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Experiences of Home-living Vulnerable Older Adults with Clinical Depression During the COVID-19 Pandemic: A Qualitative Study

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Abstract

Objectives. Little is known about the diversity of older adults' experiences during the COVID-19 pandemic. We therefore investigated the pandemic experiences of home-living vulnerable older adults with depression, an understudied subpopulation.

Methods. We conducted unstructured interviews with $N=20$ older (60+ years) adults with clinical depression receiving care in their homes in June and again in December 2020. Interviews were coded according to the grounded theory approach.

Results. We identified eight themes. Participants described *feeling disconnected* before and during the pandemic, which they attributed to their physical impairments and old age. Their *social relations* with family, medical providers, and caregivers helped them feel connected. Participants did not feel significantly impacted by the *COVID-19 pandemic*, but they missed social and physical contact. During the pandemic, isolation was normalized. Participants therefore experienced *loneliness* due to their isolation, but also a sense of *togetherness* with the rest of society. Isolation within the home was re-framed as *cocooning*, which provided a sense of autonomy. Participants nevertheless expressed *resignation*.

Conclusions. Home-living vulnerable older adults with depression experienced loneliness but also a degree of relief during the pandemic.

Clinical Implications. Positively re-framing isolation and the stability of formal caregiving helped participants endure *feeling disconnected* during the pandemic.

Keywords: everyday experience, mental health, loneliness, social isolation, grounded theory, resilience

Introduction

Older adults are at greater risk of severe disease from COVID-19 and have also been disproportionately affected by measures designed to mitigate the spread of the virus. Nevertheless, an impressive plethora of studies have found that, as a group, older adults have demonstrated remarkable resilience during the pandemic (Bruine de Bruin, 2021; Costantini & Mazzotti, 2020; Gómez-Salgado et al., 2020; Klaiber et al., 2021; Losada-Baltar et al., 2021; Mazza et al., 2020; Rossi et al., 2020; Sterina et al., 2021). Compared to younger adults, older adults have experienced less distress during the pandemic according to indicators of general well-being as well as indicators of specific disorders like depression, anxiety, and post-traumatic stress disorder (Feliciano et al., 2022; Shattuck et al., 2022; Sterina et al., 2021; van Tilburg et al., 2021; Wu, 2020). Qualitative studies have started to complement this body of quantitative work by providing more detailed insight about older adults' pandemic experiences, including specific stressors (e.g., mortality concerns, grief, loss of normal life) and protective factors (e.g., social support, exercise, maintaining routine, slower pace of life) (Finlay et al., 2021; Hamm et al., 2020; McKinlay et al., 2020; Nikelski et al., 2021). Overall, evidence suggests that older adults productively and proactively cope with the stressors of the pandemic.

Although older adults have clearly not experienced the pandemic in a uniform way, so far research has not been able to provide a detailed picture of the diversity of older adults' experiences. Most existing studies on older adults' pandemic experiences have focused on general population samples and/or data collected via the Internet (Sterina et al., 2021). Previous studies are therefore apt to have excluded critical proportions of the older population, particularly subpopulations of older adults who may be more vulnerable to the stressors of the pandemic.

The present study therefore contributes to the literature by using qualitative methods to develop a theoretical model describing how home-living vulnerable older adults with depression experience the COVID-19 pandemic. Researchers are rarely able to access this

population due to their limited mobility and limited physical and psychological capacity to participate. Older adults with depression represent about 7% of the world's older population (World Health Organisation, 2017). Depression rates are two to three times higher among homebound older adults in need of care compared to their counterparts who live independently (Choi et al., 2013), with about every fourth being affected by depression (Xiang et al., 2018). The study population therefore represents a significant, yet understudied minority of older adults. Moreover, the pandemic may have posed particular distress for home-living vulnerable older adults with depression who are not only at high risk for severe disease from COVID-19 due to their physical co-morbidities, but also already experienced symptoms such as low spirits, low self-worth, negative outlook, and passivity prior to the pandemic as the result of their depression (Dilling, 2015). Examination of the pandemic experiences of home-living vulnerable older adults with depression therefore offers unique insight about the potential for – but also limits of–resilience in the face of extreme limitations, and the specific resources and constraints that impact older adults' ability to cope. The few existing studies of the pandemic experiences of older adults with pre-existing depression found no evidence that depressive symptoms worsened, but also underline the importance of access to medical care and services as well as opportunities for social interactions for their well-being (Aguilar-Latorre et al., 2022; Hamm et al., 2020).

