Here people gained experience of security by communicating more openly and less restricted. "The family, the apartment, the circle of friends were retreat zones against the regulation of everyday social life [...]", writes Mau [28 p. 78].

To be able to establish a life existence in spite of dictatorship and to be satisfied is a very elementary and in times of crisis especially decisive competence. Rainer Haseloff states in an interview with the daily newspaper "Welt": "In the East, an experience is recalled that is well known to many GDR citizens: We wish things were different, but we cannot change the situation and have to come to terms with the objective circumstances." [27]. Further-more, the awareness of the lack of influence on and the permanent demand for adaptation to the respective situation required the ability to react flexibly to rapidly changing conditions. In view of the shortening of the horizon of action typical of social crises, this would result in driving on sight, on coping [28 p. 200]. These after-effects and upheavals of the post-unification years, uncertainty, unemployment, instability, and disorientation have had a lasting impact on people, and perhaps this has led to the development of transformation competence among those who have mastered the period despite all the adversities.

The socialization in the GDR and the experiences before, during and after unification show a comparative value similar to Karl Mannheim's explanation that people "who experience some-thing together in a historical phase [...] are more likely to develop a special social conscious-ness" [28 p. 200]. Since each generation participates in only one particular historical period and thus has specific experiences, a special stratification of experiences is created. Historical turning points or caesura can create a kind of bond between the individual and the collective. The tendency could be described as a far-reaching "standardization and ritualization of life", which becomes visible in the great similarity of life's paths and stations [28, p. 103]. Thus, a certain communal condensation can be assumed [28 pp. 200–201]. The experiences of the older generation with the GDR and the subsequent experiences of the fall of the Berlin Wall can be a connecting point of reference. In view of what has been achieved, confidence in one's own strengths can even be strengthened [31]. Nevertheless, no cultural repertoire has emerged from the shared history in and with the GDR and the experiences of transformation, as Mau further explains [28, p. 210].

Even if these are collective experiences that the majority of people from the East have had, the perspectives, personal attitudes, biographical backgrounds, and individual characteristics are different. Individual GDR biographies and individual fates would have been created, which had a lasting impact on the GDR. They influence how the experiences are interpreted, put into context and finally remembered. There was no singularity and universality with regard to remembering the GDR. Rather, it can be assumed that heterogeneous lifestyles and habitus formations have developed with regard to the GDR as a space of experience [19 p. 207]. Moreover, people experienced the transformation of the GDR in very different ways, which would have an impact on remembering and forgetting this historical period [11 pp. 43–44]. According to Mau, the assurance of identity also varies greatly depending on social situation, generation, and the proximity to the GDR's political system [28]. Ultimately, many personal and external factors as well as biographical key points and the stratification of age and life experiences interact, so that it cannot be assumed that the older former GDR citizens have equally developed transformation competence based on their experiences of socialization and unification. However, Mau also states "For the […] GDR, generation-specific experiences can be identified that must be seen in connection with the develop-mental phases of the system. Those who experienced the construction were socialized differently than the generation of those who as young people witnessed the stumbling and then the collapse. The time before, during and after German unification has intensified the differences in generational experiences [...]. What stage of life you were in when the system collapsed was a decisive factor in how quickly you gained distance from the old and how easy (how difficult) it was to find your way around the new" [28 p. 201]. In view of the statements of the co-researchers, it would probably be a bold attempt to compare the GDR experiences with those of the Corona pandemia and assuming a basic development of transformation competence among them. Perhaps one conclusion would be the following: The development of transformation competence is less about the concrete historical event itself, but rather about how it was experienced and valued by the people. It also depends on how the people interpreted the time of change for themselves and how their personal feelings were involved. It also seems to depend to some extent on how they use their experience to get through the pandemia. It is a question of attitude to life how upheavals are evaluated. Afterwards it is also decided whether one grows or fails by it. Moreover, not only the positive experience or evaluation of the change is decisive. Learning from the situation is also important according to Lettrari. Through the analysis of (personal) failure, an awareness of one's own resources, potentials and weaknesses can be developed. Lettrari et al. also speak of reflected or failed failure [21]. Thus, we cannot compare the "hard facts" of the "Wende" with

those of the Corona pandemia, but we can compare the feelings that were triggered in people when for example the shelves were empty. Collective resistance to crises cannot therefore be derived from the experiences of change. Nevertheless, East Germans have a special wealth of experience [36].

We suggest a different approach, as Vitzthum described in an article: “The Corona epidemic is a health crisis, but it is also a mental crisis. It is a crisis of certainties” [41]. Therefore, we should classify it as such: It is not about a simple comparison of GDR conditions versus pandemia conditions. Rather, it is about comparing and learning from what this does to people, what positive things are or can be learned from it; it is about learning for the future and rethinking this capacity for transformation competence.

Limitations and Conclusions

We would like to mention that we, as authors of the book chapter, were socialized in West Germany and our perspective is influenced by it, even though some of the authors have been living in eastern Germany for several years. In this context, we would also like to point out that we have translated all citations and text passages from German into English.

Both aspects should be taken into account and reflected upon in relation to our discussion points, because the interpretation of the co-researchers' statements cannot be detached from their own socialization or even age and life experience. Thus, it was by no means the aim of our chapter to contribute to a deepening of the presumed differences between East and West. It is difficult to write an article about “the East” and avoid the inevitable political “trench warfare” that often follows in the German East-West debate. With this article, we started the attempt to present transformation competence as a possibly concept and to explain reactions by applying it to the co-researchers in the project. By picking out individual aspects that appeared to us to be illustrative for the elaboration of transformation competence, we did not want to support a one-sided portrayal of East Germans. For, as already described in the discussion, the history of the GDR is ambiguous and was perceived differently and individually by the people. Therefore the focus should be a differentiated view and not polarization, but learning from each other from the past for the future and what we can learn from it.

When we started writing this article, only a few initial scientific studies and results regarding the corona pandemia were available. This can be attributed to the fact that the pandemia is a dynamic and rapidly changing phenomenon. There were no comparable scientific studies that put the categories “East German” and “age” in relation to the corona pandemia. Accordingly, it was a challenge to provide our generated results with an

appropriate framework based on scientific data. At the same time, our presentation and research with the older co-researchers has no general validity. Rather, they are representatives of a generation. In order to be able to make more general statements, larger-scale empirical studies would be required.

A further limitation refers to the concept of transformation competence itself. There is a lack of precision in the concept of transformation competence and the explicit distinction from resilience. This makes it difficult to identify factors that point to transformation competence. At the same time, we advocate decoupling from the dependence of the development of trans-formation competence exclusively under "Wende" experiences. In our view, transformation competence is a concept that could be used as a theoretical model and as such, applied across life spans. To date, there is a lack of further empirical studies to develop a useful theoretical model that covers a broad range of applications and as a life-spanning concept.

References

1. Amt für Statistik, Wahlen und demografische Stadtentwicklung. (2019). Statistisches Jahr-buch 2019 Landeshauptstadt Magdeburg. Magdeburger Statistische Blätter: Vol. 105.
2. Bahr, K., & Lorek, M. (2016). „Ja, wohin gehen sie denn?": Die „3. Generation Ostdeutscher" zwischen Suchen und Finden am Beispiel des 1.5 Generationskonzeptes. In A. Lettrari, C. Nestler, & N. Troi-Boeck (Eds.), Die Generation der Wendekinder. Springer Fachmedien Wiesbaden.
3. Blanckenburg, C. von, & Düben, A. (2016). Rückwanderung und Unternehmensgründung: Die Wege der Wendekinder zwischen Ost und West – Planwirtschaft und Selbstständig-keit. In A. Lettrari, C. Nestler, & N. Troi-Boeck (Eds.), Die Generation der Wendekinder. Springer Fachmedien Wiesbaden.
4. Bundesministerium für Familie, Senioren, Frauen und Jugend. (2010). Sechster Bericht zur Lage der älteren Generation in der Bundesrepublik Deutschland: Altersbilder in der Gesell-schaft.
5. Bundesministerium für Wirtschaft und Energie (2019). Jahresbericht der Bundesregierung zum Stand der Deutschen Einheit 2019.
6. Cohen-Mansfield, J., Hazan, H., Lerman, Y., & Shalom, V. (2016). Correlates and predictors of loneliness in older-adults: A review of quantitative results informed by qualitative in-sights. International Psychogeriatrics, 28(4), 557–576. https://doi.org/10.1017/S1041610215001532

7. Dahlberg, L., Agahi, N., & Lennartsson, C. (2018). Lonelier than ever? Loneliness of older people over two decades. Archives of Gerontology and Geriatrics, 75, 96–103. https://doi.org/10.1016/j.archger.2017.11.004
8. Deutsches Zentrum für Altersfragen (2020). Altersdiskriminierung und Altersbilder in der Corona-Krise.
9. Dudenredaktion. (o.J.). "Wende" auf duden online. https://www.duden.de/rechtschreibung/Wende_Kehre_Umbruch_Neuerung
10. European Commission (2014). European Innovation Partnership on Activeand Healthy Ageing. Action Groups: 2014 Achievements. https://ec.europa.eu/eip/ageing/sites/eipaha/files/library/547b777e7e45e_achievements_2014.pdf
11. Haag, H. (2018). Im Dialog über die Vergangenheit. Springer Fachmedien Wiesbaden. https://link.springer.com/content/pdf/10.1007%2F978-3-658-19263-1.pdf https://doi.org/10.1007/978-3-658-19263-1
12. Hakulinen, C., Pulkki-Råback, L., Virtanen, M., Jokela, M., Kivimäki, M., & Elovainio, M. (2018). Social isolation and loneliness as risk factors for myocardial infarction, stroke and mortality: Uk Biobank cohort study of 479 054 men and women. Heart (British Cardiac Society), 104(18), 1536–1542. https://doi.org/10.1136/heartjnl-2017-312663
13. Hummel, A. (2020, April 14). Ostdeutsche sind laut Sozialpsychologe krisenerprobt. Märki-sche Oderzeitung MOZ. https://www.moz.de/nachrichten/brandenburg/corona-ostdeutsche-sind-laut-sozialpsychologe-krisenerprobt-49400784.html
14. Ide, R. (2020, March 18). Die Wende-Erfahrungen der Ostdeutschen helfen in der Krise: Le-ben in Coronavirus-Umbruch. Der Tagesspiegel. https://www.tagesspiegel.de/politik/leben-im-coronavirus-umbruch-die-wende-erfahrungen-der-ostdeutschen-helfen-in-der-krise/25653902.html
15. k.A. (2020, July 9). Kaum Infektionen, krisenerprobte Menschen: Wie hart trifft Corona den Osten? MDR JUMP-Talk Im Osten. https://www.jumpradio.de/thema/corona/osten-corona-krise-wirtschaft-kultur-besser-schlechter-100.html
16. Kessler, E.-M., & Gellert, P. (2020). Öffentliche Kommunikation und Berichterstattung zu ‚Corona & Alter': Empfehlungen der Deutschen Gesellschaft für Gerontologie und Geriat-rie (DGGG), Sektion III (Sozial- und Verhaltenswissenschaftliche Gerontologie) (Stand 1. April 2020).

17. Kralinski, T. (2020, May 15). Wirtschaftlicher Neustart nach Corona: Erfahrungen aus dem ostdeutschen Transformationsprozess. Das Progressive Zentrum. https://www.progressives-zentrum.org/corona-wirtschaftlicher-neustart-erfahrungen-aus-dem-ostdeutschen-transformationsprozess/
18. Kubiak, D. (2020). Deutsch-deutsche Identitäten in der Nachwendegeneration. Aus Politik Und Zeitgeschichte (APUZ), 70(28-29), 35–39.
19. Leonhard, N. (2014). Gedächtnis, Wissen und soziale Integration. In O. Dimbath & M. Hein-lein (Eds.), Die Sozialität des Erinnerns. Springer Fachmedien Wiesbaden.
20. Lettrari, A. (2013a). Potenziale der Dritten Generation Ostdeutschland. Nicht entweder oder, sondern sowohl als auch! In M. Hacker (Ed.), Dritte Generation Ost. Wer wir sind, was wir wollen (3rd ed.). Christoph Links Verlag.
21. Lettrari, A. (2013b, November 30). Das Wissen der Wendekinder. Der Tagesspiegel. https://www.tagesspiegel.de/berlin/dritte-generation-ost-das-wissen-der-wendekinder/9149954.html
22. Lettrari, A., Nestler, C., & Porath, J. (2016). Wendekinder in der Berliner Republik und Euro-pa. Transformationskompetenz – eine etymologische, transdisziplinäre Exploration. In V. Benkert (Ed.), In Unsere Mütter, unsere Väter. Deutsche Generationen seit 1945. Campus Verlag.
23. Lettrari, A., Nestler, C., & Troi-Boeck, N. (2016). Einleitung: Der Werkzeugkasten zur Elabo-ration eines Forschungsfeldes. In A. Lettrari, C. Nestler, & N. Troi-Boeck (Eds.), Die Ge-neration der Wendekinder. Springer Fachmedien Wiesbaden.
24. Malycha, A. (2011a). Auf dem Weg in den Zusammenbruch (1982 bis 1990). In bpb (Ed.), Geschichte der DDR. Informationen zur politischen Bildung.
25. Malycha, A. (2011b). Der Aufbau des neuen Systems (1949 bis 1961). In bpb (Ed.), Ge-schichte der DDR. Informationen zur politischen Bildung.
26. Malycha, A. (2011c). Der Schein der Normalität (1971 bis 1982). In bpb (Ed.), Geschichte der DDR. Informationen zur politischen Bildung.
27. Malzahn, C. C. (2020, March 31). „Staatliche Autorität wird im Osten offenbar stärker akzep-tiert“. Welt. https://www.welt.de/politik/deutschland/article206922881/Haseloff-zu-Corona-Staatliche-Autoritaet-im-Osten-staerker-akzeptiert.html
28. Mau, S. (2019). Lütten Klein.: Leben in der ostdeutschen Transformationsgesellschaft (3rd ed.). Suhrkamp.

29. mdr AKTUELL. (2020). Chronologie der Corona-Krise. https://www.mdr.de/nachrichten/politik/corona-chronik-chronologie-coronavirus-100.html
30. Merkel, J. (2020). Corona-Demos: Was hinter den Protesten einer lauten Minderheit steckt. https://www.mdr.de/sachsen-anhalt/was-hinter-corona-protesten-sachsen-anhalt-steckt-100.html
31. Meynhardt, T. (2020, April 8). "Der Osten kann die Corona-Krise besser meistern als der Wes-ten". LVZ Online - Leipziger Volkszeitung, 2020. https://www.alexandria.unisg.ch/260115/1/20200408%20LVZ_-Der_Osten_kann_die_CoronaK-2114613840-Artikel.pdf
32. Michael, H., Maiwald, S., & Staemmler, J. (2013). ritte Generation Ost. Wer wir sind, was wir wollen. In M. Hacker (Ed.), Dritte Generation Ost. Wer wir sind, was wir wollen (3rd ed.). Christoph Links Verlag.
33. Presse- und Informationsamt der Bundesregierung. (2020, March 18). Fernsehansprache von Bundeskanzlerin Angela Merkel [Press release].
34. Rafnsson, S. B., Orrell, M., d'Orsi, E., Hogervorst, E., & Steptoe, A. (2020). Loneliness, Soci-al Integration, and Incident Dementia Over 6 Years: Prospective Findings From the Eng-lish Longitudinal Study of Ageing. The Journals of Gerontology. Series B, Psychological Sciences and Social Sciences, 75(1), 114–124. https://doi.org/10.1093/geronb/gbx087
35. Robert Koch-Institut. (2020, July 29). Informationen und Hilfestellungen für Personen mit einem höheren Risiko für einen schweren COVID-19-Krankheitsverlauf. https://www.rki.de/DE/Content/InfAZ/N/Neuartiges_Coronavirus/Risikogruppen.html
36. Scheffer, U. (2020, April 20). Hilft die Erfahrung der Wende in der Corona-Krise? Publik-Forum. https://www.publik-forum.de/Politik-Gesellschaft/fuer-den-osten-nichts-neues
37. Schindler, I. (2009). "Resilienz - Gedeihen trotz widriger Umstände": Diskussion eines Kon-zepts und seine Bedeutung für biographische Fallinterpretation und biographisches Erzäh-len. Diplomarbeit. Rosswein. Hochschule Mittweida-Rosswein.
38. Schmidt, C. (2018). Wie Zeitschriften, nur anders! Fanziness alss Medien der Bricolage In JuBri-Forschungsverbund Techniken jugendlicher Bricolage (Ed.), Erlebniswelten. Szenen, Artefakte und Inszenierungen: Interdisziplinäre Perspektiven. Springer Fachmedien Wiesba-den.

39. Sülzle, A. (2018). Forschen mit Fanzines. In JuBri-Forschungsverbund Techniken jugendlicher Bricolage (Ed.), Erlebniswelten. Szenen, Artefakte und Inszenierungen: Interdisziplinäre Perspektiven. Springer Fachmedien Wiesbaden.
40. Unger, H. von. (2014). Partizipative Forschung: Einführung in die Forschungspraxis. Springer VS.
41. Vitzthum, T. (2020, March 13). Dass eine Ostdeutsche dieses Land führt, ist ein Glücksfall. Welt. https://www.welt.de/debatte/kommentare/article206534725/Corona-Merkels-DDR-Erfahrung-ist-in-der-Krise-ein-Vorteil.html
42. Weltgesundheitsorganisation - Regionalbüro für Europa. (2020). Pandemie der Coronavirus-Krankheit (COVID-19). https://www.euro.who.int/de/health-topics/health-emergencies/coronavirus-covid-19/novel-coronavirus-2019-ncov
43. Wright-St Clair, V. A., Neville, S., Forsyth, V., White, L., & Napier, S. (2017). Integrative review of older adult loneliness and social isolation in Aotearoa/New Zealand. Australasian Journal on Ageing, 36(2), 114–123. https://doi.org/10.1111/ajag.12379

Ewa Grudziewska, The Experience of Loneliness in Older Adults During the COVID-19 Pandemic – a Polish perspective

Introduction

I recently read in a magazine that seniors are dying today not only as a result of COVID-19, but also due to fear, despair and loneliness. For many people, ageing is a difficult stage of life, and now one must additionally face feelings of endangerment and loneliness which are a certain type of borderline experience, especially in times of isolation. At times, a lack of support may lead to death.

In recent times, increasingly more studies and analyses whose aim is to demonstrate the way in which the pandemic has impacted people's lives have emerged. For the purposes of this research, the way in which Polish seniors cope in the era of COVID-19 was important. Do they feel lonely? What are the determining factors of their sense of loneliness?

At the beginning of November 2020, the Seniors' Congress took place at the Maria Grzegorzewska University in Warsaw, a cyclical event whose main objective is to show how contemporary seniors life, the difficulties they struggle with, and also to present the initiatives which are intended to activate seniors. As a participant, I had the opportunity to "meet with" seniors on-line as the organizers were forced to do so as a result of the COVID-19 restrictions. I was greatly impressed by the seniors who actively took part in the Congress by sharing their thoughts on the current situation. It was shocking that the majority of these people coped with isolation well, showing that even in one's own home, or in a social assistance home, it is possible to actively spend time and not give up. One of the seniors, Stenia (91), who was a participant in the Warsaw Uprising (as a nurse), compared the current situation to the occupation of Poland during the Second World War. The conclusion of her speech was that we can not lose hope or cheerfulness in any of these situations, that we should find joy in the smallest of things, whether this be a phone call from a scout helping seniors, delivering a warm meal, or going shopping. Strength for the times of isolation that lie ahead can and should be drawn from this short conversation.

Old age and loneliness, must they go hand in hand?

A survey conducted by the National Institute of Seniors (Krajowy Instytut Gospodarki Senioralnej) in August 2020 revealed that one of the most frequent problems that seniors indicated throughout the COVID-19 pandemic was limited access to medical care (including specialists), a lack of reliable information about SARS-CoV-2, and feelings of loneliness [1].

Both old age and feelings of solitude are rarely mentioned in daily conversations, and this includes representatives of academic disciplines dealing with these issues. It is more frequently possible to find studies that create an image of active seniors, who manage themselves well with daily activities, have many passions and interests, who develop due to having more free time, meet with friends, take part in various initiatives organized in their place of residence, and travel. It should be kept in mind that there are also seniors who struggle with several illnesses that complicate their daily lives, require assistance and support, and who experience intense solitude or even loneliness [2].

The need for social interaction is part of human nature. Loneliness can affect anyone regardless of age or social position. It is a universal, timeless, ahistorical phenomenon and constitutes a specific sign of our times. Long-term loneliness that is not the result of our own decision may result in a depressed mood, depression, physical illnesses and a reduction in quality of life. Aside from their negative impact on well-being, loneliness and social isolation have a significant detrimental effect on the mental and physical health of seniors [3]. The outbreak of COVID-19 has contributed to the loneliness of seniors who have already been affected by this problem to a great extent.

In terms of definition, loneliness and solitude are used interchangeably [4, 5]. In gerontological literature, these terms are defined as separate concepts. Thus, loneliness is "(...) a state resulting from one's own choice and consists in spending time only with oneself", while solitude "(...) results from an underdeveloped inner world, lack of order in which we create for ourselves a rhythm of existence different from that of the external world, other ways of measuring values and in which we are free of defeat, humiliation, triumph (...). It is a world free of suffering caused by others" [6]. It can be said that loneliness is searching for oneself, the ability to concentrate on one's inner world, and a certain type of indifference to the world. Loneliness gives a person distance, readiness to retreat and a sense of internal self-sufficiency, however, in the case of solitude, people do not find help in others and in their own inner world.

Zofia Dołęga differentiates three types of loneliness: (1) social loneliness (physical, objective), which is characterized by a lack of social bonds0 or belonging to a community, experiencing isolation and marginalization, a sense of being ignored or unneeded, or being unsatisfied with one's social relationships; (2) emotional loneliness (subjective) that manifests itself in a deficit of positive emotions and relationships with significant others, and also a sense of lacking close and satisfying emotional bonds, often related with a negative self-image as a partner in social relations; (3) existential loneliness, which is characterized by the lack of identification with generally accepted values, life goals and norms, and also not being anchored in the world and not accepting and agreeing with a specific image of the world [7, 8: 139-150].

The Association of the Little Brothers of the Poor conducted a survey in 2018 which revealed that 3 in 10 Poles aged 80 or older mentioned experiencing loneliness, however 1 in 10 stated that they feel lonely very often, if not always. In the group of 80+ seniors, half of them lived alone, 30% reported feeling lonely, 30% did not attend social functions, 20% did not have anyone to spend their free time with, and 10% of the surveyed seniors did not have anyone they could speak with about daily life [9].

The determining factors of loneliness in seniors may include:

– cultural factors associated with e.g., changing one's place of residence (in a care and treatment facility or in a social assistance home) as the result of a deterioration in health. Therefore, seniors must change their habits and adjust to the prevailing daily rhythm and habits;

– a lonely lifestyle, which is mainly a feature of residents of large cities;

– the loss of a close relative (widowhood) – this type of loneliness impacts solitude, and may also be the cause of depression or the deterioration of one's physical condition. Seniors approach death in a different way than young people, as in a certain sense, they are closer to it, because their family members, friends and neighbours are passing away;

– awareness of the inevitability of death – it can be said that the more seniors find themselves at the end of their lives, the more they may experience feelings of loneliness and solitude. A change in temporal perspective can also be observed in seniors, i.e., concentrating on the past and present, but without a future perspective [10; 84-90];

– the manner old age is treated in society, social reception and stereotypes;

– having a family does not prevent feelings of solitude, although it may serve as a factor that minimizes its experience [11].

In his analyses, G. Klimowicz presented the following three types of loneliness, making their occurrence dependent on their source causing them: a) interpersonal loneliness – "longing for" caused by death or departure of close people, b) social loneliness - triggered by isolation from or rejection by one's environment, c) cultural loneliness – evoked by a feeling of being different in the context of functioning in a group, d) cosmic loneliness - being "beyond" the meaning, experience of hopelessness and meaninglessness of life, e) psychological loneliness – experiencing alienation from one's own "self". This differentiation

seems to be particularly relevant when we attempt to relate it to the experience of older people. All of the categories may be attributed to the experiences of elderly people [12].

A consequence of isolation caused by the COVID-19 restrictions is a prolonged uncertainty about the future, a very high level of stress, hopelessness, anxiety mixed with a sense of being overwhelmed, as well as helplessness. This experience makes it difficult to cope without the assistance of one's environment. Therefore, it is important not to leave seniors alone as loneliness narrows one's field of view. This causes that attention is directed towards a person's deficits, e.g., physical illness, difficulties moving around, etc.

The author's own research

Sixty seniors took part in the study, whose number of samples was to a large extent conditioned by the COVID-19 restrictions. The average age of the participants was 76 – the youngest was 61, and the oldest, 91. Analyzing the gender of the surveyed seniors, 66.7% were women, while 33.3% were men. The largest group of participants in terms of place of residence consisted of seniors from cities with a population of more than 500 000 inhabitants (61.7%), while the smallest group was made up of people living in cities of from 50 000 to 150 000 people (5%). In terms of marital status, 63.3% of the surveyed seniors were widows or widowers, and only three participants were divorced (5%). The seniors were also asked if they had children, which from the point of view of the analyzed variable, was significant. Of the surveyed seniors, 83.3% maintain contact with their children, while 16.7% did not. As far as level of education is concerned, the largest group of participants was made up of people with secondary education (41.7%), 31.7% of the respondents had vocational education, 10% completed elementary education, while 16.7% possessed higher education. From among the surveyed seniors, 13.3% were professionally active, and combined their employment with retirement benefits (11.7%) or disability allowances (1.7%). The largest group constitutes seniors whose main source of income was retirement benefits alone (81.7%).

Table 1. The features of the surveyed seniors

		N	%
Sex	**Women**	40	66,7
	Men	20	33,3
Place of residence	**Village**	9	15,0
	City up to 50 tys. People	11	18,3
	City of from 50 to 150 tys. People	3	5,0
	City over 500 tys. People	37	61,7
Marital status	**Miss/Bachelor**	3	5,0
	Married	16	26,7
	Widow	38	63,3
	Divorce	3	5,0
Maintain contact with children	**Yes**	50	83,3
	No	10	16,7

Education	**Primary**	6	10,0
	Vocational	19	31,7
	Secondary	25	41,7
	Higher	10	16,7
Professional situation	**Professionally active**	8	13,3
	Professionally inactive	52	86,7
Sourveyed	**Retirement benefits**	1	1,7
	Retirement benefits	49	81,7
	Disability allowances	2	3,3
	Employment with retirement benefits	7	11,7
	Employment with disability allowances	1	1,7

For the purposes of collecting the empirical materials, the Revised Loneliness Scale (R-ULCA) adapted by M.M. Kwiatkowska, R. Rogoza & K. Kwiatkowska [13] (2017) was used. The R-UCLA includes 20 items reflecting satisfaction or dissatisfaction with social relations, half of them being formulated positively. In previous analyses [14] (Russell et al., 1980), each of the items had a discriminating power higher than 0.40, and, as in the case of the previous and further version, the reliability was perfect ($\alpha = 0.94$). Originally developed as an unidimensional measure, recent research suggests more complex interpretation possibilities, i.e., treating the loneliness as a construct established through two or the three distinct factors [15, 16, 17]. B.A. Austin [15] (1983) proposed that the loneliness can be defined not by two, but by three factors. These three factors of loneliness can be described as follows: (1) Intimate Others, which refers to solitude, rejection, withdrawal, feeling of exclusion and the breaking of social relations with other people, it is related to the unpleasant feeling of solitary confinement and being alone in the literal meaning of the word; (2) Social Others, which refers to not having a social network to connect with and lack of the feeling of closeness in relation with other people (in terms of their availability), it refers to the lack of contact with close relatives or trusted people who form a sense of safety and support; and (3) Belonging and Affiliation, which refers to a lack of a sense of group identity (affiliation) and bonds with a community, it refers to the weaker links with a social group and feeling more like an individual than a part of a group [15, 16].

The obtained results of the study were analyzed statistically. The values of the analyzed measurable parameters were represented by the average value and standard deviation, while the unmeasurable parameters were represented by numbers and percentage. The independent student's t-test was applied investigating the differences between the two groups. The Pearson's correlation coefficient and linear regression were used to verify the dependencies between the variables. The statistical significance was $p < 0.05$. The database and statistical test were conducted in the SPSS 27.0 package.

Results

At the outset, it was decided to determine the general average result for loneliness and its dimensions. Detailed results are presented in Table 2.

	M	SD	Min	Max
Intimate Others	22,83	5,82	10,00	35,00
Social Others	8,77	3,49	5,00	17,00
Belonging and Affiliation	10,98	3,38	6,00	21,00
Loneliness	42,58	11,18	21,00	67,00

Table 2. Loneliness - descriptive statistics

The conducted analyses revealed that in the Intimate Others scale, the minimum score was 10 points, the maximum score was 35 points, while the average score amounted to M = 22.83. In terms of Social Others, the minimum score was 5 points, the maximum score was 17 points, and the average score amounted to M = 8.77. As far as Belonging and Affiliation is concerned, the minimum scare was 6 points, the maximum score was 31 points, while the average score amounted to M = 10.98. In terms of Loneliness, the minimum score amounted to 21 points, the maximum score was 67 points, and the average score was M = 42.58.

The next step in the conducted analyses was to determine if the surveyed seniors' gender differentiated their sense of loneliness. The analyses conducted by using the (independent) student's t-test revealed that this sociodemographic variable does not statistically significantly differentiate loneliness. It can be observed that a slightly higher average score was obtained by the surveyed men in all three of the analysed dimensions, i.e., Intimate Others, Social Others and Belonging and Affiliation, as well as in Loneliness. Detailed data is presented in Table 2.

Table 3. Gender and loneliness in the surveyed seniors

	Women		Men		t	P
	M	SD	M	SD		
Intimate Others	22,80	6,29	22,90	4,91	-0,062	0,951
Social Others	8,72	3,20	8,85	4,09	-0,130	0,897
Belonging and Affiliation	10,95	3,21	11,05	3,79	-0,107	0,915
Loneliness	42,47	11,16	42,80	11,50	-0,105	0,917

It was then decided to verify if the age of the surveyed seniors significantly differentiates their sense of loneliness. As a result, as a dividing point for comparing the groups, the average age of 76 was adopted. The group of people under 76 consisted of 29 seniors, while 31 people were found in the 76+ group. Detailed results are presented in Table 4.

