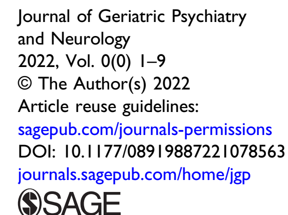
Original Article

Explaining the Psychosocial Effects of COVID-19 Among Older Hong Kong Chinese People—A Qualitative Analysis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Abstract

Background: Social distancing and "stay-at-home" orders are essential to contain the coronavirus outbreak; however, there are growing concerns about physical and other mental distress in older people. Apart from quantitative data, their feelings, thoughts, and experience are essential to inform the implementation of patient-centered health care policy. **Aim:** This study explained the psychosocial effects of COVID-19 on Hong Kong Chinese older people. **Design and Setting:** This was a qualitative study. Twenty-three participants aged between 63 and 86 were recruited in primary care through purposive sampling. **Method:** Semi-structured in-depth telephone interviews were conducted to explore participants' experience during the COVID-19 pandemic. Grounded theory was used to analyze the data. **Results:** Three themes, nine subthemes, and 24 quotes were identified. The 3 themes included the psychological response of fear, annoyance, and worrisome; social isolation leading to loneliness and physical exhaustion; and the coping strategies in adversity. Fear was the major emotional response, which was not entirely explained by the uncertainty of the disease, but also the embedded routines norms and values. Loneliness was aggravated by the depleted family and community support. Physical distancing had intensified ones physical demand on self-care, especially among those with comorbid illnesses. The use of digital tools and telecommunications maintained the social connection, but the overexposure had led to a vicious cycle of anxiety and distress. **Conclusion:** Self-isolation has disproportionately affected older individuals whose only social contact is out of the home. Online technologies can be harnessed to provide social support networks and a sense of belonging, but its adaptive and positive uses should be encouraged. Interventions can also involve more frequent telephone contact with significant others, close family and friends, voluntary organizations, or health-care professionals, or community outreach teams. Enhancing the values of older people's in calamity through active engagement may also potentially reduce the detrimental effect of social isolation.

Keywords

psychosocial effects, older adults, COVID-19, qualitative, coping strategies

Introduction

On March 11th 2020, the World Health Organization (WHO) declared the 2019 novel coronavirus (COVID-19) outbreak a pandemic.[1] This has brought the world to a juddering halt; leaders across the globe have invoked extraordinary measures to contain the virus. These include shutting down of the national borders, enforcement of quarantine measures, closure of schools and universities, and cancellation of mass gatherings and events. Government officials have asked members of the public to avoid going out and reduce social activities such as meal gatherings or other community events, and maintain

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appropriate social distance with other people as much as possible.[2]

Hong Kong has a high population density, with its location in close proximity to the first epicenter of COVID-19 and has a highly developed international transportation networks, making it vulnerable to importation as well as local spread of this novel human infection. Although Hong Kong did not implement complete lockdown, there were all-round containment measures including border control, home quarantine policy, active case findings, closure of schools, and more importantly, social distancing.[3] In the absence of a medical cure and vaccine for COVID-19, public health strategy of social isolation has successfully reduced the risk of viral transmission and infection.[4]

However, the distancing clashes with the deep-seeded human instinct to connect with others.[5] Social connection helps people regulate emotions, cope with stress, and remain resilient during difficult times.[6] By contrast, loneliness and social isolation can worsen the burden of stress and produce deleterious effects on physical and mental well-beings,[7] particularly among the vulnerable groups.[8] According to the national-wide surveys in China, negative emotions such as anxiety, depression, and anger increased, while positive emotions and life satisfaction decreased during the pandemic.[9,10] In our local cohort study, social and emotional loneliness, anxiety, and insomnia increased significantly among older people in the pandemic.[11] The findings were consistent with other overseas population studies which revealed widespread concerns about the effect of social isolation, such as increased stress, anxiety, depression, and other negative feelings in the older populations.[12-14]

While there is increasing quantitative evidence of the adverse psychosocial consequences among older people, their feelings, thoughts, and experience have not been adequately explained, which are essential to inform the development of relevant patient-centered care, especially in primary care setting.[15] This study aimed to explain the psychosocial effects of COVID-19 among vulnerable older people and formulate strategies based on current qualitative data and previous published quantitative data.[11]

Methods

This was an explanatory qualitative study secondary to a published quantitative study which reported loneliness, anxiety, and insomnia of COVID-19 on a prospective cohort of older adults with multimorbidity in primary care.[11] Ethics approval was obtained from the Survey and Behavior Research Ethics Committee of the Chinese University of Hong Kong. Verbal informed consent was obtained before the interview started.