Methods

Our research was guided by a constructivist–interpretivist paradigm. Instead of making presumptions about how home-living vulnerable older adults with depression would experience the pandemic based on their limitations, we were interested in participants' *own* views and lived experiences. We therefore conducted problem-centered, open and unstructured interviews. Following the grounded theory approach by Corbin and Strauss (2015), we identified common

themes in the interviews and developed a model of the impact of the pandemic on home-living vulnerable older adults with depression.

Sampling

We interviewed $N=20$ participants of the active control condition of the PSY-CARE study. PSY-CARE is a random-control trial designed to investigate the feasibility and effectiveness of providing outpatient cognitive-behavioral psychotherapy to home-living vulnerable older adults with depression (prospectively registered at ISRCTN55646265; for study protocol, see Gellert et al., 2020). Eligible PSY-CARE participants were 1) 60 years and older; 2) living at home; 3) in need of long-term care (as assessed by the German compulsory state nursing care insurance) and 4) had a clinically significant depressive disorder. Clinically significant depression was determined during baseline assessment at the participants' home using a modified structured clinical interview for mental disorders (Mini-DIPS, Margraf, 1994), resulting in a tentative diagnosis of major depression or depressive adjustment disorder as well as the 12-item Geriatric Depression Scale (GDS-12R, Sutcliff et al., 2000) with a cut-off of 4 for inclusion. Exclusion criteria were acute psychosis, mania or hypomania, terminal stage of a progressive disease, moderate to severe dementia, as well as communication difficulties and visual or hearing impairments that would severely affect an individual's capacity to take part in the study, which was assessed by clinicians in the baseline interview conducted in the participant's home.

Recruiting participants from the active control condition of the PSY-CARE study allowed us to quickly and efficiently access members of this hard-to-reach population during the pandemic and profit from an established rapport. As part of their participation in PSY-CARE, participants and their caregiver had received self-help literature and two sessions of individual telephone counselling conducted by a trained certified psychotherapist prior to their participation in the current study.

Prospective participants were contacted via telephone. They were informed about the current study and asked whether or not they wanted to participate. Participation did not have any repercussions on their participation in the PSY-CARE trial. All those contacted agreed to participate.

Concurrent data collection and analysis is fundamental to the grounded theory approach. We first contacted eight active control group participants. The eight participants were chosen because they reflected the characteristics of the study population and had a maximum variation with regard to demographics. Based on initial analysis of the eight interviews, we decided to purposefully sample participants with different degrees of depression and need for care. After the 18th interview, theoretical saturation had been achieved; that is, additional interviews did not generate new information. We conducted two additional interviews to gather specific information and verify some of our initial results.

Participants' characteristics

All the participants were Caucasian German citizens living in Berlin; most (90%) were women. Each participant suffered from at least one pre-existing physical condition (e.g. cardiovascular diseases; joint and bone diseases; respiratory diseases, asthma or shortness of breath; cancer diseases; diabetes mellitus; skin diseases; stomach or intestinal diseases; gallbladder-, kidney- or liver disease; bladder problems; eye or vision problems) ($M=3.8$ comorbidities, range: 1 to 7). Table 1 displays additional characteristics of the sample.