Table 4. Age and loneliness in the surveyed seniors

	Up to 76 years		**76 years and more**		**t**	**P**
	M	**SD**	**M**	**SD**		
Intimate Others	19,76	3,86	25,71	5,92	-4,576	**0,000***
Social Others	7,59	3,04	9,87	3,57	-2,661	**0,010***
Belonging and Affiliation	10,07	3,16	11,83	3,41	-2,082	**0,042***
Loneliness	37,41	8,51	47,42	11,32	-3,849	**0,000***

The independent student's t-test revealed statistically significant differences between the compared groups of seniors in terms of age. The conducted analysis revealed that people aged 76 and older (M = 25.71) experience Intimate Others to a greater extent than participants under 76 (M = 19.76; $p < 0.000$). As far as Social Others is concerned, significant differences between the compared groups of seniors were also observed. It turns out that seniors aged 76 and older experience Social Others to a greater extent (M = 9.87) than people under 76 years of age (M = 7.59; $p < 0.010$). A complete or partial lack of Belonging and Affiliation is more frequently a feature of seniors aged 76 and older (M = 11.83), and the conducted analyses revealed statistically significant differences ($p < 0.042$). In terms of Loneliness, the difference is also significant, in which a higher intensity of this variable is present in seniors from 76+ group ($p < 0.000$). Similar results were obtained in research conducted by Nowicki et al. (2018), in which it turned out that the older a person is, the higher the sense of loneliness.

Next, it was decided to verify whether maintaining contact with children differentiates the surveyed seniors' sense of loneliness during the COVID-19 pandemic. Therefore, the independent student's t-test was applied. The conducted statistically analyses showed differences in the surveyed group of seniors in relation to two scales. Detailed data is presented in Table 5.

Table 5. Maintaining contact with children and loneliness in the surveyed seniors

	Contact with children		**Not contact with children**		**t**	**P**
	M	**SD**	**M**	**SD**		

Intimate Others	22.06	5.84	26.70	4.11	-2.391	**0.020***
Social Others	8.24	3.22	11.40	3.75	-2.756	**0.008***
Belonging and Affiliation	10.64	3.33	12.70	3.27	-1.791	**0.079**
Loneliness	40.94	10.82	50.80	9.58	-2.676	**0.010***

The obtained results should not come as a surprise, because, as it turns out significantly higher average scores are characteristic of the surveyed seniors who do not maintain contact with their children. In terms of Intimate Others, the difference is significant at the level of $p < 0.020$, however, in Social Others $p < 0.008$. Significant differences were not noted in Belonging and Affiliation. Maintaining contact with children significantly differentiated Loneliness ($p < 0.010$).

It was also decided to verify, by means of the Pearson's correlation coefficient, which sociodemographic variables correlate with the sense in loneliness of the surveyed seniors. The obtained results (Table 6) show that the age of the surveyed seniors reveal significant correlations between all of the dimensions of loneliness and the global sense of loneliness. On the other hand, no correlations were found between any of the analysed dimensions of loneliness, however, maintaining contact with children significantly correlates with Intimate Others, Social Others, and Loneliness.

Table 6. Loneliness and age, gender and contact with children - correlations

	Sex	**Age**	**Contact with children**
Intimate others	–	.515**	.299*
Social Others	–	.330*	.340**
Belonging and Affiliation	–	.264*	–
Loneliness	–	.451**	.331*

∗∗ Correlation is significant at the 0.01 level (2-tailed).
∗ Correlation is significant at the 0.05 level (2-tailed).
– Correlation is not significant.

Finally, it was verified whether the analysed sociodemographic variables create models with loneliness and its dimensions. Therefore, the regression analysis was applied (Table 7). The obtained results showed that both age and maintaining contact with children are predictors of loneliness in seniors. The variables in the model explain 30% of the variances for Loneliness, 21% of variances for Social Others and 34% of the variances for Intimate Others. The most significant predictor of Loneliness is the age of the surveyed seniors ($\beta=0.447$), as in the case of Intimate Others ($\beta=0.518$) and Social Others ($\beta=0.317$).

Table 7. Regression results

	Dependent Variable	**Intimate others**	**Social Others**	**Belonging and Affiliation**	**Loneliness**
	Independent Variables	**β**	**β**	**β**	**β**
Sex		–	–	–	–
Age		.518**	.317*	–	.447**
Contact with children		.246*	.310*	–	.286*
N (df)		56	56	56	56
R^2		.341	.211	.115	.298

** Significant at 0.01
* Significant at 0.05
– Not significant

Research findings

The conducted analyses showed that seniors are characterized by a low level of loneliness both in the global dimensions and in terms of Intimate Others, Social Others and Belonging and Affiliation, which revealed the averages for the surveyed sample. Looking at the differences in terms of loneliness in relation to the sociodemographic variables such as age, gender or contact with children, it was observed that gender does not determine loneliness in seniors. However, the intensity of loneliness and its dimension increases with age, which is consistent with research carried out in this age group, i.e. people 60+, confirmed by studies conducted by C.M. Perissinotto et al. [18] and A. Singh & N. Misra [19]. Maintaining contact with close relatives (children) also significantly contributes to loneliness in seniors. These dependencies were confirmed by the Pearson's correlation coefficient and the linear regression analysis. Of course, these findings may be interpreted in relation to this specific sample and not to the entire population of seniors, however, this is certainly a trend that should be verified in a larger number of participants.

How can loneliness and solitude be prevented in seniors?

In terms of the consequences of isolation caused by COVID-19, it is obvious that all age groups have been negatively affected. Is it possible to avoid this type of effects both in terms of physical, but above all, mental health?

With all certainty, a brief telephone conversation with close friends and relatives (children, grandchildren, friends, or acquaintances) would be a "medicine" for many people, after all, daily conversations are a very important elements of our lives. Mobile phones with video functions, computers with Internet access are available (provided that one is able to operate them, although increasingly more seniors are perfectly able to manage themselves with new technologies). In the absence of close friends or relatives, assistance is provided by non-governmental organizations or special hotlines, e.g. The National Helpline for Seniors operating under the auspices of the Association of the Little Brothers of the Poor.

In Poland, a series of activities have been introduced in response to the implemented restrictions, which are aimed at supporting seniors in their daily functioning, e.g., delivering warm meals, shopping, buying medication. These activities are carried out by social assistance centres and non-governmental organizations. At the governmental level, the Solidarity Assistance Corps for Seniors has been established, thanks to which Polish seniors can receive necessary help throughout the pandemic. Within the framework of support, volunteers may assist with shopping, taking dogs for a walk, housework, or dealing with official matters, and perhaps most importantly, simply speaking with seniors. The need to have conversations with others may be the impulse for acquiring knowledge and new skills by people who have not had the need to use new technology.

References

1. Zdrowie polskich seniorów w czasie pandemii. Krajowy Instytut Gospodarki Senioralnej, Warszawa 16.09.2020 – https://kigs.org.pl/wp-content/uploads/2020/09/20200902_Raport_Zdrowie-w-pandemii-002.pdf (access: 6.01.2021).
2. Fopka-Kowalczyk M. & Krajnik M. (2019). Expectations and Self-Care of Family Members in Palliative Care. The Analysis of Needs and Workshop Plan. *Educational Studies Review*, 29(2), 91-110.
3. Steptoe, A., Shankar, A., Demakakos, P., & Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences of the United States of America*, 110(15), 5797–5801.
4. De Jong Gierveld, J., van Tilburg, T. G., & Dykstra, P. A. (2006). Loneliness and social isolation. In D. Perlman & A. Vangelisti (Eds.), *The Cambridge handbook of personal relationships* (pp. 485–500). Cambridge, UK: Cambridge University Press.
5. Grenade, L., & Boldy, D. (2008). Social isolation and loneliness among older people: Issues and future challenges in community and residential settings. *Australian Health Review*, 32(3), 468–478.
6. Szczepański, J. (1984). *Sprawy ludzkie*. Wydawnictwo Czytelnik: Warszawa.
7. Dołęga, Z. (2006). *Samotność młodzieży – analiza teoretyczna i studia empiryczne*. Wydawnictwo Uniwersytetu Śląskiego: Katowice.
8. Sendyk M. (2011). Osamotnienie jako konsekwencje zaburzeń więzi emocjonalnych w rodzinie. *Wychowanie w Rodzinie*, 4, 139-150.
9. „Sytuacja społeczna osób w wieku 65+" – wyniki badania zrealizowanego dla Stowarzyszenia mali bracia Ubogich przez ARC Rynek i Opinia, https://www.malibracia.org.pl/aktualnosci/samotnosc-polskiego-seniora/ (access: 12.12.2020).
10. Dąbrowska P. (2011). Samotność osób starszych i sposoby jej przeciwdziałania. *Kwartalnik Naukowy.* 6(2), 84-90.
11. Janiszewska, M., Barańska, A. (ed.) (2013). *Samotność i osamotnienie osób starszych wiekiem*. W: J. Zimny (red.). *Samotność: rzeczywistość czy fikcja*. Stalowa Wola: Wyd. KUL.
12. Klimowicz, G. (1988). *Przeciwko bezradnej samotności*. Warszawa: Nasza Księgarnia.
13. Kwiatkowska, M.M., Rogoza, R., & Kwiatkowska, K. (2017). Analysis of the psychometric properties of the Revised UCLA Loneliness Scale in the Polish adolescent sample. *Current Issues in Personality Psychology, 5,* 1–7. doi:10.5114/cipp.2017.69681.

14. Russell, D.W., Peplau, L.A., & Cutrona, C.E. (1980). The Revised UCLA Loneliness Scale: Concurrent and discriminant validity evidence. *Journal of Personality and Social Psychology*, *39*, 472–480. doi:10.1037/0022-3514.39.3.472.
15. Austin, B.A. (1983). Factorial Structure of the UCLA Loneliness Scale. *Psychological Reports*, *53*, 883–889. doi:10.2466/pr0.1983.53.3.883.
16. Hawkley, L.C., Browne, M.W., & Cacioppo, J.T. (2005). How can I connect with thee?: Let me count the ways. *Psychological Science, 16,* 798–804. doi:10.1111/j.1467- 9280.2005.01617.x.
17. Wilson, D., Cutts, J., Lees, I., Mapungwana, S., & Maunganidze, L. (1992). Psychometric properties of the Revised UCLA Loneliness Scale and two short-form measures of loneliness in Zimbabwe. *Journal of Personality Assessment*, *59,* 72–81. doi:10.1207/s15327752jpa5901_7
18. Perissinotto C.M., Cenzer I.S., Covinsky K.E. (2012). Loneliness in Older Persons: A predictor of functional decline and death. Arch Intern Med, 172(14): 1078-1083.
19. Singh A., Misra N. (2009). Loneliness, Depression and sociability in old age. *Industrial Psychiatry Journal*, 18(1): 51-55.

Bolesław Karcz, Seniors religiosity during the Covid-19 pandemic - Catholic Church in action

Religiousness of seniors

On the basis of social cohesion research, the Central Statistical Office developed an indicator of religious commitment based on declarations regarding attitudes, activity, activity, religious beliefs, as well as the sense of belonging to a religion or religious institutions.

It was about the sense of belonging to the Church, community or religious organization, manifested in membership and shared responsibility, as well as devoting time to community work within this community and the frequency of performing this work; attendance at events or activities organized by that organization, community (and the frequency with which it occurs); membership of the Church or religious association.

The self-declaration of faith was also taken into account - attitude to religious faith, religious practices assessed as the frequency of participation in holy masses, services or religious meetings, the frequency of prayers, sense of connection with a parish, church, local church, own religious community, and finally the importance of religious faith as a value in life. The older adults are clearly characterized by the highest level of religiosity. This mainly affects people aged 75 and over, but also people aged 65–74. Among people aged 75 and over, more than half (approx. 51%) are people with at least an average level of religious commitment, including the fact that over 10% was included in the very committed group. The group of the oldest people is also characterized by the lowest share of people not religiously involved and not related to any religion (18% in total). Among people aged 65–74, the total percentage of people who were not religiously involved and not related to any religion amounted to 28%, while people who were moderately or very religiously committed to about 41%, including very committed - almost 8% [8, p. 1-6]. It is true that this is a study for 2015-2018, as there are no current data for the last two years, but the level of religiosity is probably similar, although it definitely took a different form during the pandemic. However it is important, that seniors are the largest group involved in religious practices.

To better define the essence of religiosity, we must look at its definition. PWN (State Scientific Publisher) defines religiosity as:

1) in Christian theology, the moral virtue consisting in showing God due honor through internal worship (adoration, trust, love), as well as through external worship (sacraments, prayer, asceticism);

2) in psychology and sociology of religion, the attitude of a person or a social group towards dogmas, orders and religious customs in force in a given religion, which is manifested

through the assimilation of these principles, their acceptance and compliance with them; research on religiosity is empirical in nature and uses research techniques typical of psychology and sociology.

And although religion itself eludes empirical research, it should be stated that what can be observed is the fact that religion influences people and entire communities. This also cannot be investigated directly but through the religious acts of a specific individual. Man's involvement in various forms of worship, meditation on God, talking to him in prayer, deepening religious knowledge and conforming to ethical standards resulting from religion and acting in a spirit of love for one's neighbour - this is what we call religiosity [1, p.11].

In the context of a pandemic, individual faith and religiosity take on new meaning. Shocking events, enormous experiences of losses, a feeling of helplessness in the face of the power of C-19, forces that are not dependent on man, create a huge spiritual emptiness. The most important questions are asked: about the meaning of life, illness, death, about what is most important in life. They can transform the entire thinking system of mankind. The epidemic that is lived through, as an invisible force with a mysterious effect, but bringing death to many thousands of people, becomes a challenge for the spiritual and religious life of everyone who lives it.

The coronavirus crisis may become a wake-up call in times when the perceptions related to temporality dominate. Many people think of various paradises on earth where our human longings can come true - these are paradises: huge financial resources, leisure, travel into the unknown, countless shopping, extreme sports, for which people work hard just to get these "material paradises. ". Today it is necessary to go beyond these temporal-centered images to come to a true and complete understanding of humanity. This may become possible when we break these worldly visions and open ourselves to the perspective of heaven. This paradise belongs to God, but the way to it is made through a creative life for others, resignation from self-centeredness, avoiding self-destructive actions and destroying th-e bonds and living bases of others (2, p. 90-91). George Augustin read perfectly on the ethical and spiritual level, the abbreviation COVID (Corona Virus Disease) encoded in our memory by the epidemic. He proposes that we read it as follows:

C – *confidence* (*trust God*)

O – *opportunities* (*take advantage of opportunities*)

V – *values* (*rediscover essential values*)

I – *intelligence* (*to discern spirits in wisdom*)

D – *dedication* (*give a gift to God by committing yourself to people and the world*)

It can be said that this is a spiritual and ethical program for everyone in the current pandemic [2, p. 93].

For the purposes of this study, the above abbreviation COVID, proposed by the theologian Georg Augustin, was adopted in order to recognize the religiosity of seniors in the current situation.

C - *confidence* read as trust in God becomes the basis of religious life. The Church therefore calls for the experience of the pandemic to be interpreted as God's "signs of the times". It is significant that the time of the coronavirus crisis appeared shortly after the beginning of Lent. Many of the faithful interpreted this sign as a kind of extension and continuation of the mystery of Holy Saturday. In the Christian liturgy, it is a reflection on the day of the mystery of God's burying, His hiding and silence in human history, therefore it is also the day of the feeling of human hopelessness. This Holy Saturday of 2020, during the pandemic, has become a symbol of the difficult life situation of mankind - a symbol of the enormity of fears for one's own and loved ones' lives, fears for the future and the constantly asked question: when will the current crisis end and what will life after it look like [13, p. 44].

In view of the great unknown about the future, a question arises as to how to read this crisis and how to react to it. Should this experience be accepted as naturally occurring from time to time in history? Should we trust only on the experience of scientists and wait for a scientific-medical solution? Or should it also be read in the context of faith - trust in God? Christianity can reconcile all currents in the perspective of the "signs of the times" that God gives to live this time spiritually - reflecting on the appreciation of the gift of life, being a child of God, the transience of the world, looking at earthly life as a transitional place to live with God in eternity, the discovery of the family bond and the general human community. This is the time to trust God. *This trust is justified by the fact that the Holy Scriptures, with all their respect for nature, place great hope in God's grace and therefore constantly invoke their help in prayer, in the conviction that the deepest essence of prayer is the call of SOS, i.e. a call for help in the original meaning of this abbreviation : Save our Souls… Such trust in God's grace does not interfere with taking seriously the recommendations of experts who know the secrets of nature, which God created* [13, p. 50]. Seniors who have a lot of experience in life and those who experience its decline are more sensitive to transcendence and an eschatological view. They experience the trust of God's Providence more deeply, hence their prayer commitment - a conversation with a loving Father who takes care of his children and shows that "our homeland is in heaven" [Phil 3,20].

O - *opportunities* is the use of opportunities.

The Pontifical Council for the Laity in the document entitled *The dignity and mission of the elderly in the Church* pointed out that *the pastoral care of people of the third and fourth age should make it easier for elderly people to participate in the celebration of the Eucharist, to enjoy the sacrament of reconciliation, to participate in pilgrimages, retreats and days of recollection. Elderly people should also be accompanied spiritually. They should be given the opportunity to receive the Anointing of the Sick and Viaticum. As older people make up a large percentage of media audiences, especially as radio listeners, TV viewers and readers, it is important to ensure that programs and publications are particularly suited to them, so that they offer them not only material for relaxation and recreation, but also an aid to the ongoing formation that is desirable in all ages* [4, p. 102].

In this difficult pandemic time, the availability of the holy sacraments changed dramatically, especially to the Sunday or holiday Eucharist and to the sacrament of penance. The Holy Father Francis and the Episcopates of individual countries have made unprecedented decisions to limit the faithful participating in Holy Masses, and in some countries even completely cancelled them. It was dictated by the concern to limit the spread of the C-19 virus in the name of the most important commandment of love of God and neighbour.

Instead of actually attending Mass, many parishes have introduced Internet transmissions from their churches so that the faithful can unite in the prayer of the church community. Statistics showed that this kind of participation enjoyed the greatest participation of the absent participants of the Mass liturgy. Likewise frequent radio and television broadcasts. During this time, the faithful were introduced to such content as perfect repentance for sins and spiritual Holy Communion, which so far had been used by people living in non-sacramental relationships, i.e. those who could not receive sacramental absolution under ordinary conditions and receive Christ's Body [22, p. 265].

Numerous communities of the Church introduced evangelization content in interesting forms of expression into virtual reality and social-media. Little-visited websites of individual parishes so far became a place of very active contact with parishioners, where information about the latest parish life and initiatives was provided. Many people who had not taken much religious participation so far have made virtual contact with priests [17, p. 6]. Paradoxically, (…) *it was during the period of social distance, isolation and quarantine that pastoral ministry developed in the virtual space, and the Church strengthened despite the lack of access to the sacraments of believers and the experience of a community physically gathered in the same place* [17, p. 6-7]. A very significant element of contact was telephone

conversations with priests of a pastoral nature and organization of charity aid for the elderly suffering from disease, quarantine and isolation.

V - *values* reads as rediscovering relevant values. Many people today ask themselves: *Why do we have to deal with this type of crisis?* But such a question will not take us too far. Rather, you have to ask yourself: *What is this crisis for?* It is up to each person what to learn from this difficult experience, what conclusions they draw and what they will do to contribute to a better personal and social life.

The experience of the pandemic makes us realize that the question of life, the problem of noticing *conditio humana* in all its splendour and poverty, remains constantly relevant. It is the mystery of life that we can consider from different sides. We are even more aware that our earthly and biological life is limited, which gives rise to another reflection on the meaning of death and the transition to eternal life. It is a way to appreciate the value of life as a gift from God. *In the biblical sense, life is directed towards God and towards communion with Him. It is life in God and with God that is realized in living with others. All life takes place in the living presence of God: in the arising, in becoming and sustaining of a single life, as well as in its limitation through death, and in the hope of a living community that transcends this death* [2, p. 75].

The virus made us very brutally aware of human fragility and transience, as we realized even more clearly that we are mortal - threatened by a deadly disease that consumes thousands of people a day. Thus, death makes us aware of the mystery of life, which was very accurately expressed by St. Augustine, experiencing the pain of the death of his friend: *And I became a big question to myself* [2, p. 77]. *When we perceive our life as a gift, then God in Christ appears to us as a Giver ... As a creature, I can trust that even after earthly life does not cease to fellowship with Him, which in itself is life* [2, p. 83].

The value of life as a whole, i.e. earthly and eternal life, is the supreme value in times of crisis. *Faith, therefore, illuminates the mystery of death and illuminates with its light old age, which is no longer perceived and lived as a passive waiting for the moment of annihilation, but as a harbinger of the imminent achievement of full maturity. These years should be lived in an attitude of trusting entrustment to God, to a generous and merciful Father; this time should be used creatively, striving to deepen the spiritual life through more intense prayer and zealous service to brothers in love* [12, pt 16].

The second value is the experience of a family community. Already in the pages of the New Testament, the Christian family is presented as the domestic church. The Acts of the Apostles describes the first converted families and homes that became communities of worship, mission, and Christian help, and St. Paul describes communities of believers, i.e. the

Church, assembling at the house of Aquila and Priscilla [cf. 1 Cor 16,19; Rom 16,5], Philemon in Colossi [Philem 2], Nymphs [Col 4,15], as well as Gaius [Rom 16,23]. In the first centuries of Christianity, there were as yet no special places of God's worship, and believers in Christ flocked to ordinary houses. It was the family home that was the place of prayer, singing psalms, and most of all celebrating the Eucharist, and the place where attitudes of Christian help were shaped. St. John Chrysostom, who lived in the third century, was the first who called the family *a little church*, where the liturgy was celebrated, the texts of the Bible were considered, the truths of faith were taught, and alms were organized for the sick and the poor. He had a similar understanding of the family to St. Augustine. Following this idea, the Second Vatican Council called the family "home Church" [LG 11], where the faith is first transmitted through mutual love and common prayer, the family joins the liturgical worship of the Church and is a place where virtues are practiced and good works are performed [16, p. 120-121].

While the pandemic limited participation in services in churches and places of worship, it did help many families to understand better the essence of the domestic church, common prayer and the organization of help for others in the Christian spirit.

So far, in the efforts of parents who want to provide the best possible life for their children and the whole family, there has often been no time for themselves, for common conversations, and for their interest in children's experiences - their passions, progress in school education, sharing the time of adolescence, first infatuations and discovering love, puberty and making serious decisions about the future. The time of pandemic isolation forced to some extent to spend time together with the family. Many parents, as well as children and adolescents, worked and studied remotely at home, spent a lot of time with each other, having the opportunity to talk, get to know each other better and appreciate the gift of the family community. In many houses, people gathered together to experience the Sunday Eucharist through broadcasts or to participate in other services on-line. Many families have rediscovered the power of daily family prayer. The family, rediscovered in its essence, as *a community of life and love* [GS 48], is able to satisfy the need for care, friendship and security [16, p. 121-124].

The third value is the perception of seniors in family and social life. It is in the family community that the presence of seniors plays a huge role. Nowadays, when older people are perceived as "superfluous people", it is even more important to note that many people are reaching old age. Even today, young people or middle-aged people should remember this. In his *Letter to my brothers and sisters - elderly people*, John Paul II drew attention to the immensely important role played by seniors in society: *We all know old people who can be an*

eloquent example of amazing youth and vitality of spirit. Those who come into contact with them are able to use words to stimulate action, encouraging them by their own example. May society fully appreciate the old people who, in certain parts of the world ... are rightly honoured as "living libraries" of wisdom, guardians of the priceless human and spiritual heritage. While it is true that in the physical dimension they usually need help, it is also true that even in old age they can be a support for young people who take their first steps in life and seek their own way [12, pt 12].

The role of seniors in families and communities in the era of the coronavirus has become even more important. In many homes, children learning remotely are looked after by grandparents who help their parents by raising the young generation. They look after them, talk to them, help them learn, and shape their spiritual life through common prayer or participation in catechesis, Holy Masses and on-line services. It is one of the manifestations of religiosity, that is, the external expression of faith, bearing witness to Christian life and evangelizing the families.

However, it should be remembered that the family also has its Christian duty towards seniors, which was emphasized by John Paul II: *"Before you go gray, you will respect the face of the old man"* [Lev 19, 32]. *To honour old people means to fulfil a threefold duty to them: to accept their presence, help them, and appreciate their virtues. In many environments it is a natural way of proceeding, in line with the ancient custom. Elsewhere, especially in the more economically developed countries, it is necessary to reverse the current trend, so that the elderly can age with dignity without fear of losing relevance. We must realize that a truly human civilization is characterized by respect and love for old people, thanks to which they can feel - despite their weakening strength – they are a living part of society. Cicero wrote that "the burden of years is lighter for those who feel respected and loved by young people"* [12, pt 12].

The fourth value is appreciation of the church as a place of worship, a parish and the role of the clergy in society. Many believers suffer very badly from the lack of direct participation in the Church's liturgy due to the state authorities limiting the number of the faithful in Holy Masses and church services, and limited opportunities to use the sacrament of reconciliation and anointing of the sick. This particularly affects the sick and the elderly staying in hospitals or nursing homes. It was also necessary to reform the preparation of children for the First Holy Communion and confession, as well as the formation of young people preparing to receive the sacrament of Confirmation. In many parishes, these ceremonies were postponed, and in other cases, these sacraments were administered in small groups to conform to epidemiological recommendations. It was similar with the preparation of

the engaged couple for the sacrament of marriage and the conclusion of this sacrament by them. In the present situation, the possibility of participating in pastoral groups at parishes as well as direct contact with clergy has been limited. Many parishioners express deep pain and sadness at the inability to use the pastoral offers they have participated in and direct conversations with priests [14, p. 175-183].

The fifth value is the Church's chance to open up to those seeking a spiritual path and change of life. Many people who do not identify with the community of the Church and its teachings, lost in the covid chaos, are looking for answers to the bothering questions about the meaning of life, suffering and death. These searches are most often made in the virtual space, which the Church uses more and more often in its mission. These are contacts by e-mail or on social media and forums directed to parishes, pastoral groups, individual priests or believers, who give testimony of their faith in this space. The Second Vatican Council indicated three ways to open up dialogue: with other Christian Churches, with non-Christian religions and with "non-believers". The Czech theologian Tomas Halik describes the third group as *Noni*. They include people who do not want to be counted among the followers of any existing religion. *Noni* are not atheists who reject the possibility of God and a spiritual reality, but are a very diverse group, i.e. apateists (religiously indifferent), agnostics, anti-clericals, followers of different spirituality, syncretists, people disappointed or hurt by religious institutions and people who sincerely seek spiritual reality. He considers them a great task in the third way of dialogue, which he calls the *third ecumen.* In the future, the Church, apart from the traditional pastoral care of believers who belong to parishes or formation groups, will face a new task in addition to missionary activity focused on acquiring new members, that is *seeking spiritual accompaniment*, which already takes place in hospitals or prisons, where the service of spiritual support, consolation, and various conversations covers all those in need and is not focused on conversion in the ecclesial and religious sense. Nevertheless, conversion in the sense of *metanoia* is also at the centre of this ministry – a change of life, which Heidegger understood philosophically as *Khere* (a turn) - a departure from an inauthentic life in constant pursuit of only temporal needs, where you live like everyone else (Heidegerian "oneself", "one lives") to a real life based on the voice of conscience [9, p. 131-152]. Thus, the time of the pandemic presents the Church with new tasks.

I - *intelligence* - to discern spirits in wisdom.

Holy Father Francis on March 27, 2020 in the empty St. Peter, while praying for an end to the pandemic, delivered a very moving homily in which he said: *Thick darkness has gathered on our squares, streets and cities. They engulfed our lives, filling everything with a deafening silence and a gloomy void that paralyzes everything in its path. You can feel them*

in the air, notice them in their gestures, your eyes tell about it. We got scared and lost [6]. The pandemic has caused an acute fear that takes various forms, that is fear of infection, illness, death of loved ones, economic collapse of unemployment, bankruptcy and lack of development prospects, as well as fear of loneliness, loss of meaning in life and death. There is also doubt in God's Providence and fears about the future of the world. It also causes a natural fear, which is a spontaneous human reaction to the perceived danger. Nevertheless, in the midst of this chaos, there is the dangerous phenomenon of artificial fear inducement generated by the modern prophets of pessimism, the apocalyptic end of the world, and the supposed "hours of punishing God*"* [15, p. 45]. The basic mistake of these false prophets is to express themselves incorrectly and at the same time suggestively on behalf of God, giving erroneous ideas for solving a pandemic situation, falsified description of God's providence, which intervenes according to human ideas. This approach results in despair - a sense of hopelessness that leads to doubt and lack of faith in overcoming the threat.

It is wrong and dangerous to obsessively look for the person or groups of people who are responsible for the pandemic by condemning, stigmatizing and blaming them. Equally harmful is the presentation of a distorted historiosophy, invoking false revelations and dreams, misinterpreting biblical texts, as well as questioning contemporary Church teaching, e.g. on the order of nature and grace, the spiritual and material dimensions, which lead to the neglect of safety during the liturgy [15, p. 47].

We also cannot treat magically the sacraments and sacramentals or portray the Church as a "safe ark" that is reserved only for those attending Masses and services held in churches by reciting God's grace to those faithful who unite in the prayers of the church community through the mass media.

Particularly dangerous is the phenomenon of the creating and activity of pseudo-religious sects or groups using human fear related to C-19. The time of pandemic, anxiety, fear, isolation and death of loved ones causes depression states to many people who are subject to various types of contabulations and manipulations. It is used by some sects or so-called gurus who prey on people scared by the coronavirus, especially the elderly and the sick, separated from their loved ones. Often they are willing to give up their possessions, such as savings and even housing, to receive a false hope of survival. Since the coronavirus emerged, pseudo-religious groups have been attracting increasingly elderly people, terrified of the inevitable end of the world as we know it. *At the present time, the issue of health is becoming a sensitive issue, and therefore extremely delicate. Be careful ... Older people can be manipulated by some group, some self-proclaimed guru, by someone who will come and say that some particular therapy will help solve all problems* [10].

An example of such activity is the sect *Science about Happiness* spreading around the world (Japanese *Kofuku no Kagaku*). It was founded in 1991 in Tokyo by Ryoho Okawe and now finds its followers in Japan, USA, Uganda, Russia and Bulgaria. The sect's offer includes "effective exorcisms against C-19", and Okawa presents himself as having a special relationship with *El Cantara*, which is "Higher Spiritual Being" and "Higher Consciousness". *El Cantara* is the only spiritual being (depicted in the form of an angel with a white dove at his feet sending rays of grace) who combined the values of four religions: Islam, Christianity, Buddhism and Confucianism in order to obtain miracles, healings, deliverance from evil and provide happiness in life. In the temple of this sect in New York, there is distributed the book titled*: Spiritual readings on infection with the new strain of the coronavirus originated in China.* Okawa calls for faith in *El Cantara*, assuring that only he can eradicate the C-19 virus. Sect stores sell "exorcisms and blessings" for $ 100- $ 400. According to Okawa, the C-19 virus is a biological weapon that has eluded the Chinese supernaturally and turned against the communist, godless Chinese, as well as anywhere in the world where there is no "real faith" [23].

