

The impact of fear on the elderly during the COVID-19 pandemic, social support and depressive symptoms: a cross-sectional study

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DOI: <https://doi.org/10.37745/bjmas.2022.0086>

Published: 5th January 2023

Citation: Mentis M., Lamprinakou I., Garantoudi A., Mavroeidi E., Konstantopoulou G. (2022) The impact of fear on the elderly during the COVID-19 pandemic, social support and depressive symptoms: a cross-sectional study, *British Journal of Multidisciplinary and Advanced Studies: Health and Medical Sciences 4 (1),11-24*

ABSTRACT: *The COVID-19 pandemic has had a worldwide impact on all age groups, and in particular on the elderly who constitute a vulnerable section of the population which is constantly increasing in number. The adverse effects of the pandemic have been associated with increased rates of geriatric depression and the feeling of fear among the elderly, leading to social isolation, increased stress and limitation of daily activities. These factors negatively influence both the mental and physical health of the elderly whose aging deficits already render them more prone to physical, mental, social and economic deprivation. This cross-sectional study aimed to investigate how fear caused by the pandemic has affected the lives, the daily habits, the social support network and the emotional and physical state of the senior citizens in the wider area of Phaistos, in Crete, and how the impact of the pandemic is linked to geriatric depression. With a total sampling of 200 participants over 65 years of age, the measuring instruments used in the study were the SSQ-6 (Social Support Questionnaire) to investigate social support and the GDS-15 (Geriatric Depression Scale) to investigate depression.*

KEYWORDS: Elderly, depression, social isolation, pandemic, Covid-19, fear, social support, geriatrics, SSQ-6, GDS-15

INTRODUCTION

The World Health Organization defines a pandemic as an epidemic of an infectious disease during which a significant, continuous, rapid development and spread is observed in large geographical areas or countries on a global scale, which threatens the entire population (www.who.int) Pandemics result from epidemics which, in contrast to pandemics, are outbreaks of diseases limited

to specific areas on the planet. Basic common characteristics of pandemics over the centuries are their unknown course and occurrence, the fact that they are unprecedented, their transmissibility, their infectivity, their spread due to population mobility and the presence of complications that cause prolonged hospitalization for the vulnerable population. (Pitlik, 2020). In March 2020 the head of the World Health Organization stated that "*If the word pandemic is used incorrectly, it can result in an unwarranted fear and an unwarranted acceptance that the battle is over, leading to unnecessary deaths.*" (<https://www.who.int/11/3/2020>).

The dawn of 2020 found humanity struggling to cope with the emergence of a new coronavirus that spread rapidly around the world, dramatically challenging healthcare resources, public health policies and ultimately the resilience of humanity from a physical, economic, cultural and psychological perspective (Karaivazoglou et al., 2021). The new coronavirus was characterized as a severe form of acute respiratory distress syndrome (CoV -2 SARS –CoV-2). According to confirmed cases on a global scale, this disease, despite its mild pathogenesis, had the highest transmission rate, while the initial mode of transmission of the virus was from person to person through close contact. The groups of people affected were characterized as “high risk” and were mainly the elderly (>65y) and people with underlying medical conditions, such as unregulated blood pressure, people with cancer and people with cardiac, pulmonary, and metabolic diseases, such as diabetes. Covid-19 mainly targets the respiratory system, causing severe pneumonia, respiratory distress syndrome, multiple organ failure and ultimately death. At the same time, the less serious symptoms presented are bone pain, fatigue, fever, nasal congestion, headache and dry cough. Recently, many studies have reported that Covid-19 can also cause neurological symptoms, while 36% of the people affected by the disease experienced headache, vertigo and ataxia. There were also cases reporting dysgeusia and anemia. (Marques de Miranda et. al., 2020).

According to McEwen (2005), in situations of chronic stress, the body experiences additional "wear and tear" associated with a greater occurrence of symptoms and functional impairments. In this respect, the uncertainty caused by the pandemic and the changes it brought about to the daily life and the attitude towards life due to the reduction of social contact and the prolonged stay at home, have significantly affected both the physical and mental health of individuals causing situations of intense sadness and prolonged anxiety owing to intense loneliness (Armitage et al., 2020). In very recent surveys carried out in Italy, it appeared that people were experiencing high levels of stress, because of the uncertainty regarding the duration of the pandemic and the restrictive measures that have significantly affected the citizen's lives. In particular, research has revealed a wide range of psychological effects that pandemics can cause (Lima et al., 2020), such as stress symptoms, which can occur even in people who have no previous mental health problems, or they can even worsen existing mental illness symptoms (Kelvin and Rubino, 2020). Particularly vulnerable are those who have underlying diseases, such as respiratory diseases, cardiac diseases, and neoplasms(<https://eody.gov.gr/25/9/2022>). The Hellenic National Please blog Health Organization (EODY) announced that for the week from September 19 to September 25, 2022,