Table 1: Characteristics of the sample of home-lining vulnerable older adults ($N=20$).

		n (%) or range; mean
Female		18 (90%)
Age (years)		66-95; $M= 78.2$
Marital status		
	Married	3 (15%)
	Divorced	8 (40%)
	Widowed	6 (30%)
	Single	3 (15%)
Living Arrangements		
	Alone	18 (90%)
	With spouse	2 (10%)
Care grade	1 = low impairment; 5 = hard ship case	1-4, $M= 1.9$
Depression ^a	4+ = clinically relevant	4-12, $M= 7.5$
No. physical co-morbidities		1-7, $M= 3.8$
Activities of daily living ^b	0 = minimum; 100 = maximum independence	75-100, $M= 92.1$
Cognitive impairment ^c	24-30: none; 18-23: mild 0-17: severe	25-30, $M=28.6$

^aGeriatric Depression Scale, version GDS-12R validated for use among older adults in need of care (Sutcliffe et al., 2000). ^bBarthel Index (Mahoney, 1965). ^cMini-Mental State Examination (Folstein et al., 1975).

Interviews

The first major wave of COVID-19 infections in Germany occurred in March and April, 2020. The first interviews were conducted June 2-22, 2020 during a state-wide lockdown of public life. We conducted a shorter, follow-up interview six-months later between December 1, 2020 and January 4, 2021 to better understand participants' adaptation. The second interview took place during the second major wave of infections and the second state-wide lockdown (Schilling et al., 2021). Eight (seven women and one man) participants declined to participate in the second interview.

The first author (JG) conducted the interviews via telephone immediately after participants indicated consent. The interviewer had had previous telephone contact with a few of the participants to check eligibility for the PSY-CARE trial. The participants were asked to ensure an uninterrupted and quiet surrounding. The interview began with one open question:

“How do you feel during the COVID-19 pandemic?” After the initial response, the interviewer spontaneously asked follow-up questions adapted to each informant’s narration. The first interview lasted $M=30$ minutes (range: 10-87 minutes). The second interview lasted $M=24$ minutes (range: 11-54 minutes). The varied duration reflects the diversity of participants’ physical and attentional capabilities. The interviews were recorded using TapeACall Pro Version: 4.10.0 by audioskript and transcribed verbatim using f4transkript Version: 8.01. (802).

Ethical Approval

This study complies with the Declaration of Helsinki and APA ethical principles and was approved by the local Ethical Committee of MSB Medical School Hamburg (MSH-2018/20). An amendment of the ethics, which entailed adjustments due to the pandemic, was approved by the Ethical Committee of MSB Medical School Berlin (MSB-2020/33). Informed written consent for research and recording voices was obtained from all participants. Identifying information (e.g., names, places) was omitted from the transcripts.

Research Team and Perspective Management

The research team was comprised of the three German study authors (JG, EMK, PG). The first author J.G. is a white, female, 32-year-old psychodynamic psychotherapist-in-training and doctoral student with clinical experience in the field of long-term care and geriatric mental health care. The second author E.K. is a white, female, 45-year-old professor of clinical geropsychology with a background in lifespan psychology; she is head of an outpatient psychotherapy clinic for older patients with extensive experience working with older patients in diverse clinical settings. The third author P.G. is a white, male, 40-year-old professor of social and behavioral gerontology with a research focus on quality of life in old age. The diverse expertise of the research team was helpful for considering the data from different perspectives. Our different professional qualifications and experiences (clinical geropsychology, lifespan psychology, gerontology) were helpful for analyzing the data from various perspectives. In

regular team meetings, we critically discussed how our personal and professional experiences and assumptions might influence the research process. Bracketing our own biases (Morrow, 2005) was part and parcel of our regular team meetings where we discussed our analytic process to validate the results. Additional structured methods of reflexivity included taking field notes during the interviews, memo writing, and diaries.

Data Analysis

JG and EMK separately conducted the data analysis. Two additional researchers (women, aged 25) at the advanced master-level in clinical psychology and psychotherapy assisted with the coding process.