Also in South Korea, the apocalyptic sect of *Sincheonji* (Church of Jesus Christ of Heaven and Earth) founded in 1984 by Li Man Ki, who describes himself as the immortal incarnation of Jesus. Sect leaders forbade their members to follow the hygienic regime during a pandemic by wearing face masks and keeping people distant during collective services. They argued this with "God's wrath" that would reach anyone who did not follow the sect's recommendations, and the refusal to participate in the rites was unacceptable. Li Man Ki said that *if you betray our church, you become a dog and a pig; you lose your right to salvation.* He also called the C-19 "the devil's act" to discourage people from joining the ranks of *Sincheonja*. The authorities surveyed over 210,000 members of the sect. Some of them refused to do the tests. The Korean public filed a petition to ban the sect and collected over 1.25 thousand signatures of the citizens. South Korean authorities have brought charges against the guru of this sect regarding, among other things, murder, injury and violation of state laws regarding epidemiological control. Over 60% of 7500 people infected C-19 in Korea are *Sincheonji* followers. The sect has become one of the sources of the epidemic in this country. The sect operates in South Korea, the USA, China, India, New Zealand, Australia, as well as in some European countries, such as England [18].

In Poland, a sect called *New Covenant Church in Lublin* propagates various false information about the pandemic. According to them, C-19 is a product of the Chinese Communist Party, and Poland still belongs to the communist bloc due to the pandemic. They call the coronavirus a "biological weapon" as well as the "virus of the Chinese Communist

Party." They believe that the sect suffered losses by not being able to meet in public, and many of them had to go into quarantine, which contributed to financial and moral losses. The leader of the sect - Paweł Chojecki - founded an independent television called *Go against the current*, which presents only absurd theories about the virus, preached by the leader. Sect members and viewers of this television are urged not to watch any other information on the subject. There was created a system of mutual observation within the sect, and warnings against making friends and making new acquaintances. There was also organized an action called, which threatened the health and safety of Polish society, and Poles were threatened that all protective measures imported from China were deliberately infected with coronavirus. In his theses, Chojecki also refers to biblical texts, which he interprets as he pleases, bending them to his own false theories [22, p. 285-286].

There are many such sects and pseudo-religious groups in the world. They take advantage of the fear and anxiety caused by the pandemic. So you need to be very careful not to succumb to this type of manipulation. Therefore, the Church teaches to discern spirits in wisdom, because *mature religiosity requires human cooperation with God, combining human activities with openness to the gift of God's grace, reliable knowledge with deep faith, daily activity with fervent prayer* [15, p. 47].

D - *dedication* is to give a gift to God by committing yourself to people and the world.

The pandemic drew our attention to mutual love even more. Love for our neighbour is the most important distinguishing feature of biblical ethics. It can even be said that it has become a heritage of world culture. Mentioned in the Old Testament in Leviticus [Lev 19,18] [19], it was defined by Jesus as the most important commandment [Mark 12,28-34] [19], while the parable of the Good Samaritan became an image of mercy towards others, extending them beyond the boundaries of Christianity. *The love of neighbour is an ethics that puts the other in front of us, within our sight. It is not condescending but humble, not disrespectful but empathetic. It does not reach far away, but remains close to us, moving and touching. It is a matter of the heart - or it is not love of neighbour* [20, p. 100]. The commandment of love applies not only to the person of one's neighbour, but it strengthens those who follow it in three ways. First of all, it says: *You love*, so it is about personal commitment and not for someone else to do it. The second thing is to *love your neighbour*, that is, not anyone, but someone who lives in our world. This is a dimension of our responsible treatment of other people. And the third thing is that we should *love our neighbour as ourselves* - not selfishly, but also not as part of self-destruction. It is about shaping your humanity by finding fulfilment in helping others [20, p. 106].

Very rightly, the Church over the centuries, using its own capabilities, in the face of the lack of state organizations at that time until the modern times, built its own hospitals (shelters for the care of infected and seriously ill people). They served to care for the sick and isolate them, thus protecting others as well as enable pastoral care for patients and residents. Similarly today, church charities, incl. Caritas, Misereor, Adveniat, Missio, Renovabis help those in need all over the world, regardless of religion, skin colour or belief. In this way, the Church supports sustainable development, reduces risk and prevents social marginalization. The Church also has a duty to follow the rules of social distancing that are dictated by state authorities, based on the recommendations of medical experts, and strongly recommend them to be followed. It is inscribed in the most important commandment - love of God and neighbour [20, p. 119].

During the pandemic, numerous initiatives for seniors also play a very important role. *Therefore, all social initiatives, thanks to which the elderly can not only take care of their physical and intellectual condition and develop relationships with others, but also become useful by giving others their time, skills and experience, deserve recognition* [12, pt 16]. An important form of activity of seniors are various forms of education, currently mainly on-line. It can be carried out in various institutions - both organized (e.g. schools, universities, courses), and in informal institutions - through contact with the press, radio, television or the Internet [7, p. 295]. The rapidly developing universities of the third age also play an important formative and educational role. It is a new quality in the area of lifelong learning and intellectual and psychophysical activity [11, p. 13]. These institutions not only help retirees to organize their free time, but also often influence their spiritual development [5, p. 229].

The third age is the stage in life that should be used to engage in supporting others [21, p. 81-87]. Despite good health, these people sometimes have no motivation to engage in such pro-social activities. Therefore, those movements and organizations that help the elderly to abandon the attitude of distrust and resignation and try to make them those who are engaged in the service of love, share their wisdom and are witnesses of hope, deserve attention. *Let grandparents be active again in families, in the Church and in society. When it comes to families, let grandparents continue to be witnesses of unity in them, values based on fidelity to the one love that breeds faith and joy in life* [3].

To sum up - the topic of the religiosity of seniors during Covid19 based on the example of the activities of the Catholic Church - draws special attention to four aspects related to the social teaching of the Church.

1. The sociological and theological reflection indicates that the size and nature of the crisis should be properly assessed, that is, pandemic is not an apocalypse but a temporal phenomenon, the effects of which can be limited by decisive, appropriate and effective action. It is an experience that should make us reflect and seek a responsible life in security and freedom.
2. The crisis gives direction to our ethos, that is, all economic, social and medical activities are intended to emphasize the importance of human dignity. This is the stage of introducing global solidarity, which takes place first in our immediate environment and results in Christians from faith in God, and is carried out within the framework of the most important commandment - love of God and neighbour.
3. The Church as a community is to accompany all manifestations of the experience of sickness, suffering, sorrow, care and fears that affect individuals and their families in this pandemic time, as well as to comfort, strengthen, support people and remind people of the hope of eternal life, which does not negate the earthly, but illuminates it with its light.
4. Finally, service to others is also necessary. By undertaking charity work, the Church is there where general needs are met, in health care, in nursing the sick, in work with children and youth, in the field of education. This is done depending on the possibilities and social needs. Many of these actions are now carried out through the media

   [20, p. 127-129].

The principles of social life, i.e. the principle of the common good, solidarity and subsidiarity, to which the Catholic social teaching calls, are implemented in the pandemic era, going far beyond the boundaries of the Church, embracing spiritual and charitable help every person and above all seniors.

It is worth citing the reflection of one of the Internet users who wrote that *mankind got exactly the disease it needed. We stopped respecting health, so the disease made us realize that we should care more about it. We stopped being in families, so the disease locked us in our homes to remind us and teach us how to function with loved ones. We stopped respecting the elderly and the sick, so the disease exposed them the most so that we would remember how vulnerable they were. We have stopped appreciating health workers and pharmacists, so the disease has allowed us to see how essential they are. We stopped respecting teachers, so the disease closed our schools so that parents could try to teach their children themselves. We paid a lot of attention to our appearance and comparing ourselves, so the disease covered our faces to make us understand that beauty is not in appearance. The pandemic took a lot from*

us, but at the same time gave us the opportunity to learn and understand what is most important in life [16, p. 124-125].

References:

1. Adamski F., *Socjologia religii. Wprowadzenie*, in: *Socjologia religii*, (red.) F. Adamski, Petrus, Kraków 2011.
2. Augustin G., *Świadczyć o życiu w śmiertelnym świecie*, in: *Odkrywanie wspólnoty. Wiara w czasach pandemii koronawirusa*, (red.) W. Kasper, G. Augustin, Kraków 2020.
3. Benedict XVI, *Dziadkowie są cennym skarbem każdej rodziny*, https://opoka.org.pl/biblioteka/W/WP/benedykt_xvi/przemowienia/dziadkowie_05042008.html
4. Dziedzic J., *Kościół wobec starości. Perspektywa pastoralnoteologiczna*, Polonia Sacra 19 (2015) 1 (38).
5. Dziedzic J., *Starcie osób starszych. Przeszkody i szanse w poszukiwaniu godnej starości*, in: *Odnaleźć wykluczonych. Wsparcie terapeutyczno-duszpasterskie pacjentów szpitala Specjalistycznego im. dr. Józefa Babińskiego w Krakowie*, (red.) J. Dziedzic, J. Klimek, Wyd. Szpital Specjalistyczny im. dr. Józefa Babińskiego SP ZOZ w Krakowie, Kraków 2014.
6. Francis, *Homilia poprzedzająca błogosławieństwo Urbi et Orbi*, https://papiez.wiara.pl/doc/6235496.Franciszek-podczas-modlitwy-o-ustanie-pandemii (27.01.2021).
7. Gagat-Matuła A., M. Myśliwiec, *Wychowanie do starości*, in: *Starzenie się z godnością*, (red.) S. Steuden, M. Stanowska, K. Janowski, KUL, Lublin 2011.
8. Główny Urząd Statystyczny, *Życie religijne w Polsce. Wyniki badania spójności społecznej 2018*, https://stat.gov.pl/obszary-tematyczne/inne-opracowania/wyznania-religijne/zycie-religijne-w-polsce-wyniki-badania-spojnosci-spolecznej-2018,8,1.html (15.12.2020).
9. Halik T., *Pandemia jako doświadczenie ekumeniczne*, in: *Odkrywanie wspólnoty. Wiara w czasach pandemii koronawirusa*, in: *Odkrywanie wspólnoty. Wiara w czasach pandemii koronawirusa*, (red.) W. Kasper, G. Augustin, WAM, Kraków 2020.
10. Handerek Katarzyna, *Mieszkałam w sekcie*, https://www.polskieradio.pl/9/325/Artykul/2626431,Uwaga-Koronawirus-sprzyja-sektom (27.01.2021).

11. Ilnicka R., *Wychowanie do starości*, in: „Edukacja i Dialog" 4 (2006).
12. John Paul II, *List do moich Braci i Sióstr – ludzi w podeszłym wieku*, 16. http://www.vatican.va/content/john-paul-ii/pl/letters/1999/documents/hf_jp-ii_let_01101999_elderly.html[5]
13. Koch K., *Koronawirus widziany oczyma wiary*, in: *Odkrywanie wspólnoty. Wiara w czasach pandemii koronawirusa*, (red.) W. Kasper, G. Augustin, WAM, Kraków 2020.
14. Lipiec D., *Rozmowa duszpasterska w dobie pandemii*, in: *Duszpasterstwo w czasie pandemii*, Instytut Gość Media, Katowice 2020.
15. *Nota Komisji Nauki Wiary Konferencji Episkopatu Polski w związku z pandemią koronawirusa. „Jezus żyje i chce, abyś żył"*, in: *Duszpasterstwo w czasie pandemii*, Instytut Gość Media, Katowice 2020.
16. Przygoda W., *Wartość Kościoła Domowego w dobie pandemii*, in: *Duszpasterstwo w czasie pandemii*, Instytut Gość Media, Katowice 2020.
17. Skworc W., *Słowo wstępne abp. Wiktora Skworca, przewodniczącego Komisji Duszpasterstwa KEP*, in: *Duszpasterstwo w czasie pandemii*, Instytut Gość Media, Katowice 2020.
18. Stańko Katarzyna, *„Le Monde": epidemia Covid-19 zdemaskowała działalność sekty Shincheonji z Korei Płd.*, https://forsal.pl/artykuly/1460145,le-monde-epidemia-covid-19-zdemaskowala-dzialalnosc-sekty-shincheonji-z-korei-pld.html (27.01.2021)
19. World English Bible

    Lev 19,18 - *You shall not take vengeance, nor bear any grudge against the children of your people; but you shall love your neighbor as yourself: I am Yahweh.*

    Mark 12,28-34 - *One of the scribes came, and heard them questioning together. Knowing that he had answered them well, asked him, "What commandment is the greatest of all?" Jesus answered, "The greatest is, `Hear, Israel, the Lord our God, the Lord is one: you shall love the Lord your God with all your heart, and with all your soul, and with all your mind, and with all your strength.` This is the primary commandment. The second is this, Thou shalt love thy neighbor as thyself. There is none other commandment greater than these." The scribe said to him, "Truly, teacher, you have said well that he is one, and there is none other but he, and to love him with all the heart, and with all the understanding, with all the soul, and with all the strength, and to love his neighbor as himself, is more than all whole burnt offerings and sacrifices." When Jesus saw that he answered wisely, he said to him, "You are not far from the kingdom of God." No one dared ask him any question after that.*

20. Söding T., *Dystans i kontakt*, in: *Odkrywanie wspólnoty. Wiara w czasach pandemii koronawirusa*, (red.) W. Kasper, G. Augustin, WAM, Kraków 2020.
21. Lipiec D., *Rozmowa duszpasterska w dobie pandemii*, in: *Duszpasterstwo w czasie pandemii*, Instytut Gość Media, Katowice 2020.
22. Ziębińska B., Uniwersytety Trzeciego Wieku jako instytucje przeciwdziałające marginalizacji osób starszych, WN Śląsk, Katowice 2010.

23. Zwoliński A., *Od powietrza… Ludzie w czas zarazy*, Petrus, Kraków 2020.
24. https://ekai.pl/sekta-nauki-o-szczesciu-w-czasie-pandemii-koronawirusa/ (27.01.2021).

SOCIAL care and support

Linda Garcia, Louise Bélanger-Hardy, Martine Lagacé, To care or not to care: What have we learned from COVID-19 about our attitudes toward older adults?

> "Putting feminist conceptions of justice as care at the center of COVID-19 recovery may help us to recognize that we all deserve to live in a decent and just society that cares about us, cares for us through its priorities and investments, and supports our ability to care for each other" [9 p. 57]

The COVID-19 pandemic has unveiled and continues to unveil some of humanity's finest moments of empathy and solidarity. Unfortunately, the crisis has revealed the darker side of human conduct as well. In speaking about the COVID-19 worldwide, Antonio Guterres, Secretary General of the United Nations noted that "we see the disproportionate effects on certain communities, the rise of hate speech, the targeting of vulnerable groups, and the risks of heavy-handed security responses undermining the health response" [11].

The Secretary General reminded us as well that the ethical decisions we are making in this time of crisis are intricately tied to matters of human rights. Indeed, as store fronts and communities in Canada display signs saying "we're all in this together", public authorities have been making decisions about who can circulate freely, who has access to health care, and who can enlarge their social circles. Those decisions reveal much about how we really care about one another, while significantly challenging the perception that we are really "all in this together".

One of the so-called vulnerable groups targeted at the first signs of the virus were older adults. The significant impact of COVID-19 on individuals with multiple chronic conditions, of which a significant number are older, has been well documented. But, by far, what has left the most lasting impression on our communities is the impact of the virus on health and its disproportionate effect on the number of deaths in the older age group. This is one of the reasons why older adults were the first to be asked to stay confined to their homes.

The image of a vulnerable population in need of help from its fellow citizens quickly emerged which led to such measures as intergenerational assistance programs, designating shopping times slots for older adults, and so on. In other words, a discourse of protection of older adults began to materialize.

While this bleak situation was unfolding, a parallel trend started to occur worldwide. Some citizens began showing signs of not caring about the plight of older adults, possibly in reaction to increasingly restrictive demands to adapt to the pandemic. Advocacy groups and scholars documented references to hateful comments on social media about the impact of COVID-19 on older adults, with terms such as #boomerremover circulating widely on the

Internet. As well, at times, generations have been pitted against each other regarding the spread of the disease. As the crisis appeared to slow down, the need to open the economy appeared to have overshadowed the need to mitigate the risks facing older adults, at least in some instances. Many citizens ignored deconfinement measures and exhibited a lack of concern for the impact of their conduct on vulnerable groups, including some older adults. An important point to note is that older adults themselves sometime exhibit similar attitudes towards the very aged, the "super seniors" or "vulnerable and helpless" seniors. Some members of both younger and older generations apparently believe that the "we" in "we are all in this together" does not concern "them".

Explaining this type of behaviour is difficult and, while addressing this complexity goes beyond the aim of this chapter, we do argue that the current health crisis has brought to the forefront what appears to be an absence of "caring for the other". This lack of caring has not only occurred at the individual level but more broadly as well. Indeed, in Canada at least, the dismal situation in long-term care homes during the COVID-19 crisis, leading to over 80% of the COVID-19 related deaths in the country [13], has unveiled a number of serious ongoing problems within the long term care system. The pandemic has simply shined a light on issues that have existed for a long time.

In this chapter, we argue that the COVID-19 pandemic has had a significant impact on our desire and ability to care, and that older adults have been disproportionately affected by society's ineptness at caring, especially in western, high income countries. We suggest as well that our attitudes can be explained, at least in part, through the phenomenon of ageism. Negative conceptions of age influence how society values older adults but also, more generally, how we value care.

The first part of the chapter defines and illustrates the notion of ageism. We then examine the concept of care, relying on some of the contributions of scholars such as Tronto and others. We focus specifically on four dimensions of care: between generations, towards the very vulnerable, towards caregivers and by institutions and governments. We conclude by suggesting that, in the months, and perhaps years to come, our collective and individual efforts to contain the consequences of the COVID-19 pandemic must include genuine compassion and care not only for older adults but towards each other as well.

The unveiling of ageist attitudes

Within Western culture, the process of ageing and the status of old age are often negatively depicted [28]. The fact of growing older is largely associated with physical and psychological decline. Robert N. Butler was amongst the first researchers to study the

profound “malaise” expressed by many individuals towards ageing and old age, conceptualizing it as “ageism” [4]. Precisely, ageism refers to the “complex, often negative construction of old age, which takes place at the individual and the societal levels” [2 p.3]. Ageism underlies a cognitive, affective and behavioral component, namely a) negative stereotypes associated with ageing and old age (vulnerability, uselessness, helplessness, lack of autonomy, etc.); b) prejudice, i.e. negative emotions manifested towards older adults and c) discriminatory aged-based behaviors, such as avoidance, negligence and abuse of older adults [3]. Importantly, ageism may be manifested in a subtle way such as patronizing and over-accommodating language as well as overprotective behaviors. Although subtle ageism, also called “compassionate ageism”, may stem from a well-intentioned desire to help, it still conveys the predominant perception of older adults as frail, vulnerable and helpless individuals. Ageism may also take a hostile form such as physical, financial and verbal abuse. As stated previously, the discourse around older adults conveyed on some social media platforms at the very beginning of the pandemic – whereby the Covid-19 virus translated in the hateful hashtag “boomer remover” – undoubtedly echoes overt and hostile ageism.

Ageism permeates numerous social arenas and is particularly prevalent in health care contexts. Indeed, older patients can be the target of ageism on the part of health care providers – even if manifested in a subtle and well-intentioned way. This is so simply because care providers often perceive older adults as psychologically and physically fragile due to their age. For example, relying on secondary data stemming from surveys and clinical observations, Ouchida and Lachs [20] argue that during medical encounters, care providers communicate – verbally and non-verbally – in different ways with older adults than with younger adults. Specifically, physicians are more impatient and less engaged with older patients. They are also less likely to respond to the issues they raise.

Along the same lines, a substantial number of scholarly studies have documented the use of patronizing language during medical encounters with older patients. Health care providers may unknowingly patronize older adults using “elder speak.” This includes speaking slowly, with exaggerated intonation, using elevated pitch and volume, repeating oneself, and using simpler vocabulary and grammatical structures. The source of ageist communication seems to lie with care providers who may have subconscious misconceptions and stereotypes that older patients are frail, helpless, irritable, and dependent. In turn, older patients perceive elder speak as demeaning which results in lower self-esteem, withdrawal from social interactions, and depression [1]. Moreover, among residents with dementia living in long-term-care settings, elder speak has also been associated with increased resistance to care.

In sum, decades of studies on ageism demonstrate that this form of discrimination is prevalent in many facets of Western culture, for example, work, media, and healthcare. The negative impact of ageism on older adults is well-documented, increasing physical problems and feelings of social isolation while lowering self-esteem and self-efficiency. Notwithstanding the prevalence and negative impact of ageism, it remains one the most socially condoned form of discrimination. Under-reported cases of abuse and neglect in long-term care homes speak volumes on the prevalence of ageism. As will be argued below in this chapter, the pandemic seems to have exacerbated long time anchored ageist attitudes toward older adults, acting as a magnifying glass in terms of ageism's negative outcomes. This in turn appears to be linked to the absence of a "caring attitude" towards older adults.

Caring in an ageist society

At the time of the writing of this chapter, the world was still battling the repercussions of COVID-19. As countries struggle with their decisions about whether to open up borders, re-stimulate their economies, support their citizens and guide them in the best public health response possible, scholars are documenting the more subtle impacts of this pandemic, including social isolation.

The remedies for social isolation necessarily include contact with other people and this is severely impacted by containment measures requiring social distancing. Furthermore, academics working in the field of ageing have acknowledged for some time that older adults, in high income countries at least, are at disproportionate risk of social isolation. Should we not, then, be reflecting on how concerned we really are about the care others receive during a disruptive situation such as a pandemic?

Tronto (30; 31; 29] and Tronto and Fisher [32] have written extensively on the ethics of care. In their words, Tronto and Fisher [32] suggest that caring be viewed

"as a species activity that includes everything that we do to maintain, continue, and repair our 'world' so that we can live in it as well as possible. That world includes our bodies, our selves, and our environment, all of which we seek to interweave in a complex, life-sustaining web." [32, p. 40]

Tronto and Fisher's conception of care is at odds with the individualistic approach espoused by Western societies. Care presupposes a concern for the effect we have on each other and requires an ethical and moral duty to respond to each other's needs.

During the ongoing pandemic, there have been instances where citizens of all ages have shown concern for others and where caring for one another has been at the forefront of individual and community initiatives. However, as the pandemic and its aftermath unfold, we

unfortunately continue to see significant evidence of lack of concern for others. The challenges of "caring" occur in a number of contexts including intergenerational interactions, very vulnerable populations, relations with caregivers and finally, public authorities' interventions before, during and after the pandemic.

Caring about other generations

The public discourse on ageing and older adults – whether conveyed by the media, the government, or the research community – shapes or at least partly shapes individual perceptions and personal experiences of ageing. The process is one of normalization and internalization of social representations of ageing within a person's scheme of beliefs [22]; in turn, the process influences how members of different generations perceive and interact with one another.

Within the intergenerational discourse, many studies have concluded that representations of ageing and older adults are mostly negative and polarized [15]. On the one hand, the ageing process is depicted either as a social and economic burden whereby older adults are associated with rising health-care costs, especially seniors living in long-term care facilities. On the other hand, studies point to a mainstream public discourse that praises older adults who manage to counter signs of ageing and embody images of youthfulness. In both cases, as argued by scholars, such polarized representations are fueling ageism at the *inter* and *intra* generational levels [23]. In the former, negative, and homogenized views of ageing may deepen the gap between younger and older generations, while in the latter case, "false positive" views of ageing may actually create a divide amongst older adults themselves.

The COVID-19 pandemic sheds further light on representations of ageing and older adults in the public discourse and the ways younger and older generations perceive and care for one another. Studies conducted at the very beginning of the crisis are quite revealing to this effect, pointing to an exacerbation of ageist stereotypes. For example, Jimenez-Sotomayor, Gomez-Moreno & Soto-Perez-de-Celis' [14] content analysis of the portrayal of older adults in social media shows that almost a quarter of 362 tweets posted during the period of March 12 to 21, 2020 reflected offensive and denigrating content towards older adults. Mainstream media portrayed older adults as "vulnerable" individuals needing to be protected from the virus and its impact [8]. It goes without saying that this vulnerability label (applied solely on the basis of age, i.e. persons aged 65 years old or more) not only reinforces ageist stereotypes but positions older adults as victims that cannot take part in a process of collective resilience against the virus [19].

Caring about the most vulnerable

Older adults living in long term care homes (LTCH) constitute some of the most vulnerable citizens affected by the COVID-19 pandemic. Many of the residents in LTCH are part of the "oldest old". The Ontario Long-Term Care Association (OLTA), the largest association of its kind in Canada, confirms in one of its recent reports that 82% of residents (public and private facilities combined) are over 75 years of age and 55% are over 85 years of age [18]. These statistics, representative of LTCH residents across Canada, are unlike the demographic make-up of residents of 30 or 40 years ago, when residents were younger. Furthermore, due to successful "*ageing at home"* programs, older adults in LTCH live with more complex and chronic health conditions than yesteryear thus presenting the staff with an increasingly older population with complex needs and in need of increasingly specialized care.

In fact, beyond age, the presence and nature of two or more chronic health problems, i.e., comorbidity, increases the vulnerability of people living in LTCH. It continues to be clear, as it was when COVID-19 presented itself in China and Italy, that those most susceptible to the coronavirus are those with multiple health conditions, particularly diabetes, chronic obstructive pulmonary disease, and cardiac conditions. Why, in Canada, did we not anticipate and, above all, plan for the eventuality of a crisis involving older adults with such conditions?

One feature of LTCH in Canada is that personal support workers (PSW) who care for the residents' most basic needs and activities of daily living are not a self-regulated, autonomous profession. Their wages are low, and their precarious situation leads them to work in more than one LTCH. One of the most publicized issues of the COVID-19 pandemic was the retention of PSWs who, in some cases, left their workplaces due to burnout or inadequate protective equipment. The absence of several employees forced those who remained to continue working in conditions that were not only very difficult, but also more conducive to the further contamination of residents, as employees moved from floor to floor or from LTCH to LTCH. We wonder how this could have been allowed since authorities knew full well, from the outset of the pandemic in Canada, that the COVID-19 virus was highly contagious and could be transmitted by asymptomatic individuals.

We equally wonder why the push to provide sufficient personal protective equipment to the staff was not prioritized as it had been when the focus was on acute care. It became very clear when the pandemic was declared in mid-March 2020 that protective measures, including masks and other personal protective equipment, were not available in sufficient numbers. The lack of planning and preventative measures in LTCH must be decried when authorities knew

that these places were highly vulnerable to the spread of the virus and that the disease could wreak havoc on residents.

In the end, the health crisis caused by COVID-19 exposed a disturbing reality: many of our most vulnerable older adults live in environments where health providers are overworked, poorly paid, and where their specialized skills are neither recognized nor valued.

Caring about caregivers

The importance of understanding the role of unpaid care has been heightened by the COVID-19 pandemic. About 8 million Canadians provide care to a relative or a friend [26], comprising more than 80% of the care needed and contributing to over 25 billion dollars in unpaid work [12]. This is also not limited to Canada. The demographic change is so great worldwide that no country in the world, whether low-, mid- or high-income will be able to adjust without supporting a strong informal caregiver base. The complexity and importance of care have never been clearer. Faced with the added burden of COVID-19, family and friends are tested as they seek to provide support despite reduced, withdrawn or canceled community respite services and home care.

Yet, while there have been numerous news reports, preliminary studies, commentaries, and political speeches about the effect of the pandemic, very few have addressed the needs of this very significant portion of our population. We have known for years that those who care for older adults, especially older adults with dementia, need help from others to carry on [21], but that these needs are often unmet or ignored by formal health care workers. While caregivers of older adults are not homogenous in their needs, all of them require a form of relief from caregiving duties and time for themselves. Queluz et al [21] found evidence that caregivers' inability to take care of themselves was "directly related to lack of help from others [21 p. 48]".

The data on the long term impact of the pandemic on caregivers remains to be collected, but we can reasonably presume that results will confirm this impact was significant, especially since we know the experience of caregiving often has negative consequences on caregivers' health and wellbeing [25]. Some caregivers of older adults are now left to care for their loved ones with no additional care and support from others, whether they be paid caregivers or family, friends or volunteers. As well, these caregivers must deal with the effects of the COVID-19 pandemic on their own lives. Greenberg, Wallick and Brown [10] point out that it is difficult for these caregivers to find down time and respite from the demands placed on them.

Studying a group of caregivers living in India, Vaitheswaran et al [33] have described the increased demands made on caregivers of people with dementia during the crisis. This group of older adults may not fully understand the COVID-19 situation, leaving it up to caregivers to manage public health recommendations in addition to dealing with the care they habitually provide. With the pandemic adding to other demands, Vaitheswaran et al [33] report additional concerns from caregivers related to issues such as the protection of loved one from disease, managing isolation with older adults who do not understand the situation, and changes in routines which are known to impact some of the behaviours expressed by the unmet needs of the care receiver with dementia.

Fortunately, there has been some level of social support given to older adults during the COVID-19 pandemic and this has filtered to caregivers as well. Technology has helped caregivers stay connected, essential groceries and needs have been provided by kind family members, neighbors and volunteers, and some informal support has been given through advocacy groups through online means and visits from a distance [16]. However, at the time of the writing of this chapter, we still struggle to manage the new cases of COVID-19, we continue to push aside the needs of those caring for older adults. As has been noted above, we rely extensively on these individuals to make sure that older adults' needs are met. If not met prior to COVID-19, there is certainly no chance that COVID-19 helped matters. The forgotten group of caregivers of older adults will most definitely need care post pandemic.

Caring from a systemic / governmental perspective

The COVID-19 pandemic's disproportionate impact on older adults living in long-term care points to the need for consideration of the role played by governments and by care institutions in managing the crisis. Clearly, in Canada at least, the pandemic has revealed the inadequacies and weaknesses of existing networks and systems. While post-SARS reports led to a number of reforms in Canada, including the restructuring of public health institutions [6], little consideration has been given to pandemic management and the older population. While this may be explained by the fact that both the SARS and 2009 H1N1 outbreaks did not target older adults, we nonetheless believe it is fair to ask why preparedness plans failed to include a part of the population more susceptible to health challenges and comorbidities.