44,775 cases of COVID-19 were recorded in Greece (4,292 per million populations: 24% weekly change) out of which reinfections concerned 26% of infections. The number of intubated patients by the end of the week in question was 79 (63.3% men) with a median age of 70 years, while 96.2% of them had an underlying disease and/or age of 70 years or older. The median age of the cases was 38 years, while the median age of the deceased was 80 years (<https://eody.gov.gr/25/9/2022>).

The Covid-19 pandemic, the measures and the lockdown suddenly introduced a multitude of changes in everyday life. The working conditions, the way of communication, the moments of fun and the way people share, or experience important personal events have changed. Hence, the adjustments that every individual had to make were many and imperative. Clearly, this new situation was a psychologically oppressive condition that included all the features of a disaster. In other words, it was an unprecedented experience that started suddenly; it was an uncontrollable and very frightening condition, as it presented a significant risk for the lives of all the people testing both the mental endurance and the limits of the whole. (Kontoangelos et al., 2020) The pandemic overturns the normality and routine of individuals; it directly affects the care they receive, as the fear of infection and death and the possibility of losing their loved ones or being separated from them are the new conditions that are factored in. In particular, it is very important to note that during a pandemic, with social isolation prevailing, people, and especially the elderly, become vulnerable to the thought but also to the act of suicide due to the loss of social activities and social seclusion from their social network. This becomes even more intense when it is accompanied by anxiety or a depressive background. (Santini et al., 2020). This fact can be exacerbated by the feeling that the Third Age is undervalued during a pandemic or a burden on society due to their needs for increased health care and allocation of resources (Rosenbaum, 2020). These perceptions are reinforced in older people who feel a burden on society and their families.

Pursuant to the above, although social isolation or social distance is considered mandatory for people belonging to high-risk groups, the application of restrictive measures and the actual difficulties they entail has led to the appearance of problems in patients with existing diseases during the pandemic (Min Luo et al., 2020). As Holt-Lunstad and Uchino (2015) stated, social support, social exchange, and social networks are related concepts, which may be powerful and potentially modifiable determinants of cognitive health and mortality in the elderly population especially at this time. The absence or loss of contact with significant others, which often occurs as one ages or is ill, has been linked to a number of physical and mental health indicators, including increased mortality after myocardial infarction. Thus, older adults with little social support have an increased risk of psychiatric and physical problems (Holt-Lunstad and Uchino, 2015). According to Whitehead (2021), the fear that the age group that seniors belong to renders them automatically vulnerable makes the elderly feel immense stress which leads to depression much more easily. In this light, the coronavirus pandemic acted as a stressful factor for the elderly

affecting both their mental and physical health, due to the impact in various areas, both on an individual and societal level (Whitehead, 2021).

Depression is a disease that is very often seen in the Third Age, especially when there are chronic physical diseases and institutionalization. Hence, when a person suffers from depression, they intensively use health services and social services. In such cases depression is persistent and severe since the patient does not usually receive treatment. This is because doctors, caregivers and the elderly themselves believe that it is a result of the adverse effects that their own deficits have on the elderly. However, this type of depression should be considered pathological and potentially treatable (Katona and Katona, 2001). It is worth noting that depression in the Third Age is difficult to detect as the symptoms are considered to be the result of aging alongside the physical ailments that occur at these ages. Also, as many depressive symptoms can be seen in older people who are not depressed there is a lot of confusion. As people age their sleep schedule changes causing them to complain of sleep disturbance similar to that seen in depression, yet as mentioned in Katona & Katona (2001), sleep disorders may indicate the future onset of depression. Moreover, thoughts of death, decreased energy and motor retardation are symptoms of aging but they can also be symptoms of physical illness. Hence, distinguishing depression and dementia is equally a difficult process. Nevertheless, recognizing both is very important in order to provide appropriate treatment. In addition, anxiety makes it difficult to diagnose depression, but early detection and diagnosis makes treatment more effective (Katona & Katona, 2001).