Participants and Settings

The study was conducted during the period from 9th to 23rd April, 2020, when Hong Kong was in a state of "lockdown" 3 months after the first reported case of COVID-19 on 23rd January 2020. Participants were recruited in a pre-existing cohort of older people with multimorbidity and at a low socioeconomic class in Hong Kong; the eligibility of the cohort has been described elsewhere.[16] In brief, older adults aged ≥60 years, who had ≥2 chronic conditions, were recruited from 4 local public primary care clinics. They had to understand and speak Cantonese, had been participated in previous survey, and found to suffer from loneliness, anxiety, or insomnia.[11]

Study Design

We used semi-structured in-depth interviews to explore the psychosocial impact of COVID-19 among Chinese older adults in Hong Kong. Theoretical purposive sampling technique was used in the recruitment process in conjunction with data analysis.[17] Recruitment was stopped when theme saturation was reached, which was defined as the absence of additional insights and new themes from the participants.[18] In view of the COVID-19 outbreak and the infection control restrictions, individual telephone interviews were conducted instead of face-to-face interviews. Study has shown that telephone interviews are as effective as face-to-face interviews in the collection of qualitative data.[19] The interviews were carried out in Cantonese Chinese. A semi-structured interview guide was constructed as a point of reference to solicit participants' experience. The guiding questions include "How are you during this period of COVID-19?"; "Does your life change when compare to the time before COVID-19? What are the changes?"; "How's your physical health?"; "What's your feelings for staying at home for such a long time?" The duration of each interview was set at 45 minutes. All interviews were audiotaped and transcribed verbatim, and the written transcripts were the primary data source for analysis.

Researcher Reflexivity

The lead researcher (RWSS) is a family medicine physician with clinical and research experience on elderly care and holds a Doctor of Medicine (MD) degree in clinical research. The interviews were conducted by the second researcher (HKKL), a counseling assistant with a bachelor degree in psychology and has the experience of providing regular counseling service to older people. The work was supported by our qualitative researcher (DD) who has excellent track records on qualitative study. The team had worked together on developing the interview guides and analyzing the data.

Data Analysis

We employed grounded theory to analyze the data.[20] The analysis began after the first interview was conducted. Transcripts were read independently by the first (RWSS) and second authors (HHKC) and coded in 2 steps, that is, open coding and axial coding. In the open coding, the keywords and repeated phrases were identified and organized into meaningful and conceptual codes. In axial coding, the information with discrete codes were grouped and organized into sub-categories. To enhance the credibility and trustworthiness of the analysis, 2 rounds of coding and discussion were used to develop clear themes. Confirmability was enhanced when the same themes emerged from the transcripts; any disagreement in coding was addressed by the third author (DD).

Results

A total of 27 participants were approached for the study, 4 participants declined the phone interviews. Interview stopped after 23 interviews when no new information was provided and data saturation was reached. The background characteristics of the participants are summarized in Table 1. Three main themes, 9 subthemes, and 24 quotes emerged from our analysis.

Theme 1: Fear, Annoyance, Worrisome, and Social Media Distress

Feelings of being fearful, hopelessness, powerlessness, annoyed, frustrated, and worrisome were frequently mentioned. However, these feelings were not completely derived from the concerns about the disease or about their own safety; rather, they were embedded in the routines, norms, and values that older adults held onto. There were 4 subthemes under this main theme.

Fear, Hopelessness, and Powerlessness. Psychologically, interviewees revealed the feelings of fear because of the unbridled uncertainty with its etiology and management. They were constantly making judgments about what was and was not safe for their health, because in their minds, uncertainty equals a life-threatening danger:

> "I would be afraid of the germs when I take the elevator, like sometimes my mind would be quite restless, and sometimes I really feel like, ugh, I really can't stand it… I really feel that I can't understand why the world has become like this!"(10)

Such fear was partly resulted from disconnection from the external society. When they were forced to confine themselves within their houses, they could only allow their minds to wander:

> "The most important thing is my emotion has been affected. About the outbreak, now I stay at home and I feel very helpless. Surely, I overthink a lot. It seems not appropriate to go out, but I would overthink much more when I don't go out. Also, I'm so afraid, as it seems like I'm just waiting for my death. I seem to be isolated from the outside world."(21)