Despite foreseeable demographic changes marked by an ageing population and an increase in the number of frail older people, political and social choices regarding the most vulnerable seniors have had serious consequences during the pandemic. Despite clear indications that many of the problems were well-known for decades, the proper steps to address the risks in caring facilities were not taken early enough, with devastating results. For

example, in Ontario, Canada's most populous province, the Canadian Armed Forces (CAF) were called in to assist residents in some LTCH. After a number of weeks, the CAF Joint Task Force Central rendered public a 15-page report [17] based on the observations of its military personnel in the five Ontario LTCH deemed by the province to have required the most support. The report revealed severe instances of regulatory violations and neglect, spanning from non-adherence or non-existence of policies (ex: lack and/or improper use of personal protective equipment (PPE) by staff, use of expired medication, absence or improper charting), inadequate resources including trained staff and medical supplies, poor or little training, deficiencies in infrastructure (ex: insects, inadequate disinfection), concerns about standards of care (ex: poor catheter hygiene, poor or inexistent treatment of pressure ulcers), general neglect(and finally, violence (ex. aggressiveness, forceful feeding and degrading comments about residents). In the neighboring province, Quebec, the situation in some homes has been dire, with a large number of deaths, severe worker shortages and insufficient PPE. In one particular home, the care was reported as substandard, with residents not adequately fed, and staff deserting the home in the middle of the outbreak.

While one must recognize that not all LTCH in Canada are deficient to the extent described in the Joint Task Force report, we suggest that the information in such reports does not align in any way with a caring society, caring institutions or caring governments.

But, are governments and public bodies in the business of "caring"? The current literature suggests that they should be, and highlights the need to reflect on how care ethics can be applied to institutions and social policy. For instance, Stensöta [27 p. 185] notes that "ethics of care" has traditionally been discussed in the context of care-based settings but that, increasingly, the notion is relied on "to dissect the current arrangement of care provision (or rather non-care provision) in policies and administrative procedures". For her part, FitzGerald [7 p. 255], argues that care ethics in its "political" dimension "provides a more fruitful path forward if our concern is reaching the full radical transformative potential of an ethics of care". To this end, she "imagines" a governmental Department of Care working "towards new distributions of responsibility for care through democratic processes" [7 p. 257] and "both caregivers (whether professional or otherwise) and care receivers would need to be consulted on an ongoing basis; each programme would have to facilitate the exchange of ideas, concerns, and feedback related to the ways in which the programme is (re)structuring the caring relation" [7 p. 258]. While the creation of such a governmental department is not imminent (not to say unrealistic), the suggestion makes us reflect on the importance and relevance of "care" in transforming all facets of our societies.

Caring now and in the future

As countries move towards deconfinement and as our citizens learn to adapt to life during a pandemic, we must start to reflect on the lessons learned and on our approach to caring for one another. Did we learn anything from the COVID-19 pandemic so far? Gary and Berlinger [9] reflect on this very question. In their commentary, they rely on Tronto's [29] conception of care to highlight the undervalued status of care workers in our society. This attitude shows that we must reframe the importance given to care and we must see our commitment to caring for older adults as a societal responsibility. Gary and Berlinger [9] consider the components of the ethics of care concept to examine how societies might respond to the needs of their members rather than neglecting them in moments of hardship. Undeniably, Tronto and Fisher's [32] four phases of care can help us think about how we have approached care for one another during this pandemic and how we might repair our world as we move forward.

The first phase of the ethics of care, *caring about,* involves recognizing and listening to the needs of others. Clearly, as noted above, this has not always been the case during the current pandemic. For example, when, during the period of deconfinement, individuals gather in large groups, refuse to follow directives and, in extreme cases, deny the very existence of the pandemic, concluding that some members of society do not "care about" others, more vulnerable than they are, is logical. Notwithstanding the exemplary initiatives from many groups, mainly advocacy and volunteer groups worldwide, one seriously questions our collective and individual ability to truly care about the older members of our society.

The second phase identified by Tronto and Fisher's, *caring for,* refers to our sense of responsibility in addressing identified needs. As we have seen in the examples above, we have failed as a society to recognize our responsibility towards older adults in LTCH. Despite having known of the challenges and the demographics in LTCH for many years, we were incomprehensively unprepared for outbreaks in settings where individuals were particularly vulnerable. Only a few months into the pandemic, and after a significant loss of life, did governments step up to mitigate the devastating consequences of the pandemic on LTCH residents.

The third phase of the ethics of care, *care giving,* refers to the actual action of giving care. Once a need is identified and acknowledged action must be taken. Have we, as a society, failed in this regard as well? In large part, we believe we have. As described above, an important segment of society has been left without caregivers, without protection and without resources to address pressing needs. Numerous reports have described how older citizens were left to die alone. From a practical perspective, the tools for caring (personal protection

equipment, human resources etc.) were slow in coming [5]. Caregivers have had to wait a long time before getting help from advocacy groups and others, leaving a number of care recipients to their own devices. Governments have eventually provided assistance to LTCH, but have failed to consider the integration of families and volunteers in the circle of care.

The final phase of and Tronto and Fisher's ethics of care is *care receiving.* In this final and very important phase, ethical care is measured as a function of how well the actions respond to the needs of the care receiver. At this point of the pandemic, it is be safe to say that most of the care receiving for older adults has been related to the care of the physical self. In other words, the need to live was addressed quickly, but it can be argued that even this need was not met and continues to not being met in certain parts of the world. While older adults are now receiving attention in LTCH, it is unclear whether the caregiving actually meets the needs of the care receivers [30]. More studies will be required to assess how care receivers are faring.

Conclusion

The COVID-19 pandemic has shown us that we are as ageist as ever, that we like to blame others for what is happening and that we really are not "all in this together". Older adults are not blameless when it comes to lack of care. As noted, ageist attitudes are not the product of younger generations alone. Just like their younger counterparts, many older adults are guilty of not heeding to public health directives. Studies have shown that they prefer not to be confronted with their older selves. They can be as guilty of neglecting the needs of older adults as individuals in younger age groups. We are all in this together when it comes to our collective failure to care.

Unfortunately, there is some indication that we have many challenges ahead of us. Progressive deconfinement in many countries has led to a disregard for public health guidelines, demonstrations worldwide on the requirements needed to keep everyone safe, silence from all of us, including the boomer generation, on what is happening to older adults. We are creating societies where meeting our own needs overrides everyone else's; we make judgments based exclusively on age and we pit generations against each other. Surely this is not the ethical world in which we hope to live.

The current pandemic will end one day. What will happen in LTCH once the worst is over? How will we speak of other generations? What will happen to caregivers and what steps will our governments take to make sure older adults are respected and recognized as contributing members of our society?

We must recognize that structural, organizational, administrative and financial improvements could very well lay the groundwork for better caring of others (especially those in great need). However, we suggest that such measures will not be sufficient if they are not supported by a profound social and political rethinking of the values we hold about ageing and older persons. The first step implies an acknowledgment of the prevalence of ageism and the recognition that the phenomenon affects our ability to truly care for others.

Reflecting on our value system in the face of ageing and questioning ageism are colossal tasks, but change is achievable. We propose an upstream measure. Since ageism is a matter of representations that are acquired early in life, we believe that awareness of ageist prejudices and discrimination should be integrated to the educational pathway of the youngest members of society. Moreover, in the workplace, and particularly in long-term care settings, awareness of ageism should be a *sine qua non* condition of employment for caregivers, managers, and residents alike. We suggest that raising awareness of ageism through education and training would be the starting point for a change in our value system.

However, in order to bring about this change in values, it is necessary to go one step further and put in place political and legal mechanisms that can serve as a springboard for the development of initiatives to address ageism. This is the objective behind, for example, an international convention protecting the rights of older persons. This instrument would give older adults a voice, choices and, *de facto*, the right to demand that social actors respect their person and their health. Older adults are as diverse as any other age group. A convention is not meant to isolate them from other social groups. Rather, such an instrument aims to protect them from society's lack of recognition, lack of responsibility, lack of action and lack of effort to adequately meet their needs. A UN Convention on the Rights of Older Persons would give an additional tool to argue that older adults do indeed have a right to be cared about, cared for, and be both care givers and care receivers.

We are currently living in situations where we must continuously decide how to act, whether to put on a mask, to visit, to support others. As well, as Schimmenti, Billieux and Starcevic [24] eloquently describe, the COVID-19 pandemic has created fear: fear of the virus, fear for and of loved ones, and fear to make decisions. All these fears are age neutral. And, in this sense at least, we are indeed all in this together. We just need to care that we are.

References

1. Atkinson, J.L., & Sloan, R.G. (2016). Exploring the Impact of Age, Race, and Stereotypes on Perceptions of Language Performance and Patronizing Speech, *Journal of Language and Social Psychology*, 36(3), 287-305. https://doi-org.proxy.bib.uottawa.ca/10.1177/0261927X16662967
2. Ayalon, L. & Tesh-Römer, C. (2018), *Contemporary Perspectives on Ageism*, In *International Perspectives on Aging book series*, volume 19, 564 pages. https://doi.org/10.1007/978-3-319-73820-8
3. Ayalon, L, Dolberg, P., Mikulionienė, S., Perek-Białas, J., Rapolienė, G., Stypinska, J. Willińska, M. & de la Fuente-Núñez, V. (2019). A systematic review of existing ageism scales, *Ageing Research Reviews*, Volume 54. https://doi.org/10.1016/j.arr.2019.100919
4. Butler, R.N. (1975) *Why Survive? Being Old in America*, Harper & Row. pp. 496 pages.
5. Faghanipour, S, Monteverde, S, and Peter, E. (2020) COVID-19-related deaths in long-term care: The moral failure to care and prepare, *Nursing Ethics*, 27(5) 1171-1173. https://doi.org/10.1177/0969733020939667
6. Fierlbeck, K. and Hardcastle, L. (2020) Have the Post-SARS Reforms Prepared Us for COVID-19? Mapping the Institutional Landscape In C. Flood, V. MacDonnell, J. Philpott, S. Thériault and S. Venkatapuram (Eds) *Vulnerable – The Law, Policy and Ethics of COVID-19*, University of Ottawa Press.
7. FitzGerald, M. (2020) Reimagining Government with the Ethics of Care: A Department of Care, *Ethics and Social Welfare*, 14:3, 248-265, https://doi.org/10.1080/17496535.2020.1746819
8. Fraser, S., Lagacé, M., Bongué, B., Ndeye, N., Guyot, J., Bechard, L., Garcia, L., Taler, V., CCNA Social Inclusion and Stigma Working Group, Adam, S., Beaulieu, M., Bergeron, C. D., Boudjemadi, V., Desmette, D., Donizzetti, A. R., Éthier, S., Garon, S., Gillis, M., Levasseur, M., Lortie-Lussier, M., … Tougas, F. (2020). Ageism and COVID-19: what does our society's response say about us?. *Age and ageing*, *49*(5), 692–695. https://doi.org/10.1093/ageing/afaa097
9. Gary, M., & Berlinger, N. (2020, May 1). *Interdependent Citizens: The Ethics of Care in*

   Pandemic Recovery. Hastings Center Report. John Wiley and Sons Inc. https://doi.org/10.1002/hast.1134

10. Greenberg, N. E., Wallick, A., Brown, L. M. (2020), Impact of COVID-19 Pandemic Restrictions on Community-Dwelling Caregivers and Persons with Dementia, *Psychol Trauma.* 12(S1): S220-S221. https://doi.org/10.1037/tra0000793
11. Guitteres (2020) *We are all in this Together: Human Rights and COVID-19 Response and Recovery*. https://www.un.org/en/un-coronavirus-communications-team/we-are-all-together-human-rights-and-covid-19-response-and
12. Hollander, M. J, Liu, G. and Chappell, N. (2009) Who Cares and How Much? *Healthcare Quarterly*, Vol 12(2), 42-49.
13. Hsu AT, Lane NE, Sinha SK, Dunning J, Dhuper M, Kahiel Z, Sveistrup H. Report: Understanding the impact of COVID-19 on residents of Canada's long-term care homes — ongoing challenges and policy responses. Article in LTCcovid.org, *International Long-Term Care Policy Network*, CPEC-LSE, 4 June 2020.
14. Jimenez-Sotomayor, M. R., Gomez-Moreno, C., & Soto-Perez-de-Celis, E. (2020). Coronavirus, Ageism, and Twitter: An Evaluation of Tweets about Older Adults and COVID-19. *Journal of the American Geriatrics Society*, 68, 1661-1665. https://doi.org/10.1111/jgs.16508
15. Lagacé, M., Laplante, J., & Davignon, A. (2011). Construction sociale du vieillir dans les médias écrits canadiens: De la lourdeur de la vulnérabilité à l'insoutenable légèreté de l'être. *Communication et Organisation, 40,* 87–102. https://doi.org/10.4000/communicationorganisation.3553
16. Lightfoot, E., Moone, R. P. (2020) Caregiving in Times of Uncertainty: Helping Adult Children of Aging Parents Find Support during the COVID-19 Outbreak, *Journal of Gerontological Social Work,* DOI: https://doi.org/10.1080/01634372.2020.1769793
17. Mialkowski, C.J.J. (2020) OP LASER- Joint Task Force Central Observations in Long Term Care Facilities in Ontario, Canadian armed forces report, https://s3.amazonaws.com/zweb-s3.uploads/carp/2020/05/OP-LASER-JTFC-Observations-in-LTCF-in-ON.pdf
18. OLTCA: Ontario Long Term Care Association, (2019) *This is Long-Term Care 2019*, Toronto, Ontario Long-Term Care Association. https://www.oltca.com/OLTCA/Documents/Reports/TILTC2019web.pdf
19. O'Sullivan, T. L., Kuziemsky, C. E., Corneil, W., Lemyre, L., & Franco, Z. (2014). The EnRiCH Community Resilience Framework for High-Risk Populations. *PLoS Currents*. https://10.1371/currents.dis.11381147bd5e89e38e78434a732f17db

20. Ouchida, K.M. &Lachs, M.S. (2015) Not for doctors only : Ageism in Healthcare. Generations (electronic edition), https://www.asaging.org/blog/not-doctors-only-ageism-healthcare
21. Queluz, F, Kervin, E,, Wozney, L., Fancey, P., McGrath, P. J. and Keefe, J. (2020) Understanding the Needs of Caregivers of Persons with Dementia: A Scoping Review, *International Psychogeriatrics*, 32(1) 35-52. DOI: https://10.1017/S1041610219000243
22. Renaud, L., Bouchard, C., Caron-Bouchard, M., Dubé, L., Maisonneuve, D., & Mongeau, L. (2006). A Model of Mechanisms Underlying the Influence of Media on Health Behaviour Norms. *Canadian Journal of Public Health*, *97*(2), 149–152. https://10.1007/BF03405337
23. Rozanova, J., Miller, E., & Wetle, T. (2016). Depictions of nursing homes residents in US newspapers: Successful ageing versus frailty. *Ageing and Society, 36 (1)*, 17-41. https://10.1017/S0144686X14000907
24. Schimmenti, A., Billieux, J., and Starcevic, V. (2020) The Four Horsemen of Fear: An Integrated Model of Understanding Fear Experiences during the COVID-19 Pandemic, *Clinical Neuropsychiatry*, 17, 2, 41-45. https://10.36131/CN20200202
25. Schulz, R., Beach, S. R., Czaja, S. J, Martire, L.M, Monin, J.K. (2020) Family Caregiving for Older Adults, *Annual Review of Psychology*, 71: 635-59, https://10.1146/annurev-psych-010419-050754
26. Statistics Canada (2018) *Caregivers in Canada, 2018* https://www150.statcan.gc.ca/n1/daily-quotidien/200108/dq200108a-eng.htm
27. Stensöta, H. O. (2015). Public ethics of care: A general public ethics. *Ethics and Social Welfare*, 9(2), 183–200.
28. Trincaz, J. & Puijalon, B. (2010), « Vieillir en terre hostile » In S. Carbonnelle, (Ed), *Penser les vieillesses. Regards sociologiques et anthropologiques sur l'avancée en âge.,* Paris : Éditions Seli Arslan, 21-36.
29. Tronto, J. (1993) *Moral Boundaries: A Political Argument for an Ethic of Care.* New York: Routledge.
30. Tronto, Joan C. (2010) Ethics and Social Welfare Creating Caring Institutions: Politics, Plurality and Purpose, *Ethics and Social Welfare, 4(2),* 158-171. https://doi.org/10.1080/17496535.2010.484259
31. Tronto, Joan C. (1998) An ethic of care. *Generations, 22(3), 15*
32. Tronto, J. C., & Fisher, B. (1990). Toward a Feminist Theory of Caring. In E. Abel, & M. Nelson (Eds.), *Circles of Care* (pp. 36-54). SUNY Press.

33. Vaitheswaran, Sridhar, Lakshimarayanan, Monisha, Ramanujam, Vaishnavi, Sargunan, Subashini, Venkatesan, Shreenila (2020) Experiences and Needs of Caregivers of Persons With Dementia in India During the COVID-19 Pandemic – A Qualitative Study, Am J. Geratr Psychiatry, https://10.1016/j.jagp.2020.06.026

Joanna M. Salachna, Anna Szafranek, Institutional care for elderly people in Poland during pandemic - regulations, practice and thoughts about the future

Introduction

As a result of the spreading COVID-19 epidemic, which consequently led to a pandemic, the system of institutional care for elderly people was in 2020 challenged with previously unknown problems both in the local as well as global dimension. The new reality exposed systemic imperfections with regard to institutional care, which particularly affected and continues to affect the care of the elderly. These weaknesses manifested themselves clearly in Polish social care facilities, for elderly and somatically-ill people, and hospices (both in stationary hospice facilities as well as hospice home care). On the one hand, Poland implemented legal regulations concerning social contacts to limit the spread of infections (for instance, maintaining social distancing, wearing face coverings in public spaces or restraining the organisation of certain events – both public as well as family gatherings). However, these legal principles have concerned and apply to the general public (or individual provinces or regions of the country), and at the same time there are no detailed provisions regulating the sphere of institutional care for the elderly. Therefore, the aim of this article is to review the current legal and social situation in the field of care for the elderly and to answer the following questions: what should be the standards of institutional care aimed at elderly people during a pandemic? Who should establish these standards and what should be the methodology of their development? These questions are significant both from the sociological and legal point of view, but also from the humanistic and public health perspectives.

Socio-legal situation during the COVID-19 pandemic

General rules for the functioning of entities and institutions, as well as regulations that concern decreasing infection numbers, limiting the spread, preventing and fighting consequences, including those socio-economic of the COVID-19 illnesses, have been stipulated by the Polish parliament. These are included in the parliament's Act in force since the 8th of March 2020 [1. Law of 2nd March 2020 on special arrangements for the prevention and combating of COVID-19, other infectious diseases and crisis situations caused by them - hereinafter: u.a.cov.], which by mid-August 2020 had already been amended nearly thirty times. More detailed solutions, which aim to limit the spread of the epidemic have been, of course, included in different legal acts. Thus, separate parliamentary acts from the u.a.cov. regulate the functioning of such aspects in the era of epidemic, e.g. implementation of

operational programs co-financed by the European Union, awarding public contracts of particular importance in the indicated period, or rules of support for entrepreneurs. It is worth pointing out that so far, the state bodies (parliament and ministers) have issued a total of 246 legal acts related to the containment of the pandemic and reduction of its effects, including mainly executive regulations (in the number of 205). These include regulations from the Ministry of Health, Ministry of Family, Labour and Social Policy, Ministry of Education. Currently, 106 of these acts are in force, 67 of which are executive regulations [7; ISAP]. Another 50 draft bills were also submitted, which are to enable the efficient functioning of the state and basic institutions as well as society in times of pandemic. In addition, Polish local government units are also authorized to issue locally binding acts in connection with the current state of the epidemic, but to the extent permitted by universally binding acts (issued by state authorities).

In Poland, the state of the epidemic due to SARS-CoV-2 infections is in force (on the basis of the ordinance of the Minister of Health issued under the authorization included in the u.a.cov.) from 20th March 2020. With such a large number of legal acts, as indicated earlier, to ensure uniformity of treatment in combating and preventing infections and illnesses and the negative effects of COVID-19, it would seem that all the necessary basic issues in this area have been settled within almost six months. Namely, issues related both to the functioning of people in the "ordinary" public sphere (e.g., concerning the principles of movement, distance and basic protection measures) and (most importantly) in the "special" spheres, which include health care in the broad sense, including the elderly and the chronically ill. On the other hand, however, the multitude of various acts directly results in legal overregulation (in the sense of the number of legal acts), which by no means results in the consistency of regulations and does not give clear guidelines on how to deal with specific situations. In most public institutions, such as courts, offices and social care facilities, it is the managers who decide individually on the ways of proceeding in a situation of epidemic threat. In practice, this means duplicating patterns of conduct already established in other institutions. However, without a good recognition of the general state and the specifics of the social and institutional environment and the internal organization of individual entities, such practice is not a good solution. In such cases there is no situational adequacy of rules and procedures.

Here we decide not to present the basic legal regulations that are in force in Poland in the era of a pandemic, as they do not differ significantly from those introduced in most EU countries [11; Tello Limanco, 2020, p. 47-48]. However, from the point of view of the subject matter of the study, it is important that neither the generally applicable acts (laws and regulations), nor the internal acts issued by the relevant services (in Poland, it is primarily the

Chief Sanitary Inspector) have any guidelines concerning the rules of contacts and conduct in institutions that are social care facilities or hospices. The only regulation concerning the indicated facilities refers to the possibility of providing work by the employees of such facilities in a situation when they are under quarantine [1, art. 4e u.a.cov.] - if the persons under care agree to it. Therefore, we are dealing with a situation in which the infected personnel can continue to work. In fact, the question of whether or not the residents have consented to this practice is partly illusory (if they do not consent, the residents will be at least partially deprived of care). There are no guidelines as to whether the work of the staff is subject to the consent of all or part of the residents. In addition, the question also arises against the background of the above regulations: is it only the resident who would give their consent individually "under the care" of quarantined staff? There should be no place for such a discussion in times of pandemics or epidemics. Even if the general act leaves certain issues unregulated (it can be assumed that it is deliberately to secure flexibility in individual situations), it should force specific issues to be regulated by the local, central or facility management. Of course, it would be possible - by analogy - to assume that in recognized institutions the regulations and guidelines addressed to typical health care institutions (primarily hospitals) should be applied. Such an assumption, however "convenient" for the staff or managers, is without any factual justification, as other objectives are pursued by typical health care institutions and others by social care facilities and hospices. This in turn is implied by a number of other factors, namely the purpose of the institution and the duration of the guest/patient's stay determine the emergence of a different type of social relationship between the staff and the guests and between the staff and the families of the guest/patients. It is also important to note that the living, psychological and social needs of the guests and their families are different. These considerations argue for the need to develop a methodology for the development of rules of conduct in nursing homes and hospices in relation to epidemic risks and universal recommendations in this area.

Legal basis for the functioning social care facilities in Poland

In the Polish system of state law there are several entities managing social care facilities (municipal and supra-municipal), which at the same time determines and influences not only the determination of standards (also in the scope of dealing with crisis situations) but also clearly indicates who has the right to set those standards. Local government units (territorial self-government units) are responsible for organizing social welfare, among others in the form of running and providing places in social care facilities, and they may cooperate with churches or associations in carrying out this task [2; art. 2 sec. 2 in connection with art. 17 sec. 2 of the Act of 12 March 2004 on social welfare - hereinafter: u.p.s.]. Thus, the

functioning of the social care facilities is possible at the municipal, district and self-government voivodeships level [2; art. 17 par. 1 u.p.s.; art. 19 pt. 10 u.p.s.; art. 21 pt. 5 u.p.s.]. It is the duty of municipalities to provide their residents in need of care with a place in stationary institutions, while institutions of a supra-municipal nature take in the residents regardless of their place of residence [2; art. 17.1.16 u.p.s.; art. 19.10 u.p.s.].

Stationary social care facilities [2; art. 54-56 u.p.s.] are the basic and most important institutions offering support to people who, due to their age or health condition, are unable to function independently and require 24-hour care. It should be noted that in accordance with the regulations in force [2; art. 56 sec. 2 u.p.s.] persons in need are, as a rule, directed to an institution located as close as possible to their place of residence, which is connected with ensuring the sense of safety of the residents, not detaching them from the current environment and maintaining social relations, which in many cases they built throughout their lives.

The basic duties of social care facilities [2; Art. 55, par. 1-2 u.p.s] are to provide residential, nursing, supportive and educational services at the level of the current standard, in the scope and forms resulting from individual needs, with the organization of the facility, as well as the scope and level of its services taking into account the freedom, intimacy, dignity and sense of security of the residents. The current pandemic situation, as well as the temporary closure of the facilities applied by the authorities, allow us to assume that the above-mentioned assumptions were not fulfilled. It should be remembered that the state of health (especially the mental condition) of an elderly person living in an institutional environment is largely dependent on relations with the family and maintenance of regular social contacts. In a situation where meetings with loved ones are limited or completely impossible, the sense of security of the residents may be compromised, which in turn leads to emotional problems and even psychosomatic symptoms. The pandemic has also caused a situation of social isolation (which has a particularly negative impact on elderly people with dementia), increasing not only loneliness, but above all a sense of alienation, which has a negative impact on mental health [6; Hossein Javadi, Nateghi, 2020, p.1]. That is why it is so important to properly prepare social care facilities to function efficiently in any situation (including epidemics).

In accordance with Article 57, paragraph 1 of the u.p.s. [2], social care facilities (with the prior consent of the voivode) may be run by: local government units, the Catholic Church, other churches, religious associations and social organizations, foundations and associations, other legal entities and individuals. In connection with the designated entities authorized to run the social care facilities, a distinction is made between public (run by local government

units) and non-public (in accordance with the u.p.s., these are institutions supporting authorities, cooperating with them on a partnership basis) [9, p. 37, 295].

One of the key documents (apart from the Act on Social Welfare, social care facilities regulations, statutes and plans of individual needs of the residents) affecting the proper functioning of the discussed institutions is also the organizational regulations, developed by the management of a given social care facility. In accordance with § 4 of the Ordinance of the Minister of Labour and Social Policy of August 23, 2012 [3], it must be adopted by the executive body of the local government unit, i.e. the head of the municipality council, the mayor or the president. In the case of a community house, and if the owner of the house is a non-public entity, the organizational regulations are established by that entity.

It should also be mentioned that the individual DPSs function on the basis of plans of individual needs of the residents, and these plans should be developed (assuming that the health of the resident allows for it and the client expresses willingness to participate in creating such a plan) together with the residents. Considering the current social situation, it seems reasonable to re-examine the existing plans and adjust them to the new legal and social requirements related to the Covid-19 epidemic.

Social care facilities in Poland – the actual situation

To thoroughly analyse the lack of standards for the functioning of social care facilities during an epidemic, it was imperative to establish the number of such institutions, which at the same time outlined the number of elderly people and/or chronically, somatically-ill people that are under these facilities' care. Table 1 presents the number of places in public and non-public social care facilities in Poland, including three particular voivodeships (as at 31st December 2019). From all of the cases, institutions designed specifically for elderly and/or somatically-ill people were distinguished.

It has been considered reasonable to compare how stationary facilities (both public and non-public) in particular voivodeships responded to the epidemiological situation and if they induced (if so, under what conditions) any guidelines with regard to the functioning of social care facilities. While deciding upon the voivodeships to analyse, authors followed the contractual division of Poland into three parts: Poland A, B and C, which are classified according to their level of social and economic development, including the transport network, industry and culture, among others. Every chosen voivodeship will be represented by its municipalities, although considering a very specific socio-economic character of Masovian voivodeship (the most developed region, centre of the country, the smallest indigenous population, capital city), it was not taken into account. Additional criteria of choosing

voivodeships were: the amount of social benefits paid and municipalities' expenditure on social welfare. As of such, Poland A will be represented by local government units of the Greater Poland Voivodeship, which can be characterised with the highest expenditure (apart from Masovian Voivodeship) on social welfare. Poland B will be represented by Podlaskie Voivodeship characterised with the lowest expenditure on social welfare. Poland C will be represented by Lubusz Voivodeship with one of the lowest amounts of social benefits paid (after Opolskie Voivodeship). Moreover, municipalities in Lubusz Voivodeship have the lowest incomes in the country. While assessing the criteria, current data from the Central Statistical Office were consulted [5; GUS 2019, p. 466-468].

Table 1. Number of places and residents in social care facilities (as at 31st December 2019)

POLAND IN GENERAL			
		public facilities	Non-public facilities
registered social care facilities in total	790	572	218
number of places in total	79511	64849	14662
number of residents in total	78338	63968	14370
including: registered social care facilities for chronically, somatically-ill people and/or elderly people	326	243	83
including: number of places in social care facilities for chronically, somatically-ill people and/or elderly people	29427	24322	5105
including: number of residents in social care facilities for chronically, somatically-ill people and/or elderly people	28827	23854	4973
POLAND A: GREATER POLAND VOIVODESHIP			
registered social care facilities in total	62	51	11
number of places in total	6375	5329	1046
number of residents in total	6283	5260	1023
including: registered social care facilities for chronically, somatically-ill people and/or elderly people	27	23	4
including: number of places in social care facilities for chronically, somatically-ill people and/or elderly people	2551	2241	310
including: number of residents in social care facilities for chronically, somatically-ill people and/or elderly people	2500	2182	309
POLAND B: PODLASKIE VOIVODESHIP			

registered social care facilities in total	21	15	6
number of places in total	2337	1876	461
number of residents in total	2311	1857	454
including: registered social care facilities for chronically, somatically-ill people and/or elderly people	10	9	1
including: number of places in social care facilities for chronically, somatically-ill people and/or elderly people	956	931	25
including: number of residents in social care facilities for chronically, somatically-ill people and/or elderly people	947	922	25
POLAND C: LUBUSZ VOIVODESHIP			
registered social care facilities in total	23	21	2
number of places in total	2348	2236	112
number of residents in total	2323	2211	112
including: registered social care facilities for chronically, somatically-ill people and/or elderly people	5	5	0
including: number of places in social care facilities for chronically, somatically-ill people and/or elderly people	500	500	0
including: number of residents in social care facilities for chronically, somatically-ill people and/or elderly people	495	495	0

Source: own work based on: [10] Reports on facilities providing care and support, Ministry of Family, Labour and Social Policy, accessible online: https://www.gov.pl/web/rodzina/statystyka-za-2019 [access date: 13.08.2020]

The analysis of data from Table 1 indicates how many people in need of help are impacted by the issue of lack of standards/guidelines concerning the functioning of social care facilities in the light of the pandemic, as chronically, somatically-ill and/or elderly people constitute 36.79% of all the resident of such facilities. Moreover, both in Greater Poland and Podlaskie Voivodeships nearly half of social care facilities are allocated to chronically somatically-ill and/or elderly people (elderly people account for 39.78% and 40.97% of all the residents of these facilities, respectively). In Lubusz Voivodeship, this percentage is slightly lower (21.30%), which is nonetheless a significant group.