We used f4analyse (Version: 3.0.0) by audiotranskript to analyze the interview data. In line with Strauss and Corbin (1990), we followed a three-step coding process. In the open coding phase, we inductively derived in-vivo codes to separate each interview into units of meaning. In the second, axial coding phase, we reviewed the initial categories, identified categories that could be subsumed beneath other categories, and developed a coding system. We assessed each empirically-derived category as: causal condition, phenomenon, context, intervening condition, action/interactional strategy or consequences (Corbin & Strauss, 2015, p. 153). In the third, selective coding phase, we identified core categories. Appendix Table 1 illustrates the coding process. We then used the results of the coding procedure to generate a paradigm model that illustrated the associations between participants' conditions, experiences, and actions. JG, EMK, PG and the additional coders regularly discussed the coding process and reviewed the interim results to minimize interpretation errors (Kirk et al., 1986). The research team met regularly to critically discuss preliminary results and adapt the coding system to better represent the data. In addition to regular internal meetings, we also presented preliminary results in cross-disciplinary round table meetings in order to uncover potential blind spots related to our professional experiences as psychologists and psychotherapists.

Results

The coding procedure resulted in eight categories. Figure 1 displays the coding paradigm model. The *state of everyday life* (subcategories: physical impairment, old age as loss) led to *feeling disconnected*. The extent to which participants felt disconnected depended on their *social relations* (subcategories: family, medical, caretakers). *Feeling disconnected* within the context of the *COVID-19 pandemic* led participants to experience both *loneliness* and *togetherness*, which in turn resulted in *resignation* and *cocooning*. The categories and subcategories were consistent across the June and December interviews. We therefore disregard time point when discussing the results. JG translated interview excerpts from German to English.

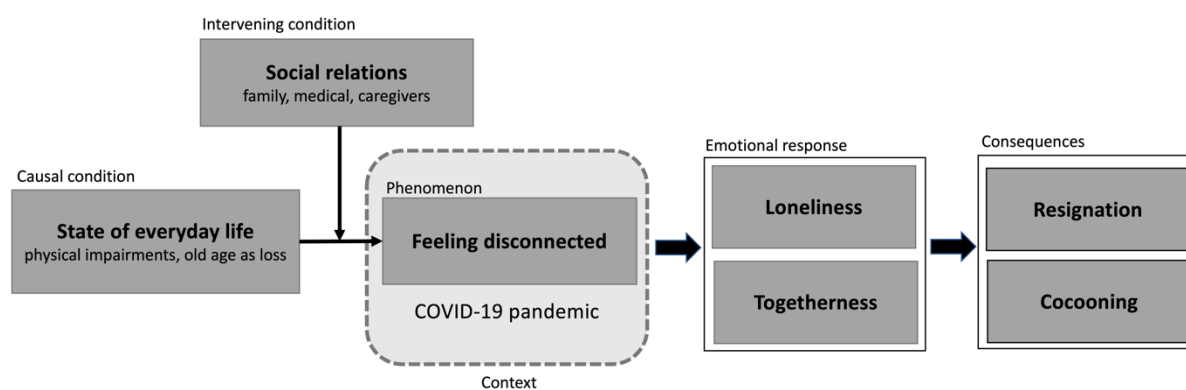


Figure 1. Coding paradigm model.

“It’s like I’m watching other people lead their life”: Feeling Disconnected

Even prior to the pandemic, participants described *feeling disconnected* from society, their former selves, and life itself. Now, all participants feel they can do is stand by and reminisce about the past:

I feel useless. What am I still able to do, or even partake in? For everyone else life is going on and I can’t keep up anymore. It’s like I’m watching other people lead their life, while my life is already over. The COVID-19 pandemic has nothing to do with it, I have felt like this for a while.

-Ms. P

I don't feel like an active part of society anymore.

-Ms. I.

I am not able to partake in life as I used to do. That makes me unhappy. I had a good life formerly and that is my only source of consolation. I actively remind myself of it and basically live in the past.