Social isolation also forced the interviewees to break up from their everyday routines:

> "I can't do anything, I can't help anyone, all I can do is nothing, isn't? I can only stay at home, lay on bed and listen to these numbers, isn't it annoying?" (20)

Annoyed and Frustrated at the Tedious and Laborious Nature of Infection Control Strategies. Hong Kong has learnt from the experience of SARS in 2003. Therefore, since the early times of the COVID-19 outbreak, many Hong Kong residents voluntarily changed their social behaviors by wearing masks, keeping physical distances in public areas, and using hand sanitizers frequently.[21] Such behavioral changes were shaped along with changes in common beliefs of social hygiene, which in turn facilitated the establishment of new social norms that were expected to be followed by every single person in the society. The interviewees therefore felt annoyed to follow the norms:

> "The very first thing when I go out is to wear a mask. Then, I've a tissue to press the button of elevator, I also bring some hand rub. What's more, I even wear googles, as it's still not good if I don't have it. All of these are necessary, and a lot more is needed too, but I don't know what to say. I also feel annoyed, especially when I return home, I've to shower from head to toe, I also have to change my clothes and clean them. Everything becomes so annoying." (23)

Meanwhile, the pressure of being forced to comply with the new social norms was compounded by older adults' age-related decline in fluid cognition; thus, they were more likely to experience greater stressor-related problem:

> "Very often I just go out but forget to wear a mask. So I often need to go back and bring a mask, which is disturbing imperceptibly. Even I've already been on the street, I have to go back and wear a mask, you see, how annoying it's." (02)

Worries About the Others. The worries were not only about their own well-being and they did not rate their personal health as the top priority in the pandemics. Rather, they were worried about transmitting the virus to their loved ones, especially their children and grandchildren, unintentionally:

Table 1. Characteristics of Each Participant.

Subject Code	Gender	Age	Diseases	Living Status	Social Security Allowance Scheme
Covid001	F	84	High cholesterol; coronary heart disease; stroke; dyspepsia; chronic musculoskeletal pain	Alone	Yes
Covid002	F	73	Chronic musculoskeletal pain; anemia; depression; cervix Cancer	Alone	Yes
Covid003	M	70	Hypertension; high cholesterol; diabetes; coronary heart disease; asthma; depression	Alone	Yes
Covid004	F	72	Hypertension; chronic rhinitis;	Alone	Yes
Covid005	F	81	Hypertension; coronary heart disease; dyspepsia; chronic musculoskeletal pain	Alone	Yes
Covid006	F	68	Hypertension; high cholesterol; chronic musculoskeletal pain; hypothyroidism; anxiety	With others	No
Covid007	F	80	Hypertension; high cholesterol; asthma; dyspepsia; chronic musculoskeletal pain; cataract; psoriasis;	With others	Yes
Covid008	F	70	Hypertension; high cholesterol; stroke; asthma; chronic musculoskeletal pain	Alone	Yes
Covid009	F	66	Hypertension; dyspepsia; chronic musculoskeletal pain; cataract; anxiety	With others	No
Covid010	F	70	Hypertension; high cholesterol; peripheral vascular disease; dyspepsia; IBS; constipation; retinal detachment chronic musculoskeletal pain; cataract	With others	No
Covid011	F	73	Chronic musculoskeletal pain; depression; anxiety	Alone	Yes
Covid012	F	69	Hepatitis B; chronic musculoskeletal pain; cataract; depression; anxiety	With others	No
Covid013	F	73	Hypertension; diabetes; cataract; depression; colon cancer	With others	Yes
Covid014	F	75	Hypertension; high cholesterol; coronary heart disease; dyspepsia; chronic musculoskeletal pain; deafness; cataract	Alone	Yes
Covid015	F	76	Hypertension; high cholesterol; asthma; dyspepsia; chronic musculoskeletal pain; cataract	Alone	Yes
Covid016	F	69	Hypertension; high cholesterol; diabetes; dyspepsia; chronic musculoskeletal pain; cataract	With others	Yes
Covid017	F	73	Hypertension; high cholesterol; diabetes; chronic musculoskeletal pain	With others	Yes
Covid018	F	72	Chronic musculoskeletal pain; cataract	With others	Yes
Covid019	F	72	Hypertension; high cholesterol; chronic musculoskeletal pain; cataract; anemia	With others	Yes
Covid020	F	86	Hypertension; dyspepsia; constipation; chronic musculoskeletal pain	With others	Yes
Covid021	F	63	Hypertension; chronic musculoskeletal pain; hypothyroidism	With others	Yes
Covid022	F	64	Asthma; chronic pharyngolaryngitis; anemia	With others	Yes
Covid023	F	71	Hypertension; chronic musculoskeletal pain	With others	Yes