With the aim of supplementation and review of implemented guidelines, or their absence, in relation to the epidemiological situation, an analysis of randomly chosen websites of social care facilities in the discussed voivodeships was conducted (Table 2). It is important

to note that the methodology of choosing particular institutions was simplified, the conducted analysis is a pilot study (the sample should not be treated as representative) and presented conclusions are demonstrative. These conclusions most importantly aim to facilitate the development of guidelines on the standards of social care facilities' functioning during the epidemic, but also to simplify establishing methodology to develop such guidelines. In each voivodeship four websites were analysed (initially, two websites were supposed to represent public institutions whereas the other two non-public facilities, located in urban as well as rural areas). However, choosing such a sample was only possible in Greater Poland voivodeship (no non-public facilities function in Lubusz voivodeship, while in Podlaskie voivodeship there is only one non-public social care facility). As a result, in the two remaining voivodeships the analysis was focused primarily on websites of public institutions managed by local governments.

Table 2. Examples of social care facilities for elderly and/or chronically somatically-ill people with guidelines implemented as a result of COVID-19

Type of a social care facility and its location	Guidelines
POLAND A: GREATER POLAND VOIVODESHIP	
Non-public social care facility (rural municipality)	No guidelines
Non-public social care facility (rural municipality)	No guidelines
Public social care facility (rural municipality)	Visits in the facility are possible every day from 10am to 12am and from 2pm to 5pm, however it is forbidden to move freely around the facility without reporting it to staff. Additional guidelines: - To enter the facility, visitor are required to notify office no. 2 by ringing a bell and wait for a member of staff to come, - One resident can be visited by the maximum of two people that are required to wear face masks, - Before entering the facility, visitors' temperature will be checked by a staff member and they will be required to use a hand sanitiser as advised by staff, - information about a visit will be noted in a visitors' registry,
Public social care facility (urban municipality)	No guidelines
POLAND B: PODLASKIE VOIVODESHIP	
Public social care facility	- No visitors until further notice,

(urban municipality)	- restrained activity of residents outside of the facility; only necessary activities allowed (until further notice).
Public social care facility (urban municipality)	- No visitors until further notice.
Public social care facility (rural municipality)	- No visitors until further notice.
Non-public social care facility (rural municipality)	No guidelines
POLAND C: LUBUSZ VOIVODESHIP	
Public social care facility (rural municipality)	No guidelines
Public social care facility (rural-urban municipality)	- No visitors until further notice; if physical contact with a resident is absolutely required, visits will be allowed only after arranging appropriate conditions with the facility's manager or their deputy,
Public social care facility (rural-urban municipality)	- No visitors until further notice.
Public social care facility (rural municipality)	No guidelines

Source: own work based on websites of particular facilities [access date: 14.08.2020]

Data presented in the above Table 2 indicate misinformation (websites of half of the analysed institutions, i.e. 6 among 12 social care facilities, lack information on their functioning during a pandemic) and the absence of not only specific, but more importantly relatively standardized guidelines on rules for the organization of social care facilities. It is characteristic that none of the analysed non-public facilities included any information on their functioning during a pandemic while guidelines in the majority of institutions were limited to a statement: "No visitors until further notice". Only two facilities allowed visits yet one of them limited the possibility to circumstances in which direct contact is absolutely required (voivodeship in Poland C) whereas the other one (voivodeship in Poland A) permits visits and their procedure was described in detail. Data suggest that stricter guidelines (mainly limiting the possibility to visit residents) are followed in social care facilities located in urban municipalities (which probably results from greater population density, population in general and more visitors) while in some rural-urban and rural municipalities guidelines allowed visits that follow the sanitary regime. As such, it appears legitimate for all institutions to be obliged to update their websites, whereas in the current epidemiological situation not only to establish guidelines on a regular basis, but also make the information available to the public (on their websites). At the same time, methodology for establishing guidelines should be uniform in the whole country to prevent residents from feeling injustice, when different institutions'

organisation and functioning are contradictory (for instance, a complete ban on any visits and the possibility to visit resident while following the sanitary regime).

Another issue, that should have been resolved at the beginning of the pandemic, was the insufficient number of staff in social care facilities, which was caused by the staff's infections with COVID-19 or/and their mandatory quarantine. Poland has recorded numerous, vocal in the media, examples of support offered to residents and staff of social care facilities by volunteers, nuns or other social services. It is important to note that the deficits in staff concern not only its quantity, but also the workers' insufficient professional competence, or its complete lack (i.e. when a social worker is required to pursue responsibilities of a nurse). A study conducted in the US among 161 workers at social care facilities showed that they performed many activities outside of their competence, for instance, physiotherapists performed simple medical tasks in addition to washing and feeding residents. Another challenge was posed by relocating residents to different rooms (in the case of people who had to undergo quarantine) since the majority of residents had been occupying their rooms for years and as a result of quarantine their personal belongings had to be moved (to maintain the feeling of safety) [8; Seshadri et. all. 2020, p. 2].

Unclear guidelines on accepting new residents in stationary social care facilities cause other difficulties. In Poland, during a period of temporary closure of social care facilities and hospices, accepting new residents was halted. Such a situation should not have occurred since families, which could not care for, or continue to care for, a terminally ill senior were deprived of the possibility of institutional support, i.e. a place in a stationary hospice. On the other hand, a potential acceptance into a stationary facility would most probably make visiting a patient impossible, which both from a perspective of a dying person and their family should not occur. For instance, in one of the German states, North Rhine-Westphalia, admitting new patients was not limited at all (however, every new patient was subjected to a 14 day quarantine). As a result of housing conditions, the situation of German residents of social care facilities is significantly better than the Polish ones (which is especially important during the pandemic) as the majority of facilities located in particular German states offer single rooms (although double rooms are occasionally offered as well) [4; Dichter et. all. 2020, p. 1-2]. On the contrary, Polish social care institutions single rooms are rarely occupied with the majority of room offered being double, triple or even quadruple rooms, which hinders everyday functioning of residents and staff considerably during the pandemic.

Diagnosis of the problem and recommendations

In the case of the discussed institutions, there are two basic problems – the lack of general guidelines on the functioning of social care facilities and actual closures of such facilities (refusing to accept new residents and excluding residents from contact with the outside environment). Yet the most serious issue appears to be the lack of clear and general guidelines for all social care facilities and hospices. However, considering methodological aspects relating to the type and the changing scale of the threat, that statement is not entirely true. This claim is justified by the variability of the risk in itself, as well as its severity in the country or a region, etc., as well as the specificity of the facility (type of facility, i.e. social care facility/hospice, number of residents, their health condition, location of the facility, number of staff, infrastructure). Hence, authors assumed that the methodology of constructing guidelines must at its base take place at two levels, i.e. nationwide/central and at the individual/given facility's level. Of course, this approach can be accused of a mistake in locating the decision-making center. For it can be indicated that local authorities have better overview of the situation in a given territory. However, such approach is not correct due to the fact that the authorities at the central level have:

- on the one hand, general data, i.e. data on the situation in the country as a whole,
- on the other hand, analytical data of individual regions relativizing their situation, which in turn provides the basis for the development of a nationwide specific map in terms of the threat, intensity and course of the epidemic. In addition, the methodological correctness requires including determinants of an intra-organizational resource nature, i.e. about staff and the use of the facility's infrastructure.

The presented assumptions indicate that guidelines in the discussed subject must consist of two basic elements: general and detailed (individual), while nationwide guidelines (level I) must be created initially. This is because of their fundamental importance and the nature of the data that the central government has at its disposal (as already mentioned). Individual /particular facility's guidelines (level II) should, in turn, regulate two areas/dimensions: intra-organizational (level IIA) and relations with the environment (level IIB). In the individual scope, the intra-organizational rules should be developed first. Intra-organizational rules such as: 1) appropriate training of employees (following rules in interpersonal contacts, using equipment, preparing food), which is, in fact, the manner of providing care; 2) the possibilities of using infrastructure (medical and/or rehabilitation equipment, size of rooms, number of toilets) imply maintaining a certain level of safety in a given facility. This level, in turn, is important in determining whether at all and what degree of contact with the outside environment may take place under given circumstances and the facility's conditions.

Considering the dynamics of the epidemic (and epidemics, in general), it is impossible to define guidelines of a general or individual nature in advance. However, it is possible to demonstrate (in the form of guidelines) recommendations as to what these guidelines should not be and/or what provisions they should contain. In this regard, of course, some preliminary assumptions are needed regarding the specificity of the functioning of social care facilities, as well as hospices. The two main assumptions are:

- the need to maintain social relations between the residents of social care facilities (or hospices) as a necessary condition to maintain the proper psychophysical condition of the residents and their family members;
- the need to ensure the functioning of social care facilities and hospices, including providing care to existing residents and accepting new ones.

Taking into account the aforementioned assumptions, in the light of previous analysis, it is reasonable to take into account the following principles in the guidelines:

1. Temporary closure of social care facilities (limiting contacts with the outside environment to the necessary minimum) cannot mean that the admission of new residents is excluded (which actually occurred in Poland). This claim applies to both nursing homes and residential hospices. The refusal to admit new residents may be treated (in the case of public institutions) not only as a failure to fulfil the tasks imposed on them, but also as actions discriminating against persons who are formally entitled to such care.
2. Residents/patients must not be completely deprived of contact with the outside environment. In this respect, a distinction must be made between the resident and their closest relatives (family members or friends) and between the resident and the environment ‘at large’ (e.g. going out to the store, going for a walk). In the former, it is possible to limit the number of people the resident may have contact with, provided that the necessary sanitary requirements are maintained. As far as the latter scope is concerned, in justified cases, it can be suspended entirely - but only temporarily and these restrictions should be consistent with the general social restrictions (the are in force nationally or locally).

While the above recommendations are of a substantive nature, one cannot underestimate a guideline of an instrumental nature, i.e. without which it is impossible to plan and implement any guideline correctly. This principle is articulated below.

3. It is necessary to introduce general principles of preparing the staff of the facilities in terms of procedures for dealing with a state of epidemic/pandemic, as well as to define the principles of organization of replacement staff (i.e. people replacing employees

excluded from the possibility of working, for instance, due to quarantine). It should be noted, however, that the scope of training should be different for the staff (employees) and different for the management of the facilities. The introduction of top-down rules in this aspect results in the uniformity of the application of procedures and the relatively efficient functioning of the whole care system on a national scale, and at the same time excludes the possibility of overinterpretation in the application of procedures. It also gives the necessary flexibility, i.e. making decisions within a generally defined framework. The training of employees is essential in order to maintain uniform safety standards. It should be emphasized that it is imperative to regulate the rules of behaviour of people working in different entities (including social care facilities), especially medical personnel. It is crucial to determine the rules of replacing employees who cannot perform contractual services. To consider in the latter case is the use of staff (e.g. medical) from primary health care institutions, which during the epidemic are mainly focused on giving medical advice on the phone.

Finally, it is important to note that the established guidelines should be: - public (socially accessible); - there is a need to publish both Level I (national guidelines) and Level II (individual facility's) guidelines, which is generally not implemented.

The development of the first-level guidelines by central authorities with the participation of a wide range of recognised experts (in the field of medical science, in particular) and practitioners is important for the social acceptability of the guidelines. This body should be known to the public, as should the voting results of this body concerning individual guidelines or groups of guidelines.

References

Legal acts:

1. Ustawa z dnia 2 marca 2020 r. o szczególnych rozwiązaniach związanych z zapobieganiem, przeciwdziałaniem i zwalczaniem COVID-19, innych chorób zakaźnych oraz wywołanych nimi sytuacji kryzysowych (Dz. U. 2020 poz. 374 ze zm.) / Act of 2 March 2020 on special solutions related to the prevention, prevention and combating of COVID-19, other infectious diseases and crisis situations caused by them (Journal of Laws of the Republic of Poland 2020, item 374 as amended).
2. Ustawa z dnia 12 marca 2004 r. o pomocy społecznej (Dz. U. 2019 poz. 1507 ze zm.) / Act of 12 March 2004 on social assistance (Journal of Laws of the Republic of Poland 2019, item 1507 as amended).

3. Rozporządzenie Ministra Pracy i Polityki Społecznej z dnia 23 sierpnia 2012 r. w sprawie domów pomocy społecznej (Dz. U. 2018 poz. 734) / Regulation of the Minister of Labour and Social Policy of August 23rd, 2012 on social welfare homes (Journal of Laws of the Republic of Poland 2018, item 734).

Literature:

4. Dichter M.N., Sander M., Seismann-Petersen S., Köpke S., COVID-19: it is time to balance infection management and person-centered care to maintain mental health of people living in German nursing homes, "International Psychogeriatrics" , Cambridge University Press: 12 May 2020, p. 1-4. doi:10.1017/S1041610220000897.
5. Central Statistical Office, Statistical Yearbook of Voivodeships, Warsaw 2019.
6. Hossein Javadi S.M., Nateghi N., Covid-19 and It`s Psychological Effects on the Elderly Population, "Disaster Medicine and Public Health Preparedness", Cambridge University Press: 15 July 2020, p. 1-2. https://doi.org/10.1017/dmp.2020.245.
7. Internet System of Legal Acts, https://isap.sejm.gov.pl/ [access date: 18.08.2020].
8. Seshadri S., Concannon C., Woods J.A., McCullough K., "It's like Fighting a War with Rocks:" Nursing Home Healthcare Workers' Experiences During COVID-19", "Infection Control & Hospital Epidemiology", Cambridge University Press: 05 August 2020, p. 1-7. https://doi.org/10.1017/ice.2020.393.
9. Sierpowska I., Pomoc społeczna. Komentarz, Wolters Kluwer, Warszawa 2014.
10. Sprawozdanie o placówkach zapewniających całodobową opiekę i wsparcie, Ministerstwo Rodziny, Pracy i Polityki Społecznej, dostępne online: https://www.gov.pl/web/rodzina/statystyka-za-2019 [access date: 13.08.2020].
11. Tello Limaco I.J., Prawa podstawowe w czasie pandemii COVID-19 w Hiszpanii, „Prawo i Praktyka" Temidnium: June 2020, p. 47-48.

Tobis Sławomir, Katarzyna Wieczorowska-Tobis, Agnieszka Neumann-Podczaska, Internet-Telephone Consultation Service for Older Persons

Introduction

The outbreak of the COVID-19 pandemic caused the introduction of unprecedented limitations in the functioning of society. Restrictions introduced concerned the operation of many institutions but also related to interpersonal contacts. The recommendation to stay at home led, among other things, to reduce the accessibility of health care facilities (e.g., GP and specialist clinics). In Poland, due to the transformation of some hospitals into COVID-19 units, in which only patients with a positive SARS-CoV-2 result are treated, entire teams of specialist clinics operating at these hospitals, from one day to another, ceased to be available to the general public [16, p.e924730]. In this situation, many older people had no one to turn to when it came to doubts and questions related to drugs, but also everyday functioning.

Moreover, significant restrictions in the functioning of other health care units, resulting from staff limitations and complicated procedures, caused diminished availability of medical consultations. Reports of problems with accessing medical advice are confirmed in many countries. At the same time, it is noted that the reduction in the number of consultations results not only from limited availability but also from the patients' reservations and hence the fear of seeking necessary help.

Among the factors of increased risk of developing COVID-19, but also those of a severe course of the disease, older age and selected chronic diseases (heart diseases, diabetes, cancer – at present or in the previous three years, and chronic obstructive pulmonary disease – COPD – or severe asthma) are pointed [9, p.401][13, p.988]. Since age is a risk factor for all these diseases in older persons, it is they who were mainly ordered to remain at home. This fact is particularly important combined with data showing that frailty, one of the most typical morbidity traits in geriatrics, is one of the essential mortality factors in COVID-19 patients [10].

All institutions involved in the activation of seniors were also closed overnight; Senior centres, day centres for seniors and the senior clubs have ceased to function. What's more, the message to the older adults by all involved in activation activities and the media has changed dramatically – also overnight. Previously, much attention was paid to increasing the activity of older persons and their social involvement. They were educated that – in order to function well, stay fit for a long time and live in their own home – they have to leave the house, meet people and be active, both physically and cognitively [11, p.7856823][6, p.828]. Meanwhile,

due to the pandemic, they were suddenly supposed to stay at home. Unsurprisingly, the seniors began to ask how to reconcile these restrictions with activity and exercise, which created a sudden increase in the demand for online services, but also for all actions that might be taken to improve the everyday functioning.

Particular attention should be paid to the older people taking into consideration the stress related to uncertainty about the future and the lack of a sense of security resulting from suddenly finding themselves in new circumstances. One of the typical features of the ageing process is less flexibility and a more difficult adaptation to new situations [19, p.11]. Undoubtedly, the pandemic created not only a sense of threat, but also forced a rapid implementation of new solutions – mostly remote, and thus allowing for social distancing and reducing the risk of exposure to the novel coronavirus; there was practically no time to get to know and get used to them.

On the other hand, the forms of classes and courses for students were changed from one day to another. Those whose future work is based on direct contact with the patient/client were deprived of the possibility of interacting with their future caretakers. This is all the more important as contemporary healthcare, and social care paradigms place the person at the centre – approach known as *person-centred care* [18, p.15]. Building a valuable therapeutic relationship between the professional and the patient or client is an essential part of this approach. It seemed impossible to simulate this in a remote learning setting. Hence, the search for solutions that could be used in this context began.

Internet-Telephone Consultation Service for older people – how it works

Information about the service and its operation was published in the press and television, both local and nationwide. Internet news websites and the website of the Poznań City Hall were also involved in disseminating the info. Additionally, information was spreading by word of mouth, as the older persons themselves informed each other about the possibilities of consultation.

The principle of the service's operation is presented in Figure 1.

Figure 1: The Internet-Telephone Consultation Service (itCS) – how it works.

Older people called the advertised phone number. The information given clearly stated that within itCS, students consulted under the supervision of academic teachers, i.e. that each recommendation issued was discussed with them.

The first contact with the senior was made by the student responsible for the technical aspects of the connection; they set the day and time of consultation and found out what were the senior's preferences regarding the connection. Video chat via Messenger (Facebook) or WhatsApp was preferred, but telephone contact was also possible. Older people were informed that – if they do not use a communicator yet – once they decide in favour of a video contact, they would receive help from students in installing and launching the appropriate application.

After settling the details, the negotiated calls followed. Each consultation consisted of at least two connections. During the first one, an interview was performed. Before the main part of the conversation, a short recording regarding the protection of personal data and their processing in connection with the General Data Protection Regulation (GDPR) was played back. After obtaining the senior's consent to the processing of personal data for consultation purposes, the students collected an interview, which varied depending on the consultation path. During this interview, seniors also raised their doubts or problems with which they turned to the itCS. After collecting the interview, the students made an appointment for a second consultation within a few days.

In the meantime, the students prepared answers to the questions asked by the seniors, solved the reported problems and developed individual recommendations for all patients. The prepared recommendations were discussed with academic teachers.

The second call involved issuing recommendations to the seniors. If necessary, monitoring rules for recommended solutions were also established. Therefore, the dates of further connections were often set to check whether the recommendations brought the desired effect. An additional intervention modifying the originally issued recommendations was also possible.

The students operating the itCS were volunteers. They acted on the basis of the *Volunteer Agreement* (including also the detailed *Regulations for the operation of itCS,* which constituted an appendix to the *Agreement*) concluded between the clinical unit, being an integral organisational part of the Poznan University of Medical Sciences, and the student. This agreement regulated the principles of voluntary activity and secured the students against possible claims of patients related to the consultations received.

Two types of the consultation were provided:

- Drug consultations, in which the students of the Faculty of Medicine and Faculty of Pharmacy participated. The purpose of these consultations was to answer questions about the principles of drug use, how to take specific medications (e.g. before or after eating), what to do when, for example, a drug is about to end, or

can additional over-the-counter medicines or dietary supplements be added to the treatment? An interview was done about the drugs to which the questions were asked, but also about the laboratory results and hospital discharge cards to ensure that the advice was best possible. A large proportion of the reported problems concerned seniors' doubts about the use of certain groups of preparations. In such a case, the role of the volunteers was to provide comprehensive information on indications for the use of these drugs, including the balance of benefits and complications that may result from applying a given therapy. Volunteers often managed to convince the older patients to start using again medications prescribed by a doctor, often significantly improving the prognosis in a given condition, but having, every now and then, an unjustifiably bad reputation.

- Consultations regarding the occupational status and level of activity provided by students of occupational therapy, with the aim to find and indicate possible activities for older people confined to the own four walls and to improve (or at least maintain) their physical and mental fitness and well-being. They were also supposed to meet neither with friends nor with members of their families. All this presented a reversion of the narrative from "go out and be active" to "stay at home and isolate." The consequence was that that the developed solutions and established habits were no more applicable and many of the seniors were at risk of not only declining fitness but also mental problems. The students thus performed thorough interviews to define the occupational status of the older subject in as broad a way as possible, taking into account various physical and social factors. For every client, recommendations addressing their unique needs, requirements, and preferences were elaborated, discussed with academic teachers, and presented to the older person. The solutions proposed ranged from physical exercise adapted to the living space of the client, via cognitive stimulation, to gaming and other pleasing activities.

The academic teachers participating in the consultations were – depending on the path – a pharmacist with a special background in geriatrics and a medical doctor (geriatric specialist) or teachers involved in educating the students of occupational therapy, with preparation in geriatrics (e.g., completed postgraduate studies in gerontology and geriatrics).

Discussion of the project's results

To assess the results of the project and to understand the perspective of seniors on the undertaken activities, in-depth interviews with seniors were carried out using communicators

commonly used for consultations in the itCS. Examples of the characteristics of people who participated in the interviews are presented in Table 1.

Table 1: Examples of characteristics of people who benefited from consultations.

Characteristics of the consulted person	Type of consultation provided
A man, 81 years old, lives with his wife, heard about the itCS on TV, very active before the pandemic, among others, involved in educational activities for seniors. Interested in herbal medicine; during the pandemic, he began using a large number of dietary supplements to increase his immunity	Drug consultation
A woman, 70 years old, lives alone, occasional contacts with her family; she found her way to the itCS thanks to friends. She could not cope with the excess of free time during the lockout; active before the pandemic participated in numerous activities organised for seniors	Consultation regarding the occupational status and level of activity
A 67-year-old woman, single, found the itCS thanks to information on TV; unable to cope with the excess of free time during the lockout; was active before the pandemic, participated in a wide range of activities for seniors	Consultation regarding drugs, occupational status and level of activity

During the interviews, seniors particularly emphasised the possibility of establishing contact with young people. Occasionally, setting up the connection took longer than the consultation itself, but this process was perceived as a valuable, unique lesson in intergenerational interactions. Whenever a video call was possible, the seniors appreciated the possibility of a visual contact with the consulting students and clearly gained an additional sense of security. Moreover, for those who were able to set up their visual communicator for the first time, it was like opening a new window to the world, because they could also use it in another contexts later on. The first connection attempts were assisted by students who provided the necessary technological support; this was particularly important in the light of a study by Peek et al. who showed that external support could play an important role in this respect, not only for the willingness to use the technology at the moment but also for the stability of the use of technological devices in the future [15, p.236].

The process of setting up a connection can be viewed as a kind of intergenerational workshop, during which students learned how to communicate with the older subjects. In practice, they learned in particular that when you are blazing a trail in an unknown world, and you need to teach someone something new, one of the essential rules is to adjust the pace of the instructions given to the recipient’s perception capability. They also learned to cope with frustration, both for themselves and for the patient, if the connection setup was complicated

and took a long time to complete. Such training is an important lesson for the young generation, perfectly skilled in technology, as it confronts a different perspective in which what is obvious for them is not obvious for another person; it appears complex, often terrifyingly alien, and also unattainable. Therefore, such experience teaches empathy, which is necessary for future work with another person. One of the students who helped to establish the connection said *"first of all, it was an invaluable opportunity for me to gain experience in contact with the patient (...). I learned how to talk, how and what questions to ask to get the information I needed. I learned that everyone should be approached individually, not treated as 'just another patient.' I was very positively surprised by how open the patients were. I had the idea that younger patients were open-minded rather than older. Meanwhile, itCS has completely changed my opinion about seniors. Previously, I was afraid of contact with an older patient, and now I recall this experience in superlatives."*

This statement shows, on the one hand, the fear of a young person from contact with an older patient, and on the other hand, the positive experience of this contact. According to many available studies, education through direct contact with older subjects has a positive effect on students' attitudes towards old age [1, p.1445][3, p. 784]. Among the potential benefits of such contact, the reduction of the phenomenon of "ageism" is particularly emphasised, as well as greater readiness of young people to undertake activities in the field of gerontology in the future [4, p.501][8, p.713].

For the students, participation in the project was also an opportunity to gain experience of working in a team, including seeking solutions based on brainstorming. The diversity of problems which seniors reported to the itCS caused that students learned how to deal with various life situations. All this is of special importance, because due to the epidemiological situation, both in Poland and abroad, practical classes where students had daily contact with older persons, were suspended. The itCS activities are in line with the paradigm of education through practice, the need of which has been emphasised for many years, particularly in the area of social work, resulting in not only a superficial contact but also establishing a relationship between the student and the older patient [1, p.1445][2, p.1]. Thanks to such a relationship, young people's understanding of the problems of old age improves and, as a result, stereotypes are broken, and a better image of old age is constructed [17].

Also in the case of older people who had to face difficulties and overcome many emotions such as fear, anxiety or nervousness while setting up a connection in order to contact the itCS, such education had a multifaceted dimension. First of all, attention should be paid to increasing the competences of older people in the use of smartphones (or computers) and applications such as instant messaging. On the screens, students and academic teachers

many times saw the smiling faces of seniors suddenly appearing, often accompanied by loudly spoken words of joy at the meeting. Seniors, accustomed to phone calls, particularly emphasised the value of a conversation conducted not only with the use of sound, but also moving image, and described this form of contact as a more satisfying one. Moreover, when the connection worked, and the patient was able to deal with the (initially) complicated equipment, they felt a sense of satisfaction and driving force. Such experience teaches the older person that it is worth making an effort, even if the task seems at first difficult or impossible to accomplish.

Seniors' ability to establish a connection and use social messaging reduces their level of digital exclusion. It is estimated that digital exclusion concerns about 30-40% of older adults in Poland, so itCS, by educating seniors who are able to share the attained skills, counteracts the phenomenon of digital exclusion. Indeed, as demonstrated, the majority of older people confirm that contact with younger people helped them acquire new skills, such as computer or internet use. Usefulness is considered to be one of the key elements of technology acceptance [12, p.425]. Moreover, it was also shown that the perception of the social presence with the use of technologies impacted the degree of perceived usefulness positively, trust and intrusiveness, which was confirmed in practice by our project [7, p.713].

For seniors consulted by the itCS, contact with students filled the gap that arose during the lockdown period, when there was a strong recommendation for older people regarding the need to isolate themselves, and not to contact even their loved ones. One of the seniors, talking about how she felt during the pandemic, when she could at long last have contact with students, said: *"someone will call, and there is this contact at the moment when there is no direct contact."* Social interactions are arguably strongly linked to positive affect, longevity, and good health. While older subjects are known to be at high risk of many dangers related to COVID-19, social distancing and isolation present challenges for their mental health. It is thus imperative to take into account this kind of toll taken on vulnerable older persons while fighting the pandemic [14]. Moreover, loneliness and social isolation are known risk factors for chronic diseases and vice versa, creating a vicious cycle and, additionally, the treatment of socially isolated older adults comes at a substantial annual cost. If they are ordered to stay at home and have their shopping delivered, and consequently avoid social contacts, actions must be taken to compensate for the consequences of social isolation for their physical and mental health.

As demonstrated by the meta-analysis of Wrzus et al, while the family network was stable in size from adolescence to old age, both the personal network and the friendship network decreased over time [20, p.53]. Contrariwise, the pandemic affected all social

contacts equally, as it introduced the fear that relatives could be infected during the visits, hence even the grandchildren were requested not to visit their grandparents. Henceforth, the itCS was a welcome response to the existing situation, as it filled the unmet needs that were present and gave the opportunity to establish contact with another person at a time when any meetings were de-recommended.

"I hear that many people suffer from this situation [the epidemic], that their psyche fails. I met these [young] people [students] for the first time, but my tolerance is high, and I recognise that as young people they can behave well and that they are willing to help." In this statement, the senior appreciates the possibility of contact with another person, even if it is only a remote one, but at the same time presents his positive attitude towards young people. Such a good attitude of seniors to young people was also shown in the study conducted by Cybulski et el, which showed that as many as 85% of the older persons surveyed gave a positive answer to the question whether they like the contact with young people, even if these contacts are rare and limited to meetings a few times a year [5, p.1099]. According to this study, almost half of the surveyed older participants of the University of the Third Age believed that it was necessary to integrate seniors and young people to achieve mutual profits. Among the benefits that seniors may derive from contacts with young people, the greater chance of seniors being more active in many areas of life is emphasised.

The profits of remote contact between a senior and a student within itCS are thus multidirectional, with not only an individual dimension but also a social one. These effects, although observed particularly "here and now" during the pandemic, are also long-term in nature and apply to both the younger and the older generation. In summary, it is worth quoting the words of one of the seniors consulted by the itCS, who said: *"due to the COVID-19 epidemic, the world has changed and the itCS has become a mainstay, a hope [...]."*

Summary

The initiative was created out of concern for older persons who are at increased risk of a severe course of COVID-19 infection. Thanks to itCS, they were able to obtain professional and reliable drug advice on an ongoing basis while reducing exposure to the novel coronavirus. The aim of the activities undertaken was the consultation of older people by means of remote communication, such as instant messaging or telephone.

Satisfied patients are the best showpiece of itCS. We hope that there will be more and more of them over time. We are working on a solution that will allow us to transfer the itCS experience to the post-pandemic times.