-Ms. F.

“I just can't do it physically anymore”: State of Everyday Life

Participants attributed *feeling disconnected* to the *state of everyday life*. In particular, they blamed their disconnection on their physical impairment:

I have such severe immobility, that essentially, I am only able to move myself with help from others.

-Ms. K.

There is just no joy in life anymore, because I just can't do it physically anymore and there is nothing I can change about that.

-Ms. B.

Participants also cited their chronological age as the main reason for *feeling disconnected*. They saw old age and aging as an inevitable process of loss:

Yes, well you must be satisfied to still be alive. You need to understand, I turned seventy-seven and in March I will turn seventy-eight. That you need to keep in mind. I am quite old and that will not change.

-Ms. O.

I already told you I am ninety-one years old. I don't have friends. My last friend has already passed.

-Ms. I.

There are fewer birthdays to celebrate than there are funerals to go to.

-Ms. G

“I don’t have any problems with the pandemic”: COVID-19 Pandemic

When first asked, most participants explained that the pandemic had impacted their day-to-day life only minimally. They perceived their individual risk of infection as low due to their limited social interaction, but their risk of severe disease as high:

I don’t think I will get infected. I don’t see many people, but if I did, I believe I wouldn’t survive it.

-Ms. E.

I can’t be infected because I don’t have any contact to others.

-Ms. K.

I am not scared of the corona virus. I don’t have any contact to other people, and basically never leave the house.

-Ms. B.

Everything is the same. I wear a mask when I go outside und keep my distance from others. I don’t see other people and my family is fine. As I said I don’t have any problems with the pandemic.

-Ms. F.

Only those participants with a friend or relative who had been infected with COVID described being more deeply impacted by the pandemic. Participants often recounted being told how to behave. When participants expressed concern about getting infected, it was only with regard to how it would affect other people:

My son had it. He was hospitalized for 13 days. And since then, I am not allowed to leave the house, go for a walk or anywhere, to the supermarket and nothing. He says he doesn’t want to lose me. I must stay home. He scolded

me; said what do you think is going on in the hospitals? Old adults who are admitted don't have a chance because young people will be cared for first, he thinks. And from a rational standpoint he is right. With all my pre-existing illnesses I won't leave it alive. And that I believe him, that I know.

-Ms. O.

***“Just to be hugged occasionally is helping me so much”*: Social Relations**

Social relations with family, medical providers, and formal caregivers helped participants to feel more connected—before and also during the pandemic. Participants described face-to-face contact with family and friends as providing a sense of interpersonal connection and meaning, as well as an opportunity to live vicariously through others and hence be connected to life:

I love to see my family and look forward to it. Yes, to hear my grandchildren talk about what is going on in their life fills me with joy. Even though I can't experience it with them, it feels as if I am there with them. I can live through them.

-Ms. A.

The pandemic did not affect participants' medical care. Participants described physician visits as a cherished ritual and resource that stabilized the structure of their day-to-day life. For many, visiting their physician was the only time they left the house and met other people. Medical visits made participants feel less lonely and also worthy of care:

I only leave my flat once a week or when I see my doctor. I really look forward to it.

-Ms. O.

I am so thankful that my doctor visits me at home. He takes his time and really talks to me.

-Ms. I.

In Germany, people with a care grade can receive home visits from licensed caregivers for help with daily medical needs, personal hygiene and housekeeping. Caregiver visits were unaffected by safety regulations. For many participants and those without family in particular, caregivers were their only human contact -even before the pandemic:

I am visited by caregivers every day. They make my breakfast, my dinner, prepare my medicine, wash me and go grocery shopping.

-Mr. E.

I am so happy that my caregivers see me every day. Otherwise, I would never see someone so regularly. Just to be hugged occasionally is helping me so much.

-Ms. S.