> "Sometimes when my grandchild wants to pay me a visit, I'll tell him it's better not to, as he needs three transits in transportation to come to my place, which means a total of six transits in transportation for my grandchild to come here and back. I immediately am afraid of my grandchild being infected, then my daughter, who is the mother, will have a high chance to be infected too. So, it's better not to meet each other." (01)

Sometimes, they would rather take the risks of infection by themselves, even if it means that the intimacy between family members was being affected:

> "I would make soups and bring to them, simply give the soups to them and then leave. As they're still young, I'm afraid maybe I'm too clumsy. I would keep my mask on my face when I see them. Sanitizing is necessary before meeting my grandchildren. My grandchildren would tell me to come closer and eat together, then I would say it's rather not to, as it's better to keep distance." (19)

In addition to the concern over transmitting the disease, they were concerned about the possible economic downturn and recession that might affect the employment of their children:

> "My daughter lost her job. I only worry about her livelihood, as it's not okay without a job." (04)

> "I think the economy's a problem. For my son and daughter… now their… income has dropped a lot."(10)

The Vicious Cycle of Media Consumption and Distress. When going outside became annoying and stressful, interviewees started to spend more time at home. Naturally, they chose to use social media to stay connected to the society; however, the repeated media consumption about COVID-19 had become a new source of anxiety:

> "The outbreak's happening in every country on the world…Every minute and every second, there're infections to this disease, which is deadly and very dangerous… It's very risky for elderly once they become infected to the disease." (13)

> "It's been dismal previously, very depressing, as I've heard about the figures. I'm heartbroken. Listening to the news and hearing all the stuff really bother me. It's scary, and I dare not to go out." (19)

On the other hand, anxiety and uncertainty drove additional media consumption—the more they read, the more they felt distressed. This created a vicious cycle of anxiety, news craving, and panic, which was difficult to break out of:

> "At the beginning, I'd no idea how the virus was. Because I'd no knowledge about it, I would feel way more worried. I think I've been a bit more anxious every day, as I find myself spending more time on mobile phone and learning more news. I always keep an eye out for the outbreak in other places. My emotion's really affected!" (22)

Theme 2: Loneliness and Physical Exhaustion due to Disrupted Social Support

For many interviewees, physical disconnection was detrimental because it disrupted all types of social support that they had relied on, especially among those whose social contact was mainly "out of home".

Depleted Family support. In times of societal stress, warmth of breath and bodies, of holding hands and hugging, of talking and listening, is a primary source of comfort. These connections are pivotal for responding to and maximizing our survival in times of crisis. Such emotional support was deprived:

> "My two grandchildren were stuck at home in mainland, they didn't come here. From the last time we had dinner, which was around Lunar New Year holiday, till now, they haven't come here ever since. In the past, we see each other almost every day, but now, we haven't seen each other for three months already." (19)

Another population of older people who were deprived of family support was those living in residential care homes, as their friends and family members were not currently permitted to visit:

> "I used to hike every day, I would go to Sha Tin Wai to visit my husband. Since the outbreak's been like this, then the building he lived in has confirmed case at the beginning of the month. I brought him back there on 2 Feb (2020), then I've been forbidden to see him. He can't come back, he hasn't come back since the Lunar New Year." (16)

Heightened Social Isolation With Closure of Elderly Centers and Churches. Some older adults did not have close family or friends and depended on the support of voluntary services or social care. The major source of their tangible and emotional social support came from routine daily contacts with acquaintances during grocery shopping and gatherings with community groups and fellowships in places of worship. COVID-19 forced them to discontinue their daily routines and made the support they needed intangible:

> "I'm not allowed to go to the church, it's also been shut down, I can't go to there. So, I don't have any social activity anymore. It's been very dumb." (07)

> "As going out is forbidden, everywhere is closed, like centers, community centers, all are closed. Previously I could go there directly and seek help about daily life or computers. Now, I can't, thereby I've a lot of questions piled up." (11)