According to the above, in this study we aimed to investigate the effect of fear caused by the pandemic and how this relates to social support and depression in the elderly living in the wider area of the Municipality of Phaistos, Heraklion, in Crete. Our purpose was also to examine whether the fear that the elderly experienced because of the pandemic has affected the degree of their compliance with the instructions of experts and to what extent the elderly have changed their lifestyle and daily habits because of the pandemic. Moreover, we aimed to investigate if this fear has led the elderly to limit their contacts with their social support network, if it has affected their emotional mood and to what extent it is linked to the development of depressive symptoms.

METHODS

The current research is cross-sectional and the quantitative approach has been applied. The study population is 200 senior citizens over 65 years of age who are permanent residents of the Municipality of Phaistos. The sample of the study was obtained in the month of October 2020 with the systematic random sampling method. The sample was drawn from the population of the elderly who visited the Moira Health Center and its regional clinics. The research was approved by the 7th Health Region of Crete (A.P.53625/19-11-2020). An effort was made to ensure that the sample size was representative of the study results. The implementation time period was October 2020.

Instruments

The research tools used to collect the data are the following: **1)** The Social Support Questionnaire (SSQ-6) was used to investigate social support. The SSQ-6 is a pre-made structured questionnaire on socio-demographic characteristics, health status and the impact of the pandemic on the daily life of the elderly. Cronbach's α internal consistency reliability ranged at common excellent levels ($\alpha = .94$) for both subscales of the Social Support Questionnaire, the subscale which measures the number of people providing social support and the subscale which measures the degree of satisfaction with the provided social support (see Appendix II: Table 16). It was in perfect agreement with the reported reliability levels of the Questionnaire for the Greek population (Gouroundi, 2011. Stalikas, Triliva, and Roussi, 2012). **2)** The Geriatric Depression Scale (GDS-15) was used to investigate depression. The GDS-15 is a psychometric test developed in 1986 by Sheikh and Yesavage (1986) specifically for use in the elderly. It captures the mood and emotions of the elderly and also possible symptoms of depression. It is self-completed, although many times it is considered appropriate for the examiner to read it to the patient, which was also done in this study. The main objective of the Scale is mainly to detect the mental concerns of the patient, and also evaluate their perception of the quality of life without including questions about physical difficulties. The scale is thought to capture four subfactors: The cognitive (depressive content of thought), the affective, the social isolation and functioning factor and the feeling of helplessness and fear of the future. The reliability of the Geriatric Depression Scale is 0.81 and the internal reliability is 0.85. Regarding the specificity of this scale, it is between 67% and 80%, while its sensitivity is between 79% and 100%. The geriatric depression scale has been adapted to Greek by Fountoulakis (Fountoulakis et al., 1999). The questionnaires were completed in the form of an interview.

Statistical analysis

After collecting the 200 questionnaires (n=200 participants), they were analyzed on the IBM SPSS software. For the statistical analysis, a distinction was made between categorical and quantitative variables. For the quantitative variables, a distribution test was applied according to the criteria of the Kolmogorov-Smirnov test. It appeared that the variables did not follow a normal distribution, hence non-parametric statistical tests were chosen to analyze the data. For the categorical variables, the descriptive characteristics were calculated in the form of frequencies in absolute values and percentages (N, %). For the quantitative variables the descriptive characteristics were calculated in the form of mean values and standard deviations (m.t., t.a.). A test was then performed to investigate possible statistically significant differences between the variables, using the Pearson chi-square test and the Mann-Whitney U test. Finally, correlation tests were performed between the two variables using the Spearman's rho correlation coefficient (correlation coefficient r). All tests were performed at a statistical significance level of $\alpha=0.05$ (highlighting P-value<0.05 as statistically significant).

RESULTS

The results of the study are important for the managing and dealing with a possible second wave of the Pandemic or a similar crisis among the target group of the elderly. It was observed that 41.5% (n=74) of the participants facing a chronic health problem were men and 58.4% (n=104) were women. On the contrary, regarding the participants without any chronic health problem only 31.8% (n=7) were men and 68.2% (n=15) were women. Performing a Pearson Chi-Square statistical test, no statistically significant difference was observed (P-value = 0.379). It was found that 53.9% (n=96) of the respondents experiencing cardiac problems were male and 46.1% (n=82) female. Also, 40% (n=2) of the respondents dealing with diseases of the digestive system were men and 60% (n=3) were women. No males were found to be experiencing psychiatric problems, compared to 2 females (100%). Regarding neurological problems only 30.8% (n=4) of the participants experiencing them were male and the majority (69.2% (n=9)) were female. Moreover, 18 women (94.7%) were found to be dealing with autoimmune diseases, while only 1 man (5.3%) from the sample had an autoimmune disease. On the contrary, 60% (n=9) of the male participants were dealing with cancer, compared to just 40% (n=6) of women.