Participants nevertheless harbored ambiguous feelings about their caregiving situation. While they expressed gratitude for their caregiver's assistance, they also loathed feeling dependent:

I hate that I can't take care of myself like I was once able to. I need someone to help me with everything. I am thankful, don't get me wrong, but I would rather do it all by myself.

-Ms. K.

“You feel alone somehow”: Loneliness

Participants experienced *loneliness*, before and also during the pandemic. Despite initially reporting that the pandemic had only minimally impacted their lives, in the course of the interview participants explicitly pined over lost opportunities for social and physical contact during the pandemic, which made them feel lonely:

We don't see each other like we used to. Moreover, even if I see my kids, we are not allowed to touch each other, aren't able to hug, you feel alone somehow. I can't even hug my daughter.

-Ms. G.

It is true, because of COVID-19 we don't see each other like we used to.

-Ms. L.

At least I saw my family on Christmas every year. This year I don't know. And when you are not sure how many more you will have it is sad and one can feel really alone.

-Ms. S

“It feels like a kind of solidarity”: Togetherness

However, during the pandemic participants experienced *loneliness* alongside a new feeling of *togetherness*. During the pandemic, people all around the world stayed at home and minimized social contact in order to protect themselves from the virus. Isolation thus became a shared experience, connecting the participants with the rest of the world:

The corona pandemic is happening to everybody in the world. It is true to all of us.

-Ms. E.

With the corona pandemic, like I already indicated, it is not a problem. I mean all the precautions or preventive measure are a challenge but otherwise I can't say that it is a really bothering me because of all my preconditions and ailments it is more like a relief that everyone else isn't able to do what they want. It feels like a kind of solidarity, like a type of compulsory solidarity behavior.

-Ms. H.

“I can’t change anything”: Resignation

Before and during the pandemic, participants saw their circumstances as unchangeable, and chose to passively accept their experience.

Well, I can’t do anything about it or change it, you have to be satisfied, that you are still there and alive, but I am not happy with it [her state of everyday-life pre-pandemic].

-Ms. O.

I can’t wind back the clock. I am old and can’t live my life like I used to. It will only get worse, I fear.

-Mr. N.

Well actually I can’t change anything [her state of everyday-life pre-pandemic]. I’m just alone and must be satisfied with my own company. Sometimes, even for days I speak to nobody, and I have to settle for that.

Ms. P.

There is nothing I can do about it. I can’t change my circumstances [health, passing away of loved ones].

-Ms. K.

The participants saw death as a welcome salvation:

I am only waiting for it all to be over, what else can I do, and I will be glad when it is. This is not how I saw myself becoming old.

-Ms. T.

I’d rather die today than tomorrow to be honest, but what can I do. I just must hope that it will be sooner than later. I don’t think I could commit suicide; I just hope to be dying soon.

-Ms. G.

***“I can do something to protect myself”*: Cocooning**

Participants tended to perceive their state of everyday life and loneliness as beyond their control. However, during the pandemic, isolation became a means by which people could proactively protect themselves from contracting and spreading the virus. This enabled participants to positively re-frame their isolation as *cocooning*; that is, as purposefully retreating from the social environment and seeking comfort within their home. Thus, while still suffering from loneliness, participants also felt autonomous:

Yes, I am more alone, than I have ever been. But this is how it must be for now. I don't want to be infected and don't want to infect others. That's the only thing I can do, and I am protecting myself.

-Ms. F.

We all only stay in our flats or houses. You go shopping for groceries and that's it. And that is really, really hard for me. Yes, for everybody not only me, but we all need to do it.

-Ms. M.

The only place I feel safe is my own home. I am so thankful that my flat is nice and comfortable, so I feel very secure there. This way I at least feel like I can do something to protect myself [from a potential infection].

-Ms. E.