Participants expressed that social isolation had reduced their personal space. The loss of space might not only refer entirely to the loss of physical space for social gatherings but also to the space extended from family to community where their social network was built upon and their social roles were fulfilled. With the lockdown, they felt the shrinking of space at both the physical and psychological dimensions:

> "In the past when everything is fine, I can go out when I'm in bad mood, I can join activity, now, everything is not allowed. It feels like I've always been stuck at home, cook meals and do housework, that I don't have my own space anymore." (09)

Absence of Community Support and Pre-Existing Comorbid Illnesses had Intensified Ones' Physical Demand. The extended lockdown brought new challenges to our vulnerable older adults, as they needed to balance between their health and household chores. Interviewees revealed that the lack of community service support, such as home-helper service and meals-on-wheels, was having the worse impact on them, especially among those who were frail and living alone:

> "I really can't do many things. Many housework is out of my ability, like changing bedsheets. For the floor, I can only sweep the floor, but I can't mop the floor, as I can't twist the mop dry, I wouldn't be so nervous if I hadn't swept the floor in the old days, because they (home- helpers) would come and help." (01)

Comorbidity of physical illnesses, such as cardiac diseases and pain conditions, further limited their self-caring performance:

> "My foot hurts, I can't stand to cook. It's troublesome even to buy takeaway." (07)

> "I have heart problem. I can't do these (housework) now and can't stand on high places for cleaning in the past few months" (05)

Theme 3: Coping Strategies in Adversity

The last theme centers on the older adults' exploration on new territories and sources for social support and their endeavors to coping with the adversity.

Social Support Through Online Technologies. Participants were very keen to use online technologies such as YouTube, ZOOM, and/or Facebook to keep themselves connected to their social network and maintain the daily routines:

> "Like previously we've joined some sports class, which have stopped since the outbreak, but starting from today, we can have class through mobile phone, then it seems like we've come to life again." (23)

Internet also helped to regain the disrupted family connections:

> "My son is in Singapore, he's supposed to come back at June, but now he can't, which means I'm further from my grandchild. Now I meet him online via Facetime, so we can meet online every day." (06)

Mobile text messages have modified interpersonal interactions, as more people use text-based communications rather than face-to-face encounters to connect with their friends and family members. The use of WhatsApp and other similar message-based platforms in the pandemic has allowed sharing of text messages, images, video, and audio messages; thus enabling individuals to socialize, stay connect, and support each other without actual physical contact:

> "I've some group chats with my friends. I encourage my friends, or I take some nice photos and send to them. Like when I walked pass the park, I took some photos and send to them. They saw it and appreciated it, then they realized the spring is coming and believed there is hope" (22)

Older Adults Were Being Supported by the Younger and More Mobile People in Their Neighborhood. Older people treasured the few minutes chat with neighbors in the corridors and streets during COVID-19. They helped one another on grocery shopping and shared protective materials such as masks and sanitizers when resources were scarce:

> "I have some really kind neighbors. Sometimes they have some, and I happen to bring my cart and go down there, so I buy some too. When they bought some and asked me did I buy some, I said I can't. I said if your husband can help me, then buy some for me if possible. Then next day he really bought two packs back." (14)

Some older adults who suffered from physical pains and poverty also received timely help from friends during such a difficult time:

> "As I can't walk, I can't buy. My feet were in pain this week, but my friends bought some. My friend bought from restaurant." (08)

"Like at the beginning of the outbreak, we really didn't have mask. I was so frustrated, and I didn't have money to buy mask. But my friends were very kind, one gave me some, and the other one gave me some more." (19)

Discussion

Participants in this qualitative study came from a cohort of older adults with chronic conditions[16] with evidence of suffering from social and emotional loneliness, anxiety, and insomnia during the COVID-19 pandemic.[11] They all came from an underprivileged background with the weakest social support and capital. Therefore, they had the best representation of the so-called "vulnerable elderly" and provided the richest information to the phenomenon of interest. We observed that older adults commonly expressed fear in the pandemics, and the reasons behind such emotional responses were complex. Social disconnections due to physical distancing was a driving factor, which was further aggravated by the stress and anxiety in following social norms, age-related decline in cognition, and over exposure to social media. The deep-seeded feelings of powerlessness in older people may predict subsequent health-related behaviors. For example, Jolley et al has found that the feelings of powerlessness mediated the relationship between conspiracy beliefs and lower vaccination intentions, which is likely to negatively influence people's responses to the pandemic.[22]