References:

1. Adelman, R.D., Capello, C.F., LoFaso, V., Greene, M.G., Konopasek, L., & Marzuk, P.M. *Introduction to the older patient: A "first exposure" to geriatrics for medical students.* JAGS 2007, 55(9)
2. Allan, L.J., Johnson, J.A. Undergraduate attitudes toward the elderly: The role of knowledge, contact and aging anxiety. Educational Gerontol 2009, 35(1): p. 1- 14.
3. Birkenmaier, J., Rowan, N.L., Damron-Rodriguez, J., Lawrance, F.P., Volland, P.J.. Social work knowledge of facts on aging: Influence of field and classroom education. Eductional Gerontol 2009, 35(9)
4. Cottle, N.R., Glover, R.J. Combating ageism: Change in student knowledge and attitudes regarding aging. Educational Gerontol 2007, 33(6)
5. Cybulski, M., Krajewska-Kułak, E., Sowa, P., et al. *Elderly Peoples' Perception of Young People - A Preliminary Study.* Iran J Public Health 2013; 42(10)-1105
6. Delle Fave, A., Bassi, M., Boccaletti, E.S., Roncaglione, C., Bernardelli, G., Mari, D. *Promoting Well-Being in Old Age: The Psychological Benefits of Two Training Programs of Adapted Physical Activity*. Front Psychol 2018; 9: p. 828
7. Etemad-Sajadi, R., Gomes Dos Santos, G. *Senior citizens' acceptance of connected health technologies in their homes*. Int J Health Care Qual Assur 2019; 32 (8): p. 1162-1174
8. Ferguson, A. *Wanted: Gerontological social workers-factors related to interest in the field.* Educational Gerontol 2012, 38(10): p. 713-728
9. Gémes, K., Talbäck, M., Modig, K., et al. *Burden and prevalence of prognostic factors for severe COVID-19 in Sweden.* Eur J Epidemiol 2020; 35(5): p. 401-409
10. Hägg, S., Jylhävä, J., Wang, Y. et al. *Age, frailty and comorbidity as prognostic factors for short-term outcomes in patients with COVID-19 ingeriatric care,* JAMDA 2020, doi: https://doi.org/10.1016/j.jamda.2020.08.014
11. Langhammer, B., Bergland, A., Rydwik, E. *The Importance of Physical Activity Exercise among Older People*. Biomed Res Int 2018; 2018: p. 7856823
12. Morris, M.G., Hall, M., Davis, G.B., Davis, F.D., Walton, S.M. *User acceptance of information technology: toward unified view,* MIS Q 2003, 27(3): p. 425–478
13. Neumann-Podczaska, A., Al-Saad, S.R., Karbowski, L.M. et al. *COVID 19 - Clinical Picture in the Elderly Population: A Qualitative Systematic Review.* Aging Dis 2020; 11(4): p. 988-1008
14. Older Adults, Social Isolation, and Technology During COVID-19 Pandemic. https://www.thectac.org/2020/05/older-adults-social-isolation-and-technology-during-

covid-19-pandemic/ B-TACT he Blog to Transform Advanced Care. Advancing Care through Innovation, Observation and Collaboration

15. Peek, S.T.M., Luijkx, K.G., Vrijhoef, H.J.M. et al. Understanding changes and stability in the long-term use of technologies by seniors who are ageing in place: a dynamical framework. BMC Geriatr 2019; 19(1): p. 236

16. Pinkas, J., Jankowski, M., Szumowski, Ł. Et al. *Public Health Interventions to Mitigate Early Spread of SARS-CoV-2 in Poland*. Med Sci Monit.2020; 26: p. e924730

17. Taylor, N.A., *Ageism: Abilene Christian University Students' Perception of Aging Adults*. Digital Commons @ ACU, *Electronic Theses and Dissertations 2016.* Paper 24

18. *The American Geriatrics Society Expert Panel on Person-Centered Care: A Definition and Essential Elements*. JAGS 2016, 64(1): p. 15-18

19. Wieczorowska-Tobis K. *What does it mean "to be old"*? In: Musielak M. *Many facies of being old. Health and socio-cultural aspects of aging.* Poznan University of Medical Sciences 2006, p. 11-16

20. Wrzus, C., Hänel, M., Wagner, J., Neyer, F. J. *Social network changes and life events across the life span: A meta-analysis*. Psychol Bull 2013, 139: p. 53–80

Małgorzata Halicka, Jerzy Halicki, Everyday reality at Nursing Home Care facilities experienced during the COVID-19 pandemic

Introduction

Humanity lives in an environment dominated by micro-organisms, which constitute 99,99% of all living creatures that inhabit the Earth. Each of us carries billions of such creatures without realizing that they are our best friends and most dangerous enemies. Some help us digest our food, others cause disease and epidemics [1]. Most of the infectious diseases that have plagued agricultural and industrial societies originated in domesticated animals and passed on to humans after the agrarian revolution. People living in hunter-gatherer cultures, who had only domesticated the dog, did not experience these misfortunes. Moreover, in agricultural and industrial societies, most people lived in cramped, unhygienic conditions that were a hotbed for disease [1].

Epidemics can change history. The best example of this is the Plague that has re-appeared several times over the centuries. It decimated the population for the first time in the 6th century. With Constantinople at its centre, it lasted only one year and claimed 25 million lives. In the centuries that followed, the Plague killed twice as many people and, according to historians, was instrumental in ending Rome's rule. The bacteria causing the Plague came from the East, most likely from China along the Silk Road [2].

Another Plague epidemic, known as the "Black Death", broke out in China or Central Asia, reached Crimea in 1346, and spread from there to the Mediterranean and to Europe. The disease killed around 200 million people. Plague outbreaks appeared quite regularly until the 18th century [1].

In the 16th century, a smallpox epidemic broke out in South and North America, decimating the indigenous peoples of these continents (the Incas and the Aztecs). Plague epidemics broke out in America many times in the second half of the 17th century. The 18th century European Plague epidemic took the lives of some 60 million people. In the nineteenth century Plague and cholera pandemics swept the world, claiming over fifty million lives. The twentieth century was also not free of epidemics. The biggest of these was the Spanish flu epidemic that broke out in 1918-1919, hit almost all continents, and caused the death of millions (according to various estimates, between 20 to 100 million people). Humanity in the 21st century is experiencing yet another plague - the COVID-19 pandemic, which has affected people all over the world.

Many questions can be asked about human helplessness in the context of a deadly universal disease. In this situation, it is difficult to argue with the restrictions introduced not only in social welfare institutions, but in all spheres of social life, in order to counteract the spread of the Sars-Cov-2 virus, commonly known as the coronavirus. These actions affected various areas of human life, such as the economy, interpersonal relations, and health. These new regulations have also had an impact on how social care homes work with their residents. The new legal regulations aimed at limiting the spread of the coronavirus caused the institutions to close off from the outside world: family visits and visits to specialists were suspended. The sudden change in the way care facilities operate in Poland and the new regulations made the institutionalization of residents more intense.

In this article we want to share with the Readers the opinions of the residents of a Nursing Home regarding their personal experiences related to their daily life during the coronavirus pandemic. We want to show how they dealt with everyday life in this unusual situation. What were the emotions they felt? How did staff carry out their tasks in such an incredibly difficult situation of complete isolation? Could the residents of the facility count on the support of the staff and could the employees of the facility count on the support of the city or regional authorities? We also wanted to learn from the respondents how helpful the clergy were in this situation.

Characteristics of the respondents[22]

181 residents live at the Nursing Home in Białystok (Podlasie), but not all of them agreed to participate in the study. Their reasons varied, but most often it was bad health. In a few cases, the residents of the facility were reluctant to talk about the coronavirus. Under these extremely difficult conditions, we were able to recruit 35 people to interview. This group included 12 women (4 women under 70 and 8 women aged 70 or more) and 23 men (13 of them were no older than 70 and 10 have reached 70 or more years of age). In terms of education, the majority had secondary education (16 people, including 8 women and 8 men), 13 people (9 men and 4 women) received vocational education, while 6 men had primary or incomplete primary education. As far as marital status is concerned, they were mainly unmarried (31 people), including 13 divorced (mainly men - 10 people), 10 widowed (6 women and 4 men), while those who had never married were mainly men (7 of them) and

[22]The article is based on empirical research conducted among the residents of a Nursing Home in Białystok in 2020 after the outbreak of the pandemic. The research tool was a questionnaire. A diagnostic survey was used as the research method. Due to the complete isolation of the residents, the research was carried out by two employees of the facility using a research tool prepared by the authors. In some cases the respondents did not answer all the questions. Two telephone interviews with the employees of the facility were also conducted. The research results are presented as absolute numbers.

only one woman. The largest group of respondents consisted of the deeply and actively religious. Among 16 such people, there were 9 men and 7 women. There were 13 non-participating believers (9 men and 4 women), 5 religiously indifferent respondents (4 men and 1 woman), and only 1 man who declared himself to be a non-believer. Most of the respondents (14 men and 9 women) had children. It is, however, noteworthy that 9 men had no children, while only 3 women were childless. Analysis of the socio-demographic characteristics of the sample explains, in a way, why they ended up living in a care facility.

The results of our research carried out in the group of people described above will be presented below, in relation to three problem areas: the knowledge of the residents of the facility about the coronavirus, the feelings of the residents related to the coronavirus situation, and interpersonal relations during the pandemic. These analyses will be complemented by reports of two professionals employed in two institutions: the Nursing Home in Białystok, where there was no confirmed outbreak of the coronavirus but full isolation of the residents was nevertheless introduced, and in the Nursing Home in Choroszcz, where there was a COVID-19 outbreak, as reported by one of the social workers who took care of residents at a covid sub-unit[23].

The residents' knowledge about the coronavirus

All the residents of the Nursing Home in Białystok had some knowledge about COVID-19. The respondents' statements indicate that they were aware of the vectors and symptoms of infection, the course of the disease, groups of people particularly susceptible to infection, and the possible consequences of infection, including death. Examples: "*The virus originating in China from a bat*" (W, 72 years old), "*It is an infectious disease transmitted by airborne droplets*" (M, 71 years old), "*Dangerous virus, comparable to biological weapons*" (M, 70 years old), "*A virus causing respiratory diseases in people over 65*" (M, 64 years old). It is worth adding that a few respondents (4 men and 2 women) have been tested for the coronavirus.

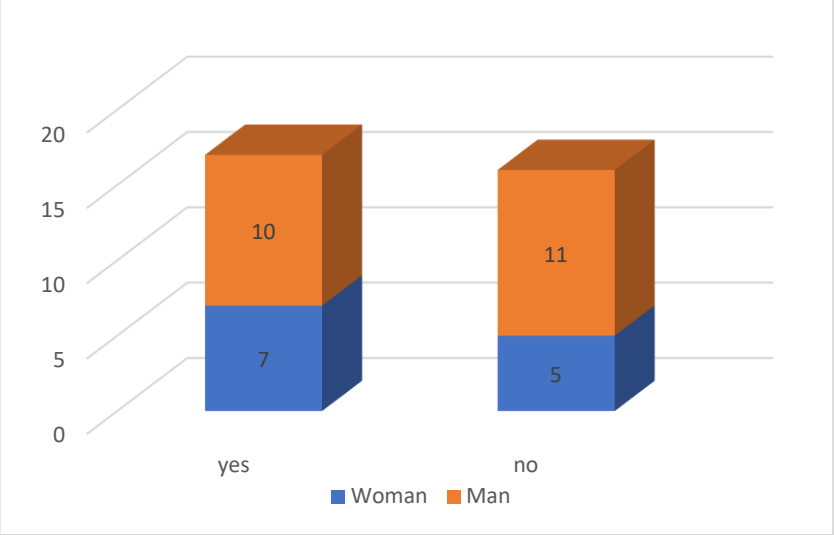
Despite the fact that there were no people infected with the coronavirus among the respondents, they were able to indicate typical somatic symptoms accompanying the disease caused by the coronavirus, i.e. increased body temperature, cough, shortness of breath, general weakness, lack of a sense of taste and smell. Only one person (male) had known or

[23]At this point, we would like to thank the Directors of the nursing homes in Białystok and Choroszcz and their employees for enabling us to conduct the research and for the interviews. We also want to express our gratitude to the patients for agreeing to participate in the research. Carrying out scientific research in the difficult conditions of a pandemic was not an easy task. All the greater is the satisfaction of achieving what we thought was impossible.

heard of an acquaintance infected with the coronavirus. However, it should be mentioned that the research was carried out in June 2020 (3 months from the introduction of the first restrictions and isolation) before the escalation of infections among elderly people, including care home residents.

The respondents were not able to clearly determine whether the facility staff instructed them about the coronavirus. Perhaps this was due to the fact that most often the activities meant to improve the residents' awareness of COVID-19 took the form of talks or individual conversations (Figure 1). The interview with a director of the facility indicates that many conversations regarding the coronavirus were conducted with the residents.

Figure 1. Coronavirus training conducted by care home staff

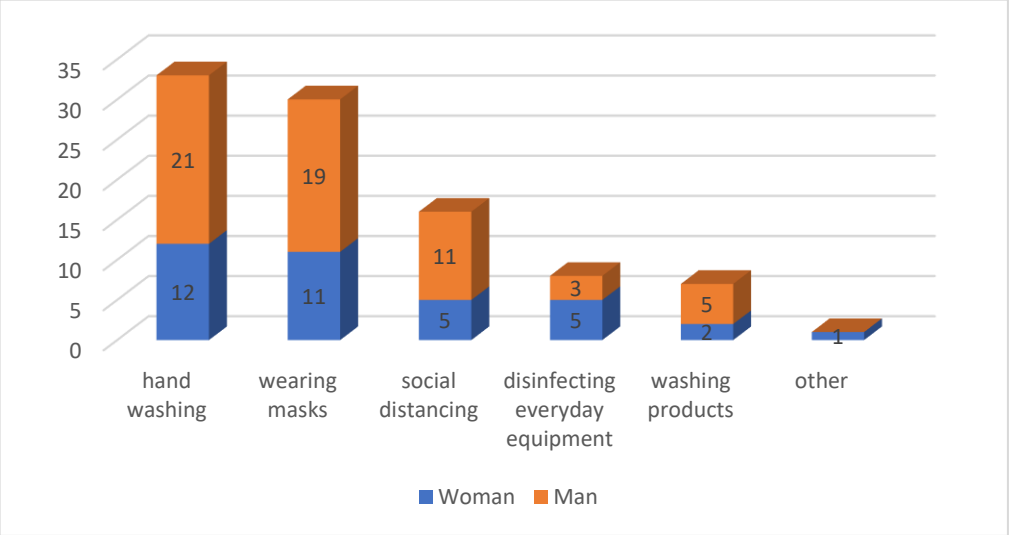


Thanks to the information about the coronavirus provided by the institution's staff, the residents displayed knowledge of the principles of the facility's functioning in the time of a pandemic and knowledge of the applicable procedures. Each of the respondents pointed out without hesitation the need to inform the caregivers or the facility staff, should suspicious symptoms be noticed in a fellow resident, which could indicate a coronavirus infection. An example of one transparent statement: "*I notify my superiors and caregivers immediately*" (M, 60 years old).

The respondents also correctly listed activities related to the prevention of infection. According to experts, today, in the face of the second wave of infections, these activities are the basic and most effective forms of preventing the spread of the virus.

In the opinion of the respondents (both men and women), the most important thing in preventing coronavirus infection is frequently washing or disinfecting hands (Figure 2).

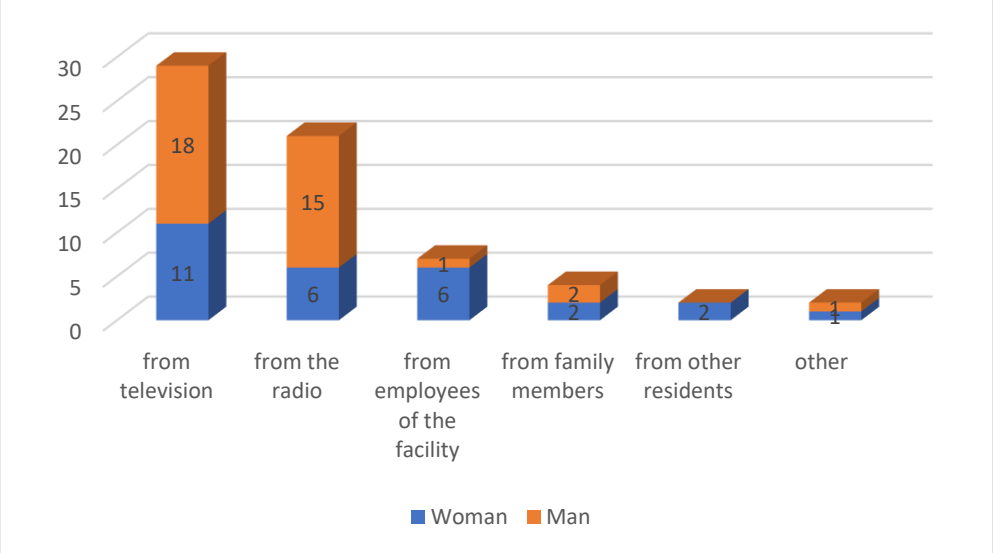
Figure 2. Prevention of SARS-CoV-2 coronavirus infection



It is also important to use protective masks (of the right type, in the right way, and in certain situations) and to keep a distance in relations with other people. It is also important to disinfect surfaces and objects of everyday use and to maintain hygiene when preparing meals.

As mentioned earlier, the employees of the facility are an important source of knowledge about the coronavirus for the residents.

Figure 3. Sources of knowledge about the coronavirus

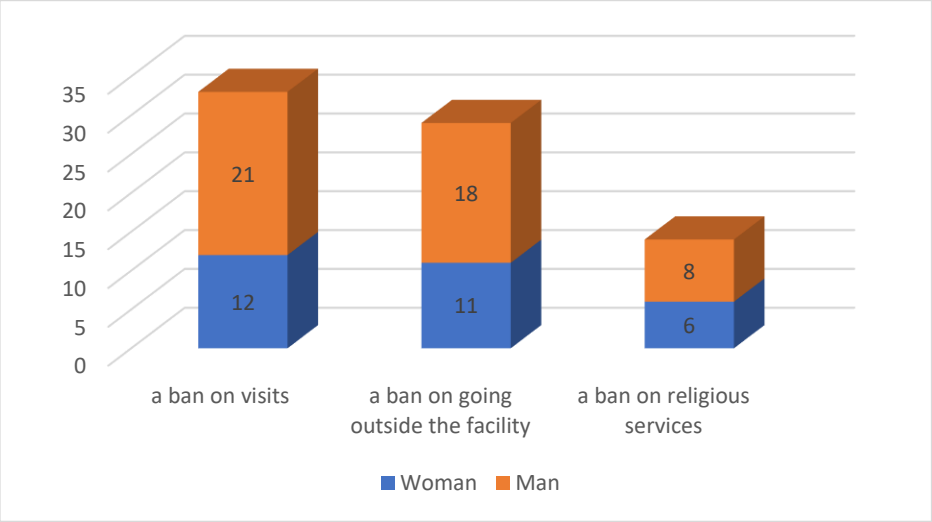


* respondents could choose multiple answers

Most frequently, however, the respondents obtained daily updates on the pandemic from the media - television and radio (Figure 3). Family members (mainly through indirect contact) and other residents are also an important source of knowledge.

In the Nursing Home where the research was carried out, as in every institution in the field of social welfare and health care, strict security measures were introduced to ensure the protection of residents against coronavirus infection. In the opinion of the respondents, first of all, an absolute ban on visits was introduced in their institution (Chart 4). Every participant knew it and pointed it out.

Figure 4. Security measures introduced in the care home for the prevention of coronavirus infection



* respondents could choose multiple answers

Residents are also forbidden to go outside the facility and to hold and participate in religious services (this was more often indicated by men). Statistical analysis shows a weak relationship between the variables (C_{kor} = 0,25), however the differences are not statistically significant (χ^2 = 1,2786; df = 2; p = 0,5276).

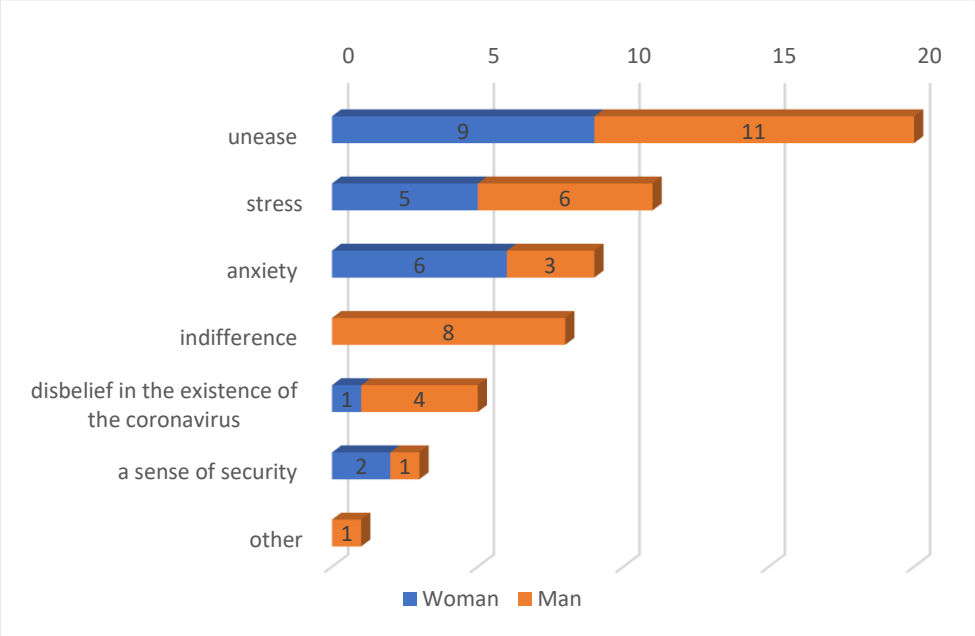
Most of the respondents (17 men and 12 women), despite having lived for many years, claim to never have met a person who had suffered from any infectious disease. Although statistical analysis shows a weak relationship between the variables (C_{kor} = 0,35), the differences are not statistically significant (χ^2 = 2,6009; df = 2; p = 0,2724). Most of the respondents (19 men and 10 women) had not experienced any infectious diseases personally.

Emotional responses to the coronavirus

The relative health of the respondents, at least in the context of infectious diseases (as described above), caused something of a shock in the face of the COVID-19 pandemic, triggering deep feelings of fear, anxiety, and uncertainty about life. Among the feelings accompanying them at the beginning of the pandemic, the respondents most often indicated

anxiety, fear, and stress (Figure 5). The new, unexpected situation caused a deep concern for their health and life, as well as that of their friends and loved ones.

Figure 5. Emotions felt by the respondents at the beginning of the pandemic



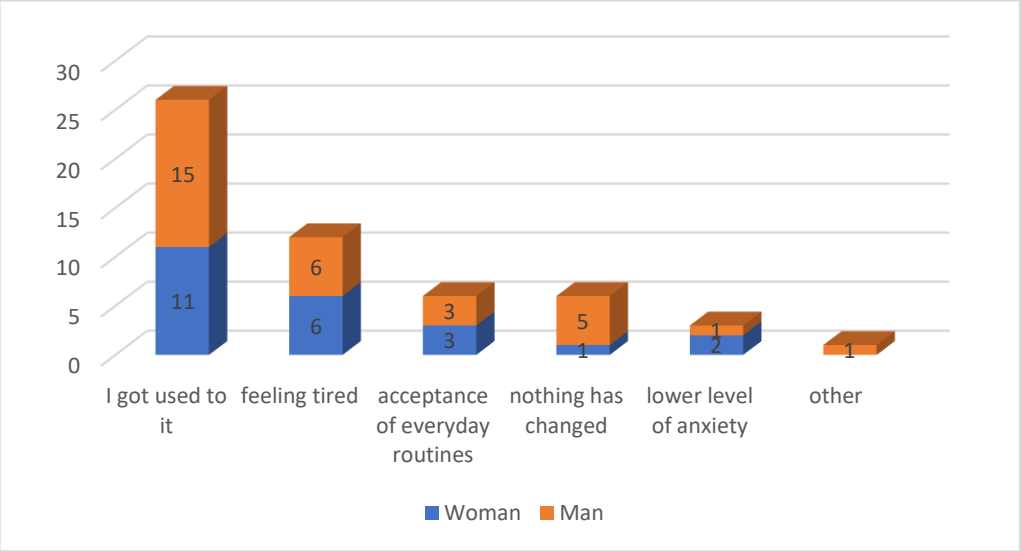
* respondents could choose multiple answers

It is interesting that men, more often than women, were indifferent to the situation, a feeling supported by their disbelief in the existence of the coronavirus. Perhaps it was a consequence of the experience of sudden change that no one was prepared for, a peculiar mechanism of optimistic rationalization, or of repression and denial of the improbable. It is important that some (albeit only a few) of the residents expressed a sense of security, which should be treated as a sign of trust towards the staff.

Interestingly, at this time, after several months of living with the coronavirus pandemic, the respondents experience similar feelings as at its beginning: "*Anxiety, fear of infection*" (W, 67 years old), "*High stress and terror*" (W, 66 years old) , "*Indifference*" (M, 69 years old), "*The same*" (M, 72 years old), "*A sense of security*" (W, 87 years old). There was also a sense of fatigue, helplessness, and habituation.

These opinions are expressed in the respondents' declarations about what has changed in their perception of the pandemic situation (Figure 6). Among these opinions, the feeling of getting used to the situation caused by the pandemic prevails, more so for men than for women.

Figure 6. Perceptions of the pandemic at the time of the research



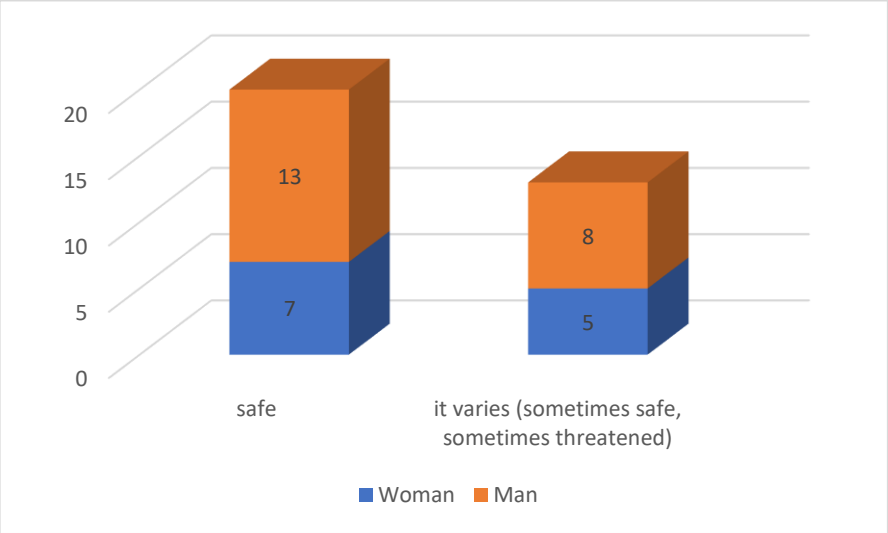
* respondents could choose multiple answers

The isolation of the residents is born of necessity and subject to formal regulations. It is also reflected in the fatigue they feel, mainly caused by the prohibition on direct contact with family and on leaving the facility. An interview with a social worker from the covid sub-division shows even more of the complexity of the situation and the emotions felt by employees as well in this life-threatening situation. Here is the account of the social worker: "*Each subsequent piece of information regarding the positive results of a staff member or resident increased the feeling of exhaustion, tension, fear, uncertainty, hopelessness, and sadness. The first thing I experienced when entering the covid ward was silence, peace, and a sense of horror, resulting from how I imagined working in such conditions, while I was presented with information on the general rules of conduct. At the beginning it was exhausting to have to stay focused while putting on all the layers of suits, being careful not to touch the eyes and mouth and during the disinfection process after leaving the covid ward*".

The surveyed residents also expressed acceptance for everyday life as it is. Some respondents claimed that nothing had changed over the 3 months. The lowest level of anxiety, which was indicated by only a few respondents, may be a consequence of "taming the coronavirus", i.e. learning about the mechanisms of the pandemic, gaining knowledge about protection options and prevention, learning to live anew in a situation of COVID-19 isolation.

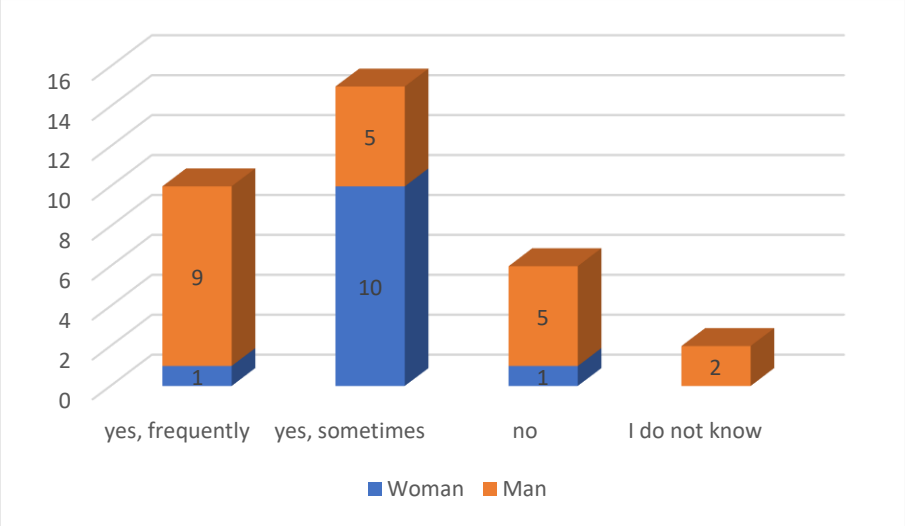
More than half of the respondents try to conduct their everyday life with a sense of security (Figure 7). Every third respondent is unable to clearly define their sense of their own security - sometimes they feel safe, other times they do not.

Figure 7. Sense of security among the surveyed residents



The residents who participated in the research also experienced a feeling of loneliness. During the pandemic, it is a part of the experience of many elderly people, including the residents of care homes. The situation of total social isolation of the respondents, expressed mainly in the lack of direct contact with the family, significantly deepens the feeling of loneliness. Experiencing a sense of loneliness is common to almost all the respondents. It was confirmed by more than half of men and almost all women (Figure 8).

Figure 8. The feeling of loneliness among the respondents



Men said that they often felt lonely more frequently than women. Most women, on the other hand, feel lonely at times. Statistical analysis shows a strong relationship between these variables (C_{kor} = 0,64) and the differences are statistically significant (χ^2 = 11,105; df = 3; p = 0,0112). Several of the surveyed men stated that they did not experience a sense of loneliness. There were also those who were unable to take an unequivocal position on this issue.

The account of a social worker explains this situation in a way. In his opinion, "*At the stage of introducing further restrictions in the facility, resulting from the general epidemiological situation in the country, a coronavirus outbreak in the facility and staff shortages, the feeling of institutionalization and isolation of the residents was growing. For safety reasons, the activities of therapeutic and physiotherapy laboratories and the gym were suspended. The residents were not able to go out into the fresh air. Thus, social rehabilitation, that is, the organized interdisciplinary work of empowering residents, treating the participant in a holistic manner, was not possible to a wider extent. This resulted in loneliness, decreased activity, frequent mood swings, depression, as well as excessive agitation, and in extreme cases even acts of aggression".*

In their statements, the residents pointed out situations that could contribute to the improvement of their well-being. Among the most frequently repeated expectations was a longing for contact with the family and going outside the facility. Residents also pointed towards a more rigorous adherence to the established rules of SARS-CoV-2 prevention. There were also statements expressing a desire to return to what life was like before the outbreak of the COVID-19 pandemic. Examples of statements: "*Allow for meetings with family*" (W, 78), "*Let us out, let our families in*" (M, 57), "*Obey the prescribed rules*" (M, 70), "*The facility should be as it used to be*"(M, 70).