Conclusions

Our results illustrate that, despite *or rather because* of their isolation, home-living vulnerable older adults with depression experienced loneliness and resignation during the pandemic, but also a sense of togetherness and autonomy. Positively re-framing isolation along with the stable provision of medical and particularly formal care helped participants feel connected during the pandemic. Our results contribute to a more diversified and nuanced understanding the impact of the pandemic on older adults and how societies can nurture a sense

of connection for vulnerable subpopulations. Our results are relevant not only for supporting older adults during the pandemic specifically, but also for meeting the challenge of population ageing more generally.

Social isolation, loneliness (National Academies of Sciences & Medicine, 2020) and passive suicidal ideation (Raue et al., 2007) are relatively common among home-living older adults with physical, functional, and mobility limitations. It is therefore not surprising that the participants in the current study struggled with *feeling disconnected* even before the COVID-19 outbreak, which they attributed to their physical limitations and old age. The perceived intertwining of their physical impairment and emotional wellbeing is consistent with other qualitative research on (Poole et al., 2022). Participants' feelings of disconnection, their resignation and their wish to die sooner rather than later can be interpreted as symptoms of their clinical depression. However, just one participant explicitly mentioned suffering from depression during the interviews. This result may reflect participants' tendency to view their depressive symptoms as a normal part of their everyday life experience as opposed to part of a mental illness (Sarkisian et al., 2003).

When asked explicitly, participants responded that the pandemic had not significantly impacted their everyday lives. Despite recognizing themselves as at high risk for severe disease, participants were rarely concerned about getting infected due to their social isolation. When participants were concerned, it was only with regard to how getting infected would affect other people. Moreover, while participants continued to feel lonely and resigned during the pandemic, they experienced loneliness and resignation alongside togetherness and autonomy. This finding is supported by other qualitative research which found that older, isolated individuals did not report feeling lonelier than before the pandemic (Bundy et al., 2021). Our results are thus consistent with previous studies demonstrating older adults' resilience during the pandemic (Bruine de Bruin, 2021; Costantini & Mazzotti, 2020; Gómez-Salgado et al., 2020; Klaiber et

al., 2021; Losada-Baltar et al., 2021; Mazza et al., 2020; Rossi et al., 2020; Sterina et al., 2021), as well as previous findings that at least some people with depression in fact experienced a degree of relief during the pandemic (Aguilar-Latorre et al., 2022; Hamm et al., 2020). That the pandemic provided the participants with a small degree of relief only goes to show just how largely *feeling disconnected*, *loneliness* and *resignation* loom over their everyday lives.

Before and during the pandemic, participants' interactions with family, medical providers and formal caregivers helped to mitigate *feeling disconnected*. Participants did not mention the loss of social or physical contact when first asked whether and how the COVID-19 pandemic had impacted their everyday life. However, in the course of the interview, participants expressed sadness over the loss of cherished opportunities for social and physical contact. It therefore seems that the COVID-19 restrictions had a bigger impact on the participants' *loneliness* than they consciously realized.

During the pandemic, isolation became a shared experience (Killgore et al., 2020) and associated with self-protection as opposed to vulnerability. Thus, the pandemic allowed participants to simultaneously experience not only *loneliness* and *resignation*, but also *togetherness* and *cocooning* as a way to make meaning of their newfound reality (Beasley et al., 2022). Similarly, a recent review of qualitative evidence identified positive re-framing as one strategy older adults use to cope with loneliness (Kharicha et al., 2018), and another study found that people with depression perceived their home as a refuge during the pandemic (Aguilar-Latorre et al., 2022). The participants still experienced isolation but felt less lonely because of the experienced *togetherness*. This result is important because socially-isolated older adults who feel lonely tend to have more depressive symptoms than those who do not feel lonely (Müller et al., 2021), and feeling socially connected also appears to help older adults maintain their well-being during the pandemic (Cunningham et al., 2021).

For many participants, their only continuous social interaction was with their formal caregivers. This result highlights how the German health care provisions provided a source of stability during the pandemic. Because their caregivers were formally employed by care facilities, participants never had cause to worry about interruptions in care. The pandemic may have more negatively affected the provision of informal care (Budnick et al., 2021).