In Chinese societies, social engagement of older people involves lifelong commitment of caring for the well-being of younger generations as a way to show care and affection.[23,24] Intergenerational relationships are characterized by reciprocity; that is, while younger generations support older relatives, older relatives assist younger family members through various kinds of activities, such as childcare, housekeeping, and cooking.[25] The engagement in these productive roles has been identified as a crucial factor responsible for greater health, well-being in later life, and preserved self-values in the society.[26,27] However, such engagement and values were temporarily truncated during the COVID-19 pandemic. Therefore, apart from formulating different strategies to explore the needs,[8] actions should also be taken to help older adults to retrieve their self-values and self-worth during the pandemic. Solutions may include encouraging active engagement of older adults in providing emotional support to needed ones by sharing their life experiences, skills, knowledge, memories, and learned temperamental strategies in adversity.[7] This can be fulfilled by either simply calling their loved ones for chatting, or by acting as volunteers in some help hotlines to support other people in the community.

Social media is an easily accessible platform for health knowledge dissemination and promotion of behavioral changes. More importantly, it allows social connection in the period of lockdown and social distancing. However, misinformation and fake news about COVID-19 have proliferated widely on social media, thereby amplifying the perception of risks and exacerbating stress responses and worries.[28-30] Fear is a central emotional response during a pandemic and it can make perceived threats more imminent.[31] Negative emotions resulting from threat are contagious, and they often drive risk perceptions more than the factual information.[32] As negative emotion increases, people tend to rely on negative information to make health decisions,[33] and the situation is worse when negative framing captures attention.[34] The lack of debunking skills of fact-checking and correction has put older people at a higher risk of media-fueled distress, with downstream mental and physical health consequences.[35] Therefore, older people need to first set the limit of COVID-19–related news consumption from local, national, international, social, and digital platform and the sources must be authentic like the WHO or CDC.[8]

As for coping strategies, mutual support among neighbors enables sharing of useful information and resources in the period of lockdown and is helpful to reduce emotional stress among older adults in the pandemic.[36,37] Therefore, fostering mutual support among neighbors by allocating resources to establish social relationships in the community is believed to be more effective than delivering direct elderly services by professional caregivers in the period of pandemic and crisis.[36] With the growing use of online technologies, digital social network can be developed among neighbors to enhance sense of belonging and connectedness. Examples include the Neighborhood Watch Scheme and Nextdoor App in the United Kingdom, which provide platforms for neighbors and communities to communicate online, encourage conversations and connections among different people, and identify the vulnerable ones.[38] Other simple interventions should also involve more frequent telephone contact with significant others, close family and friends, voluntary organizations, or healthcare professionals, or community outreach teams.[39] Tele-counseling along with crisis response service for emotional, mental, and behavioral support should need to be implemented.[40]

This qualitative study explaining the psychosocial effects of older people during COVID-19 pandemics and was supported by quantitative data published in previous research.[11] There are limitations to this study. The study only recruited older adults of ethnic Chinese in Hong Kong and may not be generalizable to other Western populations, which did not share similar socio-cultural practices and structural contexts. Besides, the semi-structured interviews were conducted over the phone; thus, the absence of visual cues might affect the depth of meanings that can be conveyed and understood.[41] Finally, information was

collected from older adults living in the community, so the experience and needs of those living in residential care were not explored.

The COVID-19 pandemic poses the biggest threats to the psychosocial health of older adults in recent decades. While collective efforts are required to deal with this global pandemic, the psychosocial consequences, especially among the older groups, will need to be addressed with well-planned patient-centered care. In this context, psychosocial assessment and monitoring should be regularly conducted in primary care, which should include queries about COVID-19–related stressors, such as exposures to infected sources, infected family members, loss of loved ones, and physical distancing; secondary adversities such as economic loss; negative psychosocial effects such as anxiety, depression, and insomnia; and indicators of vulnerability due to preexisting physical or psychological conditions. Supportive interventions, such as psychoeducation or cognitive behavioral techniques, are needed to promote wellness and enhance coping. Although most people are resilient and do not succumb to psychopathology after the pandemic, the vulnerable ones will still need fast-track referrals to psychiatric services for formal mental health evaluation and care. Proactive planning on mental health rehabilitation is needed to enhance healthy aging of older people during and after the pandemic.

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