According to the director of the facility, "*the lack of broader relations, including with the external social environment, the uncertainty of tomorrow, the lack of prospects, the inability to participate actively in Holy Mass celebrated every Sunday in the facility filled the residents with doubt, pessimism, and disbelief in quick change*".

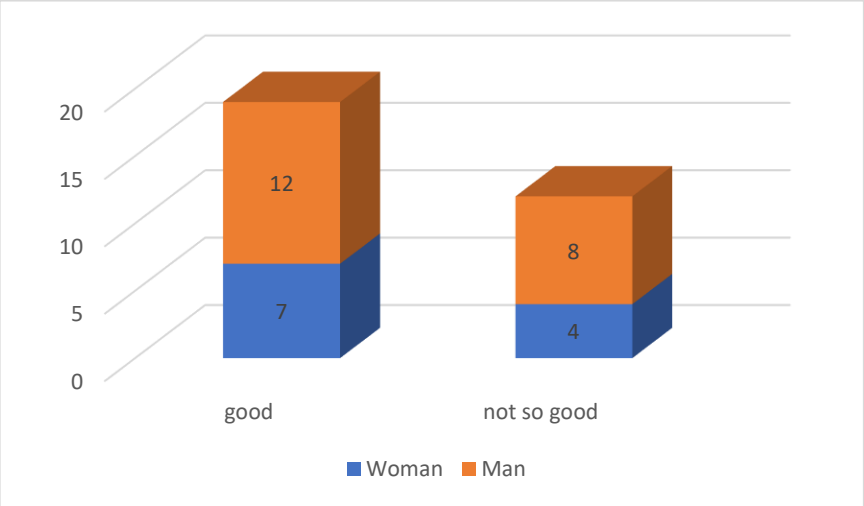
Interpersonal relations in the facility during the pandemic

We understood interpersonal relations in a care institution in a pandemic situation in two dimensions: as the relationships between residents and staff and as relationships between residents. Concerns about coronavirus infection in their contacts with staff during the pandemic were experienced by 13 respondents, which means that people who did not have such fears constituted the majority.

An even greater number of respondents did not feel any concern about contracting the coronavirus through their contacts with the residents of the facility (22 people). It is noteworthy that men experienced a lack of such concerns twice more frequently than women (15 and 7 respondents respectively). Only some people occasionally have such concerns. It is probably related to the knowledge and belief of the residents that no coronavirus outbreak was found in the facility, hence the positive attitude and greater sense of security.

Positive assessment of the relationships between fellow residents is a cause for optimism. This is evidenced by the data presented in Figure 9, which shows that 19 people assessed their relations with other residents as good, while 4 men assessed them as very good.

Figure 9. Assessment of relations with other residents



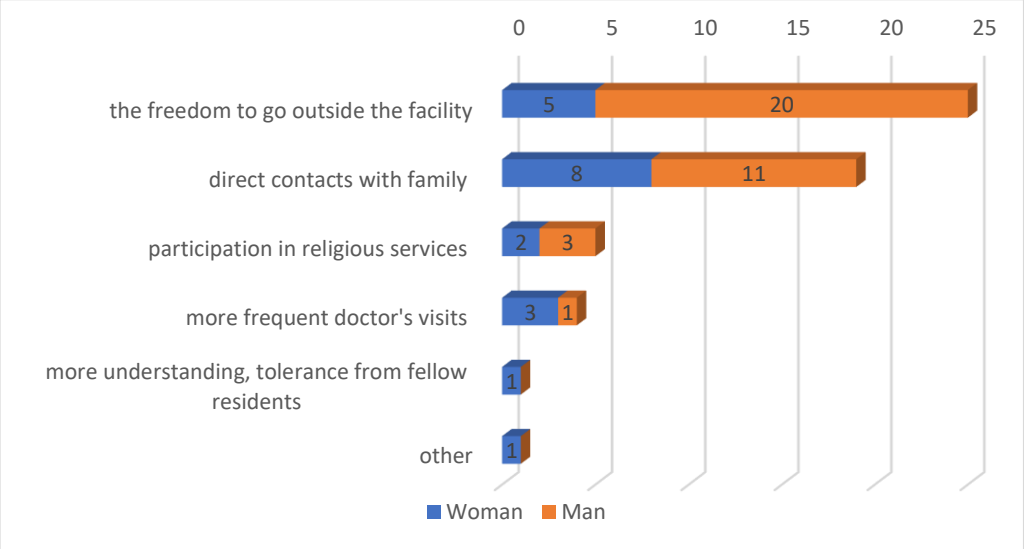
Eight men and four women have an ambivalent attitude towards their relations with other residents. These people evaluate the relationships as neither good or bad, so they could be considered unsatisfactory. Two of the respondents (1 woman and 1 man) do not maintain any relations with anyone. Perhaps it is related to the individual personality traits of the respondents.

About 2/3 of the respondents answered "yes" to the question "Is the ban on visiting the facility justified?" However, it is noteworthy that 15 of them expressed the opinion that the ban is only partly correct.

The respondents generally negatively assessed everyday life and changes in the facility brought on by the coronavirus. In their opinion, the unfavourable changes relate primarily to the ban on leaving the facility, the ban on visits that they miss and wait for, pointlessly sitting in one place, a feeling of emptiness, monotony, lack of perspectives. This assessment was complemented by the possibility for the respondents to point out three of the most important deficiencies in their experience of daily life in institutional conditions during the pandemic. It showed that the residents suffer the most from a lack of a sense of freedom expressed in freedom of movement outside the facility. This was the opinion of 25 people, only 5 of whom were women (Figure 10). It may be presumed that for some men the lack of freedom to move outside the facility is related to the inability to purchase alcohol. It is no secret that many of them are addicted to it. In the respondents' opinions, the inability to have direct contact with

the family is equally important. Nineteen respondents pointed out the inability to meet this need.

Figure 10. The needs of institutional residents during the pandemic



A few people indicated that the thing they miss the most is the ability to participate in religious services, which are not held in care homes due to pandemic restrictions. It should be noted that the residents of the facility did not express any other expectations of the staff of the facility, apart from the wish, expressed by 4 people, that medical visits to the residents would be more frequent. It was the wish of the respondents in the care of the facility that all the residents would be tested and that the pandemic would end. The residents were grateful for the care provided by the employees of the facility and expressed their thanks to the director.

The opinion of a social worker sheds light on the good practices that allow the residents' needs to be met. In his opinion, "*efforts are necessary to prevent the residents - as far as possible - from experiencing the negative effects of increased isolation. Modern technologies have been used to diversify social rehabilitation. In order to build a friendly atmosphere in the covid sub-unit, enabling the creation of a sense of security and peace, we engaged residents in joint, small scale work in the ward, depending on their health, often with music played from a large JBL loudspeaker*. Residents reacted positively to activities that brought variety to everyday life. According to the social worker, private equipment belonging to one of the members of the 3-person team was used, specifically a projector and a large screen to display media selected by the residents, i.e. a movie of their choice in the evening, playing relaxing music during the day, or playing computer games together (on a laptop). In the opinion of the social worker, "*the implementation of social rehabilitation in this way was meant to provide a substitute for "normality". To meet the needs of the residents, we also managed to organize a birthday party for one of them, attended by all the residents of the*

covid sub-unit. While working in the covid sub-unit, we would every day notice new problems of the residents, which made it impossible for them to meet their life needs; one of them was the inability to contact the residents staying in the "healthy" sub-units. We met this challenge using the projector, the Internet, and the Messenger app to communicate; using the web and a webcam we called a carer working in the "healthy" sub-unit with a request to share the screen with us and allow friends to see each other and talk remotely. Going further to meet the residents' needs, we began to contact other sub-units in the same way, so that the residents could talk to other people together".

The interview with the social worker made us aware of another problem, namely the threat of professional burnout in extreme situations, such as the coronavirus pandemic. *"A situation of increased isolation, implementation of new obligations regarding systematic disinfection of the premises, the need to pay special attention to everyday work, increase the probability of the onset or deterioration of burnout symptoms. The tense atmosphere led to many verbal conflicts between the staff, which did not facilitate overall communication and cooperation in combating the coronavirus outbreak at the facility. Chronic stress, tension, a sense of hopelessness resulting from prolonged work hours, incoming information about new coronavirus infections and deaths, meant that even an inconspicuous problem or noticing some irregularity could cause an inadequate reaction to the situation. For this reason, the employees received additional psychological support".*

Everyday life experienced by the residents and staff in a care institution during the coronavirus pandemic is a very complex problem and difficult to deal with without the involvement and support of authorities. Official sources tell us that during the coronavirus pandemic the facility where the research was carried out could count on cooperation and support from local authorities, while it was much more difficult to find understanding and support from regional authorities. And yet the needs of the residents of aid institutions should be equally important to those in power both in the city and in the region.

Conclusions

The social situation related to the emergence of the coronavirus has changed a lot in the life of every person, but the everyday life experienced in the reality of the coronavirus pandemic by the residents of care facilities and the staff employed there has - as we tried to show above - a specific character. Regardless of whether coronavirus outbreaks occurred in the facility or not, it was necessary to implement new procedures to counteract the spread of the virus. However, these steps strengthened the institutionalization of the inhabitants and their feelings of isolation. A lack of direct relations with the family and a lack of relations

with the outside world negatively affected the general well-being of the residents, as well as the staff.

In these difficult, rapidly changing conditions for the functioning of a Nursing Home, both residents and employees had to go on with their daily lives. In a situation of total isolation resulting from the public health restrictions they were in a way forced together and the hitherto routine daily activities turned out to be a challenge.

The statements of the surveyed residents and employees point towards a dynamic in the emotions they experienced and the nature of interpersonal relations in the facility - from initial fear, panic, through indifference, coming to terms with the situation, to relative peace and mutual trust and cooperation. There is no doubt that the isolation experienced by the care home residents and staff members can be seen as a situation of crisis.

When looking for the bright sides of the situation (which is very difficult due to the global and lethal scope of the pandemic), one should remember that every crisis creates the potential to get out of it stronger. Disturbed by the pandemic, long-lasting relationships within the care home, reformulation of the employee ethos, limited support for the functioning of the institution from external entities, constitute new areas requiring the development of new standards in the post-covid reality.

References

1. Harari Y.N. (2014), Sapiens. A Brief History of Humankind. London: Harvill Secker.
2. Routherford A.(2016), A Brief History of Everyone Who Ever Lived. London: Weidenfeld and Nicolson.

Chloé Gaulier, Pauline Gouttefarde, Sébastien Rabier, Vincent Augusto, Arnaud Simeone, Caroline Dupré, Solène Dorier, Jessica Guyot, Nathalie Barth, Feedback from French nursing staff in gerontology: Health reorganization acceptance related to COVID-19 crisis.

Introduction

The international alert concerning COVID-19 obliged the French Government, through the directives of the Ministry of Solidarity and Health, to mobilise and restructure the French healthcare system so that it could prepare and cope with the imminent spread of the virus. In France, this mobilisation focused on the detection and management of possible and confirmed cases. Care was mainly provided in Covid-certified establishments and mostly concerned hospitals. Nevertheless, non-hospital facilities (i.e, local doctor's clinic) and the social and medico-social sector have also had a key role in managing the Covid crisis, playing a role in detecting new cases, in isolating suspected or detected cases and in managing and mitigating the spread of the pandemic [19;22].

The escalation to Level 3 on 14 March 2020, forced the government to make greater demands on healthcare sector participants. In order for the ORSAN REB plan (Organisation of the Health System Response in Exceptional Health Situations for Epidemic and Biological Risks) to be effective, all healthcare sector participants had to be mobilised and coordinated. These unprecedented changes led to major organisational changes in healthcare practices.

Typically, 3 types of organisational change are identified and defined according to several criteria related to the Extent, Pace and Breadth (or Depth) of these changes [12]; [14]. With Covid, we are faced with a so-called 'radical' change, since major by its nature and corresponding to a genuine crisis [25, p.31]. Radical change is recommended where there be an unstable context. Radical change profoundly disrupts the usual way of doing things [13, p.98-107]; [25, p.31-42]; [27, p.25-32].

And indeed, the COVID-19 epidemic has led to a major reorganisation of care in France. Since the elderly are potentially the most at risk from the virus, because of the serious forms associated with it (16.6% of positive cases are between 70 to 79 years old and 18.4% are 80 years old or older, [30]), caregivers in facilities caring for the elderly have undergone disproportionately more changes in their work. It is likely that these changes led to difficulties and required significant adaptation efforts by these staff, affecting their perception of the measures taken as well as their acceptance thereof. In fact, several questions can arise: How

did caregivers in facilities caring for the elderly perceive and experience the reorganisation of the healthcare system? Did they accept this reorganisation? Did acceptance of the changes differ according to the work contract status of the caregivers? By “status”, we mean that the caregivers either have a full-time employer (i.e., they are “institutional caregivers” or “paramedical caregivers”) or they are self-employed. What factors were identified as facilitating or hindering acceptance of these changes?

Several models attempt to capture the modalities inherent in the acceptability (and ultimately acceptance) of using a new tool or embracing a new organisation. For example, the Technology Acceptance Model (TAM) deals with behavioural intention, a factor that leads people to use a technology [6]. But another model offers a better explanatory capacity for behavioural intention: the 'Unified Theory of Acceptance and Use of Technology' (UTAUT, [28,p.425]). This model proposes 4 main factors influencing the behavioural intention and use of a new feature (tool, organisation, system, etc.): performance expectancy; effort expectancy (i.e., the degree of ease associated with use); facilitating conditions, and lastly, social influence (i.e., the influence of the people around the individual and their perception of the new feature). [3,p.355-382]; [17, p.34-46]; [28; p.425].

Although UTAUT already offered a comprehensive framework for satisfactory acceptance, an extension of this model was subsequently developed. Venkatesh et.al. thus added 3 new constructs to create UTAUT-2 [29, p.157-178]. Hedonic Motivation, referring to the satisfaction or pleasure derived from using a new technology; Price Value, referring to the cost of implementing the new feature; and lastly Habit, referring to the extent to which individuals tend to adopt automatic behaviours as a result of learning [18, p.705]. This extension of the original UTAUT model improved the explanation of the variance in behavioural intention, to wit: whereas the first version of UTAUT explained 56% of behavioural intention, UTAUT-2 allowed for 74% of behavioural intention to be taken into account [29, p.157-178].

In an attempt to answer the questions set out above, an analysis of the acceptance of these changes, with respect to the UTAUT-2 model, was conducted among caregivers working with the elderly. In the long term, the aim is to better anticipate the impact of the changes within healthcare structures, particularly with a view to future epidemic waves.

The aim of this research was to understand how the reorganisation of healthcare has been experienced by caregivers working with the elderly. From a comprehensive and interventional point of view, the aim was to identify factors identified as facilitating or hindering acceptance of these changes.

Method

The study used a mixed methodology, combining qualitative (survey by semi-structured interviews) and quantitative (survey by questionnaire) approaches. The aim of the questionnaires was to gauge, over a large sample, the degree of acceptance of the changes resulting from the reorganisation of health services. The aim of the interviews was to analyse and understand the perceptions and experiences of the healthcare professionals surveyed [5]; [11, p.135-141].

1. Survey by semi-structured interviews

The aim here was to understand the subjective reality experienced by caregivers in the face of the management of the COVID-19 health crisis (understanding and operationalisation of the changes as well as the feelings and experiences associated with it). Our sample was made up of 10 caregivers (5 men and 5 women; average age 31.1 years), mainly doctors (7 doctors, 1 intensive care anaesthetist, 1 senior nurse, 1 rheumatology intern), all practising in France in the Auvergne-Rhône-Alpes region (AURA).

All the semi-structured interviews were done by the same interviewer, using a semi-structured interview guide. To start, some socio-demographic data pertaining to the interviewees were collected. Then came the interview guide, structured around four themes: their perception of the changes imposed by the crisis; how the caregivers personally experienced these changes; the acceptability of these changes; and lastly, perspectives ensuing from the reorganisation. The interviews were conducted during the month of May 2020, i.e. just after the first pandemic wave in France [24]. The analysis of the interviews was carried out using NVivo version 11 software. A horizontal thematic analysis was carried out in order to identify recurring themes [1].

2. The questionnaire survey

This survey was conducted among a population encompassing all caregivers practising their profession in the AURA region and caring for elderly patients. More specifically, the survey population was composed of three groups of participants: institutional caregivers (hospitals / medical-social establishments), paramedical caregivers (hospitals / medical-social establishments) and self-employed or home-based caregivers. A sample of 472 voluntary caregivers was recruited using a non-random, voluntary sampling method. Of these, 83.9%

were women and 15.47% men; average age of 44.38 years (youngest was 18, and eldest was 68). Most of the survey participants were nurses. A large majority of the survey participants came from the field of non-hospitalised medicine, with 51.48% of professionals working in a private practice, 13.98% at home, 14.83% practising their profession in a nursing home and 12.92% in a hospital.

This questionnaire was developed using LimeSurvey software. It consisted of three main sections: 1) the experience and extent of organisational changes, 2) the presence and use of psychological support units to the intention of caregivers and 3) the acceptance, by caregivers, of how the Covid crisis was managed. This last part has been developed on the basis of behavioural factors identified by the second version of the Unified Theory of Acceptance and Use of Technology (UTAUT-2; [29]) which has a total of 7 factors influencing the behavioural intention to use a new feature: performance expectancy (usefulness), effort expectancy (ease of use), facilitating conditions, social influence (influence of relatives and their perception of the tool), hedonic motivation, price value and habit. These different factors were made part of the questionnaire in order to highlight the factors of acceptance or resistance to changes in the practices of caregivers working with elderly people.

The questionnaire was distributed online (by e-mail and social networks) in order to respect the anonymity of the respondents and the confidentiality of the responses for the months of May and June 2020. The results were statistically analysed in two steps: the calculation of position data for the descriptive questions (minimum and maximum responses, percentages or averages) and the analysis of the consistency of scales with calculation of Cronbach's alphas [4].

Results

1. A radical reorganisation of healthcare

1.1 Changes in the pace of work

Recurrently, the participants in this study report that they have witnessed a complete change in the organisation within health establishments (hospitals as well as nursing homes). According to the data collected, these changes appear to be more significant for institutional caregivers (including hospitals) than for self-employed caregivers (88.2% versus 51.69%). Most questionnaire survey participants reported an increase in their workload: 59.21% of caregivers employed by medical establishments, and 50% of self-employed caregivers reported having worked more hours than usual.

"What also plagued me was managing all the extra work, of which we already had a lot (senior nurse, Geriatric hospital).

1.2 A reorganization in the sector that facilitated the emergence of new skills

Caregivers who could no longer perform their usual duties were assigned to these dedicated units. It would appear that some structures/services were much more affected than others. The results show that 79.54% of the participants say that they had to acquire new work habits quickly (hygiene measures, administration of treatment procedures, etc.).

Many outpatient and non-emergency consultation services were suspended, and the premises were fitted out to receive patients with COVID-19. As a result, hospital doctors report many late consultations and more serious pathologies, wounds and problems than usual.

"I think above all that they were afraid to come; you have many people who, although with fractures or in a cast, did not want to come" (Sports doctor, Emergencies Unit).

1.3 A lack of personal protective equipment generating a fear of risk, particularly for self-employed caregivers

With regard to the perception of risk, the main change mentioned by the respondents was PPE Management. A full 44% of respondents considered that they lacked protective personal equipment (PPE) such as masks, gloves and similar. This insufficiency in terms of PPE, noted in all health sectors (hospitals, medico-social establishments, local doctors clinics), seemed, based on the quantitative data collected, even more problematic for self-employed caregivers. Indeed, 43.93% of self-employed caregivers reported this issue (compared with 29.63% of institutional caregivers and 22.06% of paramedical caregivers). Caregivers spoke at length about their difficulties in obtaining PPE and several comments reveal a feeling of insecurity and anxiety regarding these missing resources.

"I was very concerned that we would lack PPE. That was sometimes a bit complicated because we really felt we were in a tight spot", (Doctor, geriatric hospital).

This variable can be linked to the fear of risk and contamination; indeed, 70.84% of the caregivers expressed a fear of contaminating their family and 68.03% their patients. The analysis reveals that self-employed caregivers were the most concerned about transmitting the virus. The population sample declaring that they had the greatest difficulty in obtaining the necessary PPE is therefore also the population that expressed the strongest feeling of risk of contamination Our acceptance scales bear witness to this situation since the "risk perception"

variable is very noticeable for self-employed caregivers. This variable would therefore not facilitate acceptance in the management of a health crisis.

1.4 End-of-life management: the use of digital tools as an alternative

Digital tools have played an important role in this context of health crisis. They were mainly used by paramedical caregivers in order to communicate with the families of patients (as reported by 70.55% of caregivers) and to enable patients to call their families (as reported by 80.89% of caregivers). Institutional caregivers and self-employed caregivers mainly used digital tools in order to communicate with other healthcare professionals (74.07% and 56.76% respectively). On the whole, the telephone was the most used communications tool (80.88% of caregivers), followed by videoconferencing (51.85%) and telemedicine (29.63%). Paramedical caregivers considered these communications tools as playing an essential role in maintaining a relationship (healthcare professional <=> family <=> patient). However, although these technologies are perceived as necessary, difficulties persist, particularly with regard to using these technologies and the presence or absence of functional equipment. Virtual communications does not compensate for the lack of direct contact among elderly persons.

> *"They come from a generation that is clearly not at home with our new technologies and for some, seeing their loved ones on a screen was complicated to understand. For some it worked very well, but for most it was not completely satisfactory and it didn't completely make up for the lack of visits, although it's better than nothing". (Geriatrician doctor, Nursing Home).*

End-of-life management is a criterion that particularly impacts healthcare professionals, who reported that they did not always feel they are acting ethically or doing quality work. In our interviews, this feeling of powerlessness with regard to death is expressed.

> *"Sometimes the husband and the wife were in the same service and so we had the wife transferred so that she could hold the husband's hand as he was dying. We tried to be as humane as possible but this was not always the case". (Anaesthesiologist - Resuscitator, COVID resuscitation).*

The issue of end-of-life management and support was raised by the survey participants. However, ancillary and creative solutions enabled families to maintain the

connection to COVID-19 residents and patients up to their death. For example, caregivers mentioned the use of digital tools or rituals to make the departure of a patient more humane. Caregivers organised telephone slots dedicated to contacts with families which, they reported, were very beneficial. Although digital tools (videoconferencing, telemedicine, telephone calls) were widely used, they could not be set up everywhere and for all users, particularly the elderly who either didn't know how to use them or did not have the necessary equipment.

"We had patients who were very ill and it was difficult to use a digital tool with them" (MCU-PH, Infectious Diseases Department).

1.5 Isolation harmful to patients

Our survey underlines the negative psychosocial repercussions, on patient health, and in particular on older people, of the organisational changes enacted in response to Covid 19. These new conditions have led to changes in the work of caregivers. Their work evolved into a more supportive and accompanying role with older people. According to replies, the isolation of older persons inside nursing homes, combined with the discontinuance of all social bonds has had a significant negative impact on their mental health.

"It is becoming increasingly difficult for the residents to be cut off from the world (...) it's a kind of tsunami, anxiety, tendency to depression (...), the residents withdraw into themselves, they are much less communicative (...) even with nursing home staff, you can really see that they withdraw into themselves. (...). They feel sad, they have a feeling that they are locked up, in prison, and they miss their family". (Geriatrician, Nursing Home).

Moreover, visits to elderly persons in nursing home took place under conditions that emphasised protection (plexiglass, social distancing, masks...) and the residents seem to experience difficulties with this.

"We can see that there are residents who are almost more disturbed after the visits than before". (Geriatrician, Nursing Home).

2. <u>How satisfied were the caregivers with these changes?</u>

2.1 Caregivers are globally satisfied with the new organisation

Overall, caregivers expressed satisfaction with the management of the first pandemic wave. The results of the questionnaire survey show that 88.23% of institutional caregivers, 75% of paramedical caregivers and 51.69% of self-employed caregivers considered that the response reorganisation deployed to deal with the pandemic were on a par with the scale of the emergency.

This overall satisfaction also seems to favour the acceptance of caregivers in the face of this reorganisation. In fact, most of the caregivers interviewed were satisfied with the organisation that had been deployed and found it useful. Furthermore, all the systems put in place in times of crisis seem to have been approved, such as the questionnaires for analysing the state of health of pre-consultation or follow-up of positive patients at Covid-19 at home.

"I think it was very well organised and above all with great solidarity". (MCU-PH, Infectious Diseases Department).

2.2 ...with nevertheless some reservations

For 50.05% of institutional caregivers, the health reorganisation measured deployed to deal with the pandemic did not allow for continuity of care for non-COVID elderly people. Conversely, 66.18% of paramedical caregivers and 47.3% of self-employed caregivers responded that this reorganisation sufficiently allowed for continuity of care for non-COVID elderly people. It should be noted that a significant number of self-employed caregivers did not take a position on this issue. Nevertheless, institutional caregivers have less trust in government recommendations than do self-employed caregivers. Overall, 24.55% of survey participants do not trust these recommendations, due to repeated changes in Covid-response measures handed down by the government:

"The test procedure that changed every day... and that was a big problem, a source of much anxiety for the teams... one day you were being told to dress the elderly persons and the next day, you were told not to dress them, to help them wash, and not help them wash" (Doctor, geriatric hospital).

2.3 A feeling of support that promotes acceptance

The caregivers reported feeling valued, both by their colleagues and their loved ones. Overall, 67% of survey participants felt supported by their family and friends as regards following Covid-response recommendations: 34.27% of family/friends encouraged survey

participants in their work with COVID patients, compared with 28.9% who did not. More than 66% of the caregivers felt useful during this pandemic.

Cooperation, Solidarity and Communication between caregivers were the most important aspects highlighted. This cooperation was omnipresent in the decision-making process concerning the care and reorientation of COVID patients, with multidisciplinary choices and decision-making.

> *"We always made decisions as a team to try to find the best solution. There has been a lot of discussion about what kind of care to take". (Doctor, COVID acute care & rehabilitation)*

Discussion

Through this study of the acceptance, by caregivers, of organisational changes rolled out in response to COVID-19, we were able to explore how caregivers in the AURA region experienced these changes, as well as their perception thereof. Feedback, opinions and assertions made by the caregivers surveyed allowed us to understand in depth how the healthcare measures implemented in the AURA region were perceived, experienced and accepted by these front-line professionals. The UTAUT-2 model enabled us to identify the factors that influenced the acceptance of caregivers with regards to the new measures and organisation put in place in response to Covid. In the face of an unprecedented epidemic, with no possibility of comparison or reproduction based on past experience, a change in working habits is at the heart of the recommendations for managing this crisis. Therefore, for an effective change in practice, the acceptance, by caregivers, of organisational changes and new rules, can be considered a necessary condition for the effectiveness of public health policies.

1. <u>Factors hindering acceptance: what parallel with UTAUT-2?</u>

1.1 The adverse consequences of this crisis on the health of caregivers

The analysis of our data shows that, above and beyond those changes made in response to Covid, caregivers were exposed to an array of difficulties (PPE, care of non-COVID elderly patients, end-of-life management, patient orientation, pressure from families, etc.). The large workload and the massive influx of patients combined with constantly changing organisational instructions put a heavy strain on the cognitive and adaptive capacities of the caregivers. These decisions, necessarily rapid, repeated and difficult, led to strong psychological tensions and possible cognitive exhaustion [8, p.4]. These results converge with those of other studies which reveal that 57% of institutional caregivers

(hospitals / nursing homes / medico-social) claim to have experienced an increase in workload [9].

On a similar note, several survey doctors reported that they had had disturbed sleep or had taken treatments for anxiety. Similarly, 49.37% of the caregivers interviewed felt sad (from Sometimes to Frequently). Similar results have been highlighted by the MACSF (mutual insurance company, provider of insurance services for health professionals) found that over 50% of the surveyed caregivers reported that they continued to experience physical fatigue, anxiety, stress and sleep disorders (MACSF, June 2020).

End-of-life management has been particularly difficult for caregivers. While geriatric caregivers are particularly accustomed to death, restrictions on family visits and limited contact care created a sense of powerlessness in their ranks [23, p.160-167]. It would seem that these negative feelings were not so much caused by death per se, but rather but the suddenness of the onset of death and the support measures (considered inadequate) provided to the dying person [16, p. 1]. Although the survey caregivers accepted these conditions, in particular in the light of the collective interest, these conditions and this feeling of not staying by the dying person lead to "an internal revolt that is not without consequences for the caregivers and, in particular, hinders their mourning process" (for the deceased elderly person) [23,p. 4].

The repercussions, on the mental health of caregivers, of health emergencies seems to a topic at the heart of current research [7]; [8]; [20]; [23]; [31]. The caregivers surveyed also expressed the wish to have psychological support available on-site, rather than to have a special cell that they have to contact themselves - a remark all the more salient since a large majority of respondent caregivers were not even aware of psychological support services available for caregivers.

1.2 Fear: a brake on acceptance?

The caregivers surveyed commented on the lack of PPE they experienced at the beginning of the crisis. These conditions were a cause for concern amongst caregivers, altering their sense of their professionalism and of their personal safety [8, p. 1]. 68.03% of the caregivers surveyed questioned are mainly worried about infecting their relatives or patients. These data coincide with those of other studies, since 14% of caregivers decided, as a preventive measure, to live apart from their relatives during the pandemic [20]. This unprecedented health situation forced caregivers to reorganise their personal lives, leading to an upheaval between private and professional life [31, p.1). Self-employed caregivers were the least affected by the sweeping changes caused by the Covid. That said, the survey reveals

that this was precisely the category that was the least accepting of change. As regards those factors of acceptance of the changes, the Risk Perception variable was very high for self-employed caregivers. Moreover, the survey reveals that this category was the one that most suffered the lack of PPE. Although self-employed caregivers did not perceive organisational changes to the same extent as other classes of caregivers, those self-employed caregivers who experienced more difficulties replenishing PPE had a strong sense of risk. Self-employed caregivers were also less accepting of the organisational changes deployed in response to Covid. This risk-perception factor, which is part of the UTAUT-2 model, helps to explain the lower acceptance of changes by self-employed caregivers, who did not feel sufficiently protected by the proposed or imposed changes.