Strengths, Limitations and Future Research

Home-living vulnerable older adults with depression are an extremely hard-to-reach group. The current study has provided new and unique insight about the experiences of a significant and particularly vulnerable minority of older adults during the pandemic. Our results complement existing research on how members of the general older population have experienced the pandemic and add to the limited body of evidence concerning the pandemic experiences of older adults with depression (Aguilar-Latorre et al., 2022; Hamm et al., 2020). Moreover, our open approach provided this population with an opportunity to tell their own stories.

More research is needed to understand the diversity of older adults' pandemic experiences and disparities between subgroups of older adults. Our study was limited to home-living vulnerable older adults with depression in Berlin, Germany, and disregarded issues of race, ethnicity and gender. Participants were primarily Caucasian women living alone. More research is needed to evaluate the extent to which the model describes the experience of the greater population of home-living vulnerable older adults with depression. The results might not generalize to other locations due to, for instance, differences in pandemic mitigation measures or health care provisions. Systematic comparisons of people with and without depression would shed light on how depression colors experiences of the pandemic, thus further research with a comparison group of non-depressed, home-living older adults would be useful. Further studies should explore how living arrangements (e.g., alone versus communal), having

an informal versus formal caregiver, and the vaccination rollout affected the pandemic experiences of vulnerable subpopulations of older adults. Finally, intervention studies should investigate whether virtual contact can improve the feeling of connectedness for homebound older adults (O'Connell, 2022).

Clinical Implications

- Home-living vulnerable older adults with depression struggle to feel connected, before and during the COVID-19 pandemic.
- Despite or rather because of their isolation, home-living vulnerable older adults with depression experienced loneliness but also a degree of relief during the pandemic.
- *Togetherness, cocooning* and the stability of formal caregiving helped participants endure loneliness during the pandemic and demonstrate the potential to increase a sense of belonging even under conditions of prolonged and extreme social isolation.

Data availability statement

The data that support the findings of this study are available on request from the corresponding author, [EMK]. The data are not publicly available due to their containing information that could compromise the privacy of research participants.

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Appendix

Appendix Table 1. Examples of the coding process

Unit of meaning	Condensed unit	Code	Subcategory	Category
<i>For years I've been suffering from glaucoma and dry macular. And I don't know if it has something to do with my eye doctor and his treatment, if it is the macular or glaucoma, I don't know my eyesight started to decrease.</i>	Eyesight is getting worse due to glaucoma and dry macular.	Disease	Physical impairment	State of everyday life
<i>And know I am completely dependent on help. I need to be treated in bed and bathed and everything else.</i>	Dependent on assistance for daily self-care.	Ambulant care	Social relations with caregivers	Social relations
<i>I don't feel well. On Wednesday I was released from the hospital and I really don't feel well. I feel sick and my heart doesn't work as it used to.</i>	She was in the hospital because of coronary heart disease and does not feel good physically.	<ul style="list-style-type: none"> • Heart disease • Physically not feeling well 	Physical impairment	State of everyday life
<i>Because I can't bend over as I used to, I can't bend down. That is just the case when you get older.</i>	Physical limitations are attributed to old age.	Limitations	Old age as loss	State of everyday life

<i>There is nothing I can do; I cannot change it [her situation]</i>	Her situation feels unchangeable	Unchangeable circumstances	Feeling resigned	Resignation
<i>Sometimes I feel very alone.</i>	Sometimes she feels alone.	Feeling alone	Feeling alone	Loneliness
<i>There is something that gives me strength and that is my home. I have a flat that I feel comfortable and safe in, that is really important.</i>	Her comfortable living situation gives her strength and is important to her.	Comfort in one's home	Resource	Cocooning
<i>With corona we all have to battle with it, not just me on my own, that feels good.</i>	Everyone must deal with the COVID-19 pandemic, evoking a good feeling.	Shared experience	Connectiveness	Togetherness