2. Factors facilitating acceptance: the use of UTAUT-2 as an explanatory model

2.1 New work habits that make work easier

Our study reveals that the caregivers rapidly acquired skills and new work habits (hygiene measures, administration of treatment procedures, etc.) Similarly, according to another study, Covid facilitated the emergence of new working methods for 85% of caregivers, including 89% of self-employed caregivers and 81% of institutional caregivers [20]. The caregivers responded that they had acquired new skills as a result of having been dispatched to other services where they learned new skills. They spoke of new and rapid work habits.

With regard to UTAUT-2 and its Habit factor, individuals tend to adopt automatic behaviours as a result of learning [18]. If the behaviour becomes a habit, then users will be more likely to approve of it. This factor is very present here and can promote acceptance of the new organisation.

Similarly, these new work habits do not appear to have had a significant impact on the sense of efficiency or "performance" as described in UTAUT-2. We can hypothesize that those caregivers who felt overwhelmingly supported, valued and useful have, as a result, been more accepting of organizational change.

2.2 Perceived support: a lever for acceptance

The caregivers surveyed replied that they felt supported and valued, both by their colleagues and their loved ones. The social influence variable in UTAUT-2, which takes into account the influence of the entourage orbiting the individual, indicates that the more the user (here the caregiver) feels that those around him or her are favourable to the adoption of the change (in this case, the new organisation), the more the latter will be inclined to approve of it

[3]; [17]; [28]. We note that the changes rolled out in response to Covid were supported and approved by family and friends, which would encourage acceptance by caregivers. The views of family and friends and society therefore seem to have an impact on the work of professionals and the acceptance (or not) of the changes. Although some cases of violence against caregivers were reported in the media, society at large was supportive of caregivers (clapping each evening at 8pm).

3. Paradoxically, many changes were well accepted

Caregivers had to come to terms with a total reorganisation of their work habits. However, the greater the changes (scale, pace, depth, usability, etc.), the more difficult it was for individuals to adhere to them [2]; [6]; [15]; [17]; [21]; [26]; [28]. However, caregivers appear to have generally accepted and followed the recommendations. We may wonder about the particularities of this exceptional situation, which has led to many changes that have, in the end, been favourably accepted by caregivers caring for the elderly.

The caregivers have shown a voluntary and determined commitment without which the reorganisation would not have been possible [8, p. 1]. We can assume that the key role played by the medical professions during Covid had an important impact on the acceptance of health recommendations. Caregivers wanted to feel useful and in their rightful place when the pandemic hit. The favourable acceptance of organisational changes by the caregivers seems to have been impacted by the Performance Expectancy factor. Indeed, change appeared to be unavoidable in order to cope with the Covid crisis. Moreover, most survey respondents replied that they felt more valued by others during the crisis.

However, M-J Del Volgo notes that it is "dangerous to consider caregivers as heroes". To be a hero means to sacrifice yourself, to suffer in silence. The hero does not ask for help nor special resources. The hero is a superman. To consider caregivers as heroes is to place immense responsibility upon their shoulders all the while preventing them from recognising "their own vulnerability" [23, p.1]. This societal pressure on caregivers raises questions about the nature of acceptance of change (by caregivers). Indeed, we may wonder whether this acceptance is not strongly induced by social pressure. We can assume that the acceptance of changes rolled out in response to Covid 19 could be a forced acceptance, imposed by forces of an ethical nature, and by the inherent social desirability of the way in which society see the medical professions. According to this reasoning, caregivers are tempted to accept Covid-induced changes so as to adopt the behaviours expected by society [10].

Conclusion

The progress and persistence of this health crisis over several months has highlighted the need for a comprehensive approach in order to learn lessons from the first wave of this epidemic. Our research shows that the crisis has had an emotional impact on caregivers (stressful situations, working conditions, death of patients, suffering of residents' families...), and the French Academy of Medicine recommends that particular attention be paid, over a long period of time, to the mental health of the caregivers involved in the Covid-19 crisis. One of the keys to future health crises would be make psychological and social support available for caregivers.

Bibliography

1. Bardin, L. (2013). *L'analyse de contenu*. Paris cedex 14, France : Presses Universitaires de France. doi:10.3917/puf.bard.2013.01.
2. Bareil, C. (2004). *Gérer le volet humain du changement* (Transcontinental).
3. Bobillier-Chaumon, M.-É., & Dubois, M. (2009). L'adoption des technologies en situation professionnelle : Quelles articulations possibles entre acceptabilité et acceptation ? *Le travail humain, Vol. 72*(4), 355-382. https://www.cairn.info/revue-le-travail-humain-2009-4-page-355.htm
4. Cescup. (2014). *L'alpha de Cronbach*. https://cescup.ulb.be/lalpha-de-cronbach/
5. Corbière, M. & Larivière, N. (2014). Méthodes qualitatives, quantitatives et mixtes dans la recherche en sciences humaines, sociales et de la santé. Presses de l'Université du Québec (720p).
6. Davis, Fred. (1985). *A technology acceptance model for empirically testing new end-user information systems : Theory and results*. https://scholar.harvard.edu/bmiddlet/publications/technology-acceptance-model-empirically-testing-new-end-user-information
7. Dit, B. (2020, mai 22). Vécu psychologique de l'épidémie COVID-19. *ISNI*. https://isni.fr/vecu-psychologique-de-lepidemie-covid/
8. El-Hagea, W., Hingrayc, C., Lemogned, C., Yrondif, A., Brunaulta, P., Bienvenuh, T., Etaini, B., Paqueti, C., Gohiel, B., Bennabim, D., Birmesn, P., & Sauvageto, A. (2020). *Les professionnels de santé face à la pandémie de la maladie à coronavirus (COVID-19)*. Elsevier Connect. https://www.elsevier.com/fr-fr/connect/psy/les-professionnels-de-sante-face-a-la-pandemie-de-la-maladie-a-coronavirus-covid-19

9. Fabregas, B. (2020, juin 3). *Les soignants interrogés sur leur vécu de la crise sanitaire*. Infirmiers.com. https://www.infirmiers.com/actualites/actualites/covid-19-et-impacts-sur-professionnels-de-sante.html
10. Festinger, L. (1957). *A Theory of Cognitive Dissonance*. Row, Peterson.
11. Flick, U. (2020). Hearing and Being Heard, Seeing and Being Seen: Qualitative Inquiry in the Public Sphere—*Introduction to the Special Issue. Qualitative Inquiry, 26*(2), 135–141. https://doi.org/10.1177/1077800419857766
12. Giroux, N. (1991). *La gestion du changement stratégique.*
13. Guilhon, A. (1998). *Le changement organisationnel est un apprentissage*. 98-107
14. Guilhon, A., et Trepo, G. (2001). *Réussir les changements par le développement de l'apprentissage organisationnel les leçons du cas de Shell*
15. Hannan, M. T., & Freeman, J. (1984). Structural Inertia and Organizational Change. *American Sociological Review*, *49*(2), 149-164. https://doi.org/10.2307/2095567
16. Lefèvre, G. (2020, avril 1). *Covid-19 : Paroles de soignants et d'accompagnants*. Portail CFDT.fr. https://www.cfdt.fr/portail/actualites/crise-du-covid-19/covid-19-paroles-de-soignants-et-d-accompagnants-srv1_1107165
17. Lewin, K. (1946). Action Research and Minority Problems. *Journal of Social Issues*, *2*(4), 34-46. https://doi.org/10.1111/j.1540-4560.1946.tb02295.x
18. Limayem, Hirt, & Cheung. (2007). How Habit Limits the Predictive Power of Intention : The Case of Information Systems Continuance. *MIS Quarterly*, *31*(4), 705. https://doi.org/10.2307/25148817
19. Ministère des Solidarités et de la Santé. (2020). *Préparation au risque épidémique Covid-19 : Guide méthodologique*. https://solidarites-sante.gouv.fr/IMG/pdf/guide_methodologique_covid-19-2.pdf
20. Mutuelle d'assurance du corps de santé français. (2020). *COVID-19 : Quel impact sur les soignants?* MACSF.fr. https://www.macsf.fr/actualites/covid-19-impact-sur-les-soignants
21. Nielsen, J. (1993). *Usability Engineering* (Morgan Kaufmann).
22. Organisation Mondiale de la Santé. (2020). *La COVID-19 a de graves répercussions sur les services de santé soignant les maladies non transmissibles*. https://www.who.int/fr/news/item/01-06-2020-covid-19-significantly-impacts-health-services-for-noncommunicable-diseases
23. Peyrat-Apicella, D., & Gautier, S. (2020). COVID-19 : Aux frontières de la folie. *Éthique & Santé*, *17*(3), 160-167. https://doi.org/10.1016/j.etiqe.2020.06.001

24. Santé Publique France, Agence régionale de santé (ARS) Auvergne-Rhône-Alpes, Réseau Sentinelles, SOS Médecins de France, Société Française de Médecine d'Urgence (SFMU), Fédération Française des Observatoires Régionnaux des Urgences (FEDORU), Société Française d'Anesthésie et de Réanimation (SFAR), Société de Réanimation de Langue Française (SRLF), Institut national de la statistique et des études économiques (INSEE), Institut national de la santé et de la recherche médicale (INSERM), Institut Pasteur, & CNR des virus des infections respiratoires. (2020). *Point épidémio régional Auvergne-Rhône-Alpes, Spécial COVID-19*. https://www.santepubliquefrance.fr/content/download/244231/2568258
25. Soparnot, R. (2004). L'évaluation des modèles de gestion du changement organisationnel : De la capacité de gestion du changement à la gestion des capacités de changement. *Gestion, Vol. 29*(4), 31-42. https://www.cairn.info/revue-gestion-2004-4-page-31.htm
26. Thévenet, M. (1988). «Plus c'est la même chose, plus ça change». *Revue française de gestion*, 89-92.
27. Vas, A., & Ingham, M. (2004). Réorganisation, optez pour le grand angle. *L'expansion Management Review*, 25-32.
28. Venkatesh, Morris, Davis, & Davis. (2003). User Acceptance of Information Technology : Toward a Unified View. *MIS Quarterly*, *27*(3), 425. https://doi.org/10.2307/30036540
29. Venkatesh, V., Thong, J. Y. L., & Xu, X. (2012). Consumer Acceptance and Use of Information Technology : Extending the Unified Theory of Acceptance and Use of Technology. *MIS Quarterly*, *36*(1), 157-178. https://doi.org/10.2307/41410412
30. Verity, R., Okell, L.C., Dorigatti, I., Winskill, P., Whittaker, C., & Imai, N. (2020). Estimates of the severity of coronavirus disease 2019: a model-based analysis, *Lancet Inf*
31. Vignaud, P., & Prieto, N. (2020). Impact psychique de la pandémie de Covid-19 sur les professionnels soignants. *Actualités Pharmaceutiques*, *59*(599), 51-53. https://doi.org/10.1016/j.actpha.2020.08.013

Summary

List of contributors

Bohdan W. Wasilewski, Prof. dr hab. med. graduated in 1970 in medicine, worked in the following institutions: Psychosomatic Institute in Warsaw, where he completed specialization in psychiatry and received the title of Doctor of Medicine; University of Warsaw as deputy head of the Department; Medical University for Postgraduate Studies in Warsaw as head of the Department of Psychosomatics and Sexology and, until now, at the Psychosomatic Institute in Warsaw, as medical director and extraordinary professor. For two years he worked in the Psychiatric Clinic of the University of Munich, he also completed shorter research visits at the University of London, Harvard University and the University of Moscow. He has published 164 papers, he is also the author or co-author of 48 book publications, including books that have been translated into four foreign languages. Bohdan Wasilewski is a member of many scientific societies and an editorial board member in four scientific journals.
e-mail: b.wasilewski@ips.pl

Maria Łuszczyńska, Ph. D. Assistant Professor at the Faculty of Social Sciences, the Pontifical University of John Paul II in Krakow. The coordinator of International Project Global Ageing Research Partnership (2018-2021). The research areas of interest include helping skills, social workers competencies, social issues with old age, trans-generational relations, social consciousness of getting old and dying; an expert of the Polish Ministry of Family, Labour and Social Policy and other local governmental institutions.
ORCID: 0000-0003-4549-0130
E-mail: marynia77@gmail.com

Dobroniega Głębocka, is an Associate Professor and sociologist, employee of the Faculty of Sociology at University of Adam Mickiewicz in Poznań, Poland. She specializes in the issues of social assistance and integration, social work, family assistants, social services. Her research interests include sociology of social problems (disability, ageing, violence), sociology of social work and sociology of social policy. She is a member of Children's Ombudsman Experts Council, the member of the Sociology of Disabilities Section and the member of the Social Work Section of the Polish Sociological Association, and the member of the board of the Polish Association of Social Work Schools.
ORCID: 0000-0001-5774-1780;
e-mail: dobroniega.glebocka@amu.edu.pl

Mariola Racław, is an Associate Professor and sociologist in the Institute of Applied Social Sciences at the University of Warsaw, Poland. Her research interests include sociology of population (among others disability, ageing), sociology of family and sociology of social policy. She is a member of the Government Population Council and the Co-Founder and Vice-President of the Sociology of Disabilities Section of the Polish Sociological Association. Currently she is engaged in a research project carried out at Warsaw University Policies for independent living in Poland and Norway dealing with personal assistance for people with disabilities, funded by a Norway grant.:
ORCID: 0000-0002-7614-0507
e-mail: m.raclaw@uw.edu.pl

Grzegorz Godawa, Professor of the Pontifical University of John Paul II in Cracow, Institute of Pedagogy and Family Studies at the Pontifical University of John Paul II in Cracow. He is interested in the axiological foundations of social life and education as well as in social support. He is a researcher who explores the field of hospice care, particularly its

thanatopedagogical dimension. He deals with education on various levels and areas of its implementation. He is the author of more than 80 academic publications.
mail: grzegorz.godawa@upjp2.edu.pl
ORCID: 0000-0002-2283-3965

Jaroslava Hasmanová Marhánková, PhD. is an assistant professor at the Faculty of Social Science, Charles University. Her long-term research interest focuses of the sociology ageing, gender and sociology of health and medicine. In her latest researches she focused on the topic of intimacy and on the concepts of active aging. She is currently the principal investigator in the project "Social lives of dementia: cultural representations and subjective attitudes".
ORCID ID: /0000-0003-4823-8934
Email: jaroslava.marhankova@fsv.cuni.cz

Anita Richert-Kaźmierska, Ph.D. Eng., Gdańsk University of Technology Faculty of Management and Economics. Academic research fields: Economics of ageing, Seniors Policy, Social Policies, Regional Polices, Age Management, Entrepreneurship. Coordinator and researcher of several international projects: *Best Agers Lighthouses* (2012-2014), *Age@Work - Building Capacity for Age Management in Human Resources* (2020-2021), *INBETS Innovative Business Transfer Models for SMEs in the BSR* (2018-2021). She is an expert and Member of Senior Policy Council at the Ministry of Family and Social Policy (Council Secretary), Member of the Pomeranian Senior Policy Council (advisory body of the Marshal of the Pomeranian Province), Expert in BSLF for Sustainable Working Life – Thematic Working Group Age management and working conditions, Expert of Governmental Program for Seniors' Activation, Ministry of Family and Social Policy, Member of the Gdansk Seniors' Affairs Council (advisory body of the President of the City of Gdansk), Kolbudy Commune Mayor's Proxy for Seniors' Affairs.
ORCID 0000-0001-9919-5984
e-mail: Anita.Richert@zie.pg.edu.pl

Zofia Szarota, Ph. D., professor at University of Warsaw, Head of the Department of Continuing Education and Andragogy at the Faculty of Education at University of Warsaw. Among her scientific interests there are the issues of adulthood in educational contexts as well as problems accompanying old age and aging. Her research interests focus on the problems of adult learning, social integration, equality as well as social gerontology and geragogy. She is the author of over 140 publications. She is a member of editorial committees of several foreign and country scientific journals. She is also a member of the Polish Academic Andragogical Association and Association of Social Gerontologists as well as an educator at the Universities of the Third Age, lecturer of non-formal adult education. She is the secretary of the Gerontology Section of the Committee of Pedagogical Sciences of the Polish Academy of Sciences (2020-2023). She is a member of the Expert Team for Older Citizens at the Ombudsman.
ORCID: 0000-0002-6342-3153
z.szarota@uw.edu.pl

Marvin Formosa, Ph.D. is Associate Professor at the Department of Gerontology and Dementia Studies, Faculty for Social Wellbeing, University of Malta. He is the Chairperson of the Maltese National Commission for Active Ageing and Director of the International Institute on Ageing (United Nations - Malta). Prof. Formosa's interests include active ageing, critical gerontology, and educational gerontology.
ORCID 0000-0001-9222-2433
e-mail: marvin.formosa@um.edu.mt

Joanna Borowik, PhD, education, University of Białystok, Faculty of Educational Sciences. Her research areas of interest include life satisfaction of life of elderly people, intergenerational relations, especially in the context of formal and informal care of grandparents for grandchildren, educational awareness from a generational perspective, perception of childhood and youth by grandchildren raised by grandparents
ORCID 0000-0002-4683-4292
e-mail joanna.borowik@uwb.edu.pl

Helene von Stülpnagel, a gerontologist and works at the Institute for Social Medicine and Health Systems Research, Faculty of Medicine, Otto-von-Guericke-University Magdeburg in the project "social participation and self-determined aging through participatory social and digital applications in the Kannenstieg district" (STARK). Her research activities focus on aging in urban social space and participatory social research.
ORCID 0000-0001-9955-238X
helene.stuelpnagel@med.ovgu.de

Astrid Eich-Krohm, Ph. D. in sociology and two nursing degrees: as a registered nurse and nursing educator. Since 2016 she is the PI of the Core Project of the research cluster „Autonomy in Old Age" funded by the EU. Her research is based on qualitative methods and focuses on the social world of the aging population in Saxony-Anhalt, Germany. She is a senior research associate at the Institute for Social Medicine and Health Systems Research, Faculty of Medicine, Otto-von-Guericke-University Magdeburg.
ORCID 0000-0003-3456-1028
astrid.eich-krohm@med.ovgu.de

Julia Piel, research associate at the Institute for Social Medicine and Health Systems Research, Faculty of Medicine, Otto-von-Guericke-University Magdeburg and PhD student in the EU-funded research project "Autonomy in Old Age". Her research focuses on aging in close relationship and methods of qualitative research in the fields of critical gerontology, biographical and life span studies.
ORCID 0000-0002-7670-9775
julia.piel@med.ovgu.de

Bolesław Karcz,

Ewa Grudziewska, Ph.D., Institute of Social Prevention and Social Work
The Maria Grzegorzewska University in Warsaw, Poland. She works at The Maria Grzegorzewska University in Warsaw, at the Department of Social Policy and Social Work. She is an author of articles, editor and co-editor of publications on social work (professionalization of social workers), rehabilitation pedagogy (probation officers, prisons) and therapeutic interactions for children and adolescents with behavioural disorders. Head of postgraduate studies in judicial and extrajudicial mediation and sociotherapy.
ORCID: 0000-0003-2353-0197
e-mail: egrudziewska@aps.edu.pl

Linda Garcia, Ph.D., Director and Professor, LIFE Research Institute, University of Ottawa. Field of interest: older adults, dementia, transitions, communication, social relationships, caregivers, interdisciplinary research. Her research interests focus on the impact of physical and social environments on the functioning of individuals with neurological disorders, especially dementia. Working with colleagues from other professions, she strives to understand and offer solutions for capitalizing on ways to facilitate the social integration of

individuals with functional limitations. She is interested in developing interventions that include approaches based on human interactions. She is keenly interested in improving quality of life in long-term care. Prior to joining the University of Ottawa in 1993, Professor Garcia worked for over 10 years in a large teaching hospital as a Speech-Language Pathologist and department head. After completing her PhD with Dr. Yves Joanette, she worked as a professor in the Audiology and Speech-Language Pathology Program. She then moved on to help create the Interdisciplinary School of Health Sciences and became its first Director in 2010, prior to becoming Vice-Dean of the Faculty of Health Sciences in 2014 and the Director of the LIFE Research Institute in 2019. She has been a member of the Steering committee for the Champlain Dementia Network for over 15 years, represents the University of Ottawa at the Council of Ontario Universities' Ontario Interdisciplinary Council for Aging and Health, and more recently sits on the Board of the Eldercare Foundation of Ottawa, being tasked with developing the innovation plan for the foundation, which focuses on long-term care in Ottawa's publicly funded homes.
ORCID ID 0000-0003-0396-9557
Email: lgarcia@uottawa.ca

Louise Bélanger-Hardy, B.A, B. Soc Sc, J.D., LL.M., Full Professor, Faculty of Common Law, University of Ottawa, Canada
Professor Louise Bélanger-Hardy's research interests include professional responsibility, consent in the medical and research settings, liability of mental health professionals and tort compensation for mental harm. She has been a member of several Research Ethics Boards, and is currently associated to the LIFE Research Institute and the Centre for Health Law, Policy and Ethics, both at the University of Ottawa. Her current research interests focus on liability issues in the context of private home care for older adults, and issues linked to human rights of older adults.
ORCID: 0000-0002-4633-4271
Louise.Belanger-Hardy@uottawa.ca

Martine Lagacé, Ph.D. in Psychology, Full Professor, Department of Communication / School of Psychology, University of Ottawa, in Canada. Professor Lagacé was Vice-Dean, Governance at the Faculty of Arts from 2014 to 2018, and Director of the Department of Communication from 2011 to 2012. Her field of interest and research interests center around the psychosocial aspects of aging, particularly the impact of age-based discrimination. In the francophone community, her academic work on ageism has been groundbreaking.
ORCID: 0000-0001-7691-5854
Martine.Lagace@uottawa.ca

Joanna M. Salachna, professor of legal studies; professor at Lomza State University of Applied Sciences - Faculty of Social Sciences and Humanities; solicitor (legal counsel); specialised in public finance law and administrative law. Author of nearly 200 research studies;;
ORCID: 0000-0001-5748-0170;
e-mail: jsalachna@pwsip.edu.pl

Anna Szafranek, Ph. D. in Sociology, specialisation: Social Gerontology, adjunct in the Department of Law Sciences, Faculty of Social Sciences and Humanities at the Lomza State University of Applied Sciences, member of the Polish research group within three international projects DAPHNE III covering the topic of violence towards elderly women,

author/co-author of numerous publications in the field of gerontology, laureate in two contests organized by Polish Gerontological Society for the best master degree thesis and PhD thesis in the field of gerontology and geriatric.
ORCID: 0000-0002-3902-0063
e-mail: annaszafranek01@gmail.com

Sławomir Tobis, PhD(Art), PhD(Sci), Chair of Occupational Therapy, Poznan University of Medical Sciences, Poznan, Poland; member of Polish Gerontological Society, Polish Psychiatric Society and Association of Polish Art Photographers; Discipline: Health Sciences; Research interests: Older adults, Functional capacity, Cognitive capacity, Art therapy, New technologies in therapy and care;;
ORCID: 0000-0002-0764-3258
e-mail: stobis@ump.edu.pl

Katarzyna Wieczorowska-Tobis, MD, PhD, professor, Geriatrics Unit, Chair and Department of Palliative Medicine, Poznan University of Medical Sciences. Poznan, Poland, President of Polish Gerontological Society, Member of the European Commission Expert Panel on Effective Ways of Investing in Health; Discipline: Medical Sciences; Research interests: Care needs in older individuals, Polypharmacy;
ORCID: 0000-0003-4017-3013
e-mail: kwt@tobis.pl

Agnieszka Neumann-Podczaska, PhD, Ass. Professor, Geriatrics Unit, Chair and Department of Palliative Medicine, Poznan University of Medical Sciences. Poznan, Poland; Expert of the Pharmaceutical Care Team at the Ministry of Health; Awarded by the Council of the Polish-U.S. Fulbright Commission; Discipline: Pharmaceutical Sciences, Research interests: Pharmaceutical care, Drug interactions
ORCID: 0000-0002-0060-7430
e-mail: ar-n@wp.pl

Małgorzata Halicka professor of the University of Białystok, sociologist, gerontologist, Head of the Department of Sociology of Education and Social Gerontology at the Faculty of Education of the University of Białystok. Areas of scientific interest: sociology of elderly people, social gerontology, social work; areas of research interest: the quality of life of elderly people, life satisfaction, educational awareness from a generational perspective, violence against elderly people. Coordinator of many research projects, head of a polish working group in two international research projects funded by the European Commission. Member of the Senior Policy Council in the Polish Ministry of Work and Social Policy. President of the Programme Committee of the University of the Third Age in Białystok and its supervisor. Author and co-author of numerous books and scholarly articles in national and international journals.
E-mail: mhalicka@onet.pl

Jerzy Halicki professor at the University of Białystok, social gerontologist, educator, Vice-Rector for Students' Affairs at the University of Białystok, Head of the Department of Andragogy and Gerontology at the Faculty of Education of the University of Białystok. Areas of scientific interest: andragogy, gerontology social gerontology, social work; areas of research interest: intergenerational transition of culture among Polish people in Belarus, the quality of life of elderly people, violence against elderly people. Head coordinator of three

research projects funded by the Committee of Scientific Research as well as his own research project funded by the Ministry of Science and Higher Education. Coordinator of the international research project "IANUS"; coordinator of a Polish research group in two international research projects funded by the European Commission. Author and co-author of numerous books and scholarly articles in national and international journals.
E-mail: j.halicki@uwb.edu.pl

Chloé Gaulier, Auvergne-Rhône-Alpes Gerontology Centre. Mrs Chloé Gaulier is a project manager at Gérontopôle Auvergne Rhône-Alpes. She is specialized in Health Promotion and Education. Actually she particularly investigates impacts of COVID-19 in the olders and caregivers.
ORCID : 0000-0001-5754-4330
e-mail : Chloe.gaulier01@gmail.com

Pauline Gouttefarde, Auvergne-Rhône-Alpes Gerontology Centre. Mrs Pauline Gouttefarde is a social psychologist specialized in Health Promotion and Education. She is a project manager at Gérontopôle Auvergne Rhône-Alpes. She supports several projects around the aging of the population. Her researches are focus on ageism and its consequences.
ORCID: 0000-0002-8093-1221
e-mail : Pauline.gouttefarde@gerontopole-aura.fr

Arnaud Simeone, Research Group in Social Psychology (UR GRePS), University of Lyon 2.
Mr Arnaud Simeone is a university lecturer in Education Sciences in the University of Lyon 2. He tooks an interest in problematics relating on social workers, their judgment of the need aid and on individual characteristics that can influence their judgment.
ORCID: 0000-0001-8070-3651
e-mail: Arnaud.simeone@univ-lyon2.fr

Sébastien Rabier, Jean Monnet University Chair at Senior Citizens Healthcare Prevention Engineering. Mr Sébastien Rabier is a biostatician in the Aging Health Chair (Jean Monnet University of St Etienne). He is specialized in epidemiology and public health. He works on the link between physical activity and the cognitive impairment in aging.
e-mail: Seb.rabier@hotmail.fr

Vincent Augusto, Mines Saint-Etienne, Clermont Auvergne University, CNRS, UMR 6158 LIMOS, Centre CIS, F - 42023 Saint-Etienne France**.** Mr Vicent Augusto is the director of the Center for Biomedical and Healthcare Engineering (Mines Saint-Étienne). He is specialized in performance evaluation and in care systems ingeneering. His work heads toward healt decision aid (discrete optimization, stochastic optimization, meta-heuristics). He also works in healt process forecast and in medical decision aid.
ORCID: 0000-0002-5063-0831
e-mail: Augusto@emse.fr

Caroline Dupré, Jean Monnet University, Chair at Senior Citizens Healthcare Prevention Engineering; Technical Support and Training Centre for Health Examination Centres**.** Mrs Caroline Dupré is a biostatician in the Aging Health Chair (Jean Monnet University of St Etienne). She is specialized in prevention and public health, epidemiology, aging, cognitive aging through cross sectional and longitudinal studies.
e-mail: Caroline.dupre@univ-st-etienne.fr

Solène Dorier, Auvergne-Rhône-Alpes Gerontology Centre. Mrs Solène Dorier is a social psychologist specialized in Health Promotion and Education. She is a project manager at

Gérontopôle Auvergne Rhône-Alpes. She supports several projects around the aging of the population and themes such as housing, technological and social innovations, health etc.
ORCID: 0000-0002-7808-0392
e-mail: Solène.dorier@gerontopole-aura.fr

Jessica Guyot, Jean Monnet University, Chair at Senior Citizens Healthcare Prevention Engineering. Mrs Jessica Guyot is a doctor in Education Sciences. She is in charge of the university research for the Aging Health Chair (Jean Monnet University of St Etienne). She is particulary interested in public health, sociology of aging, prevention of loss of autonomy and in ageism.
ORCID: 0000-0003-2990-5076
e-mail:Jessica.guyot@univ-st-etienne.fr

Nathalie Barth, Auvergne-Rhône-Alpes Gerontology Centre; Jean Monnet University, Chair at Senior Citizens Healthcare Prevention Engineering. Mrs Nathalie Barth is a doctor in the Sciences and Techniques of Physical and Sports Activities (2007) specialized in Sociology of health, aging and adapted physical activities. She is particularly interested in the promotion of health through "sport", and questions of accessibility, "care" of people with chronic diseases, weakened by age and / or social conditions. In charge of the university research for the Aging Health Chair (Jean Monnet University of St Etienne), she integrated the Gérontopôle AURA as project manager.
ORCID: 0000-0002-2457-3423
e-mail: Nathalie.barth@gerontopole-aura.fr

Celina Timoszyk – Tomczak, Ph. D. scientific interests: psychology of emotions and motivation, psychology of time, the psychology of aging. Member of the Polish Society of Gerontology, Department of Social Science, Institute of Psychology, University of Szczecin, Poland
ORCID: 0000-0002-8314-0476
e-mail: celina.timoszyk-tomczak@usz.edu.pl

Beata Bugajska, Ph. D., Associate Professor of Social Sciences in the field of Pedagogy. Head of the Department of Social Issues of Szczecin's City Hall. Research interests: social gerontology, care for the elderly, social services for older people. Vice Chairperson of the Board of the Main Polish Association of Gerontology. Author of over 60 titles, including, among others: "The Ninth Stage in the Cycle of Life – Reflections on E.H. Erikson's Theory", Ageing & Society, 37, 2017.
Department of Social Science, Institute of Pedagogy, University of Szczecin, Poland
ORCID: 0000-0003-2440-6913
e-mail:beata.bugajska@usz.edu.pl

Klaudia Piotrowska, Master degree of Social Work, PhD student at the Doctoral School of the University of Szczecin in the field of pedagogy. Research interests focus on gerontology. Employee of a non-governmental organization that runs the Senior Center. Member of the Polish Society of Gerontology.
Doctoral School of the University of Szczecin
e- mail: klaudia.piotrowska@phd.usz.edu.pl