It is important to note that 27 men (73%) and only 10 women (27%) were facing other health problems, while 41.8% (n=74) of medicated subjects were male and 58.2% (n=103) female. Out of the unmedicated subjects only 31.8% (n=7) were male and 68.2% (n=15) female. After performing the Pearson Chi-Square statistical test, no statistically significant differences were found in the answers (P-value=0.368). It is interesting to see that, 53.3% (n=8) of the male participants were not afraid for their health, in contrast to 46.7% (n=7) female participants. Regarding the participants who feared for their health, 29.2% (n=7) were men and 70.8% (n=17) women, while the physical health of 63.8% (n=44) women participants was affected for the worse since the pandemic began. Concerning the question item "I fear the economic crisis that may come due to the pandemic" none of the respondents completely disagreed with it, however 62.1% (n=36) of the respondents who agreed were women.

With regards to the fear of death or of developing health problems, 36% (n=63) of men and 64% (n=112) of women stated that they had experienced this fear, while 33.3% (n=7) males and 66.7% (n=14) female participants stated that they feared for the health of their family and the loss of a member. Furthermore, 66.7% (n=6) of the male respondents feared the possibility of hospitalization compared to 33.3% (n=3) of women, while 38% (n=19) of men compared to 62% (n=31) of women feared the possibility of personal poverty and destitution. Concerning the fear of isolation and confinement, the rate was 35.3% (n=6) males and 64.7% (n=11) females, 48.6% (n=18) of those who feared for the general economy were men and 51.4% (n=19) women. It is interesting to note that only women participants feared the feeling of loneliness (n=4) and only male participants feared the prospect of war (n=1). Finally, 6 men (66.7%) and 3 women (33.3%)

had no fear at all. It is evident from the results that there are differences in the relationship between social support and the gender of the participants. Specifically, it appeared that there was a statistically significant difference (P-value=0.019) between participant gender and SSQ1 (Mean Rank: male=88.97, female=108.35). In contrast, there was no statistically significant difference (P-value=0.243) between gender and SSQ2 (Mean Rank: men=106.04, women=96.73). *Table 1.*

Table 1: Differences in the relationship between social support and participant gender

Gender					
		Male	Female	Total	Statistical Control
SSQ1	N	81	119	200	Mann-Whitney U = 3885,5
	Mean Rank	88,97	108,35	-	Z = -2,336 P-value = 0,019<0,05
SSQ2	N	81	119	200	Mann-Whitney U = 4371
	Mean Rank	106,04	96,73	-	Z = -1,167 P-value =0,243>0,05

A very slight positive correlation was found between SSQ1 and SSQ2 (Pearson Correlation=0.192), which was statistically significant (P-value=0.006). Also, a very slight positive correlation was found between educational level (Pearson Correlation=0.150), monthly income (Pearson Correlation=0.181) of the participants and SSQ2, which were statistically significant (P-value=0.035 & 0.010 respectively). Finally, a very slight negative correlation was found between housing conditions, SSQ1 (Pearson Correlation=-0.140) and SSQ2 (Pearson Correlation=-0.195), which was statistically significant (P-value= 0.047 & 0.006 respectively). No other statistically significant association was found.

It appeared that there was a statistically significant difference in the gender of the respondents (P-value=0.014, Mean Rank: men=88.33, women=108.78), in their way of living (P-value<0.001, Mean Rank: lives alone=128.57, and living alone=90.12) and receiving medication (P-value<0.001, Mean Rank: receiving medication=105.77, not receiving medication=53.59). Also, statistically significant differences were found in housing conditions (P-value=0.012, Mean Rank: he is satisfied=96.82, he is not satisfied=128.83) and in the presence of chronic problems (P-value<0.001, Mean Rank: there is a chronic problem=106.28, no chronic problem=53.70). A very slight positive correlation was observed between the scores for "I'm not afraid for me, but for my children" and "my emotional mood has been affected for the worse since the pandemic started" and the depression score (Correlation Coefficient=0.220 & 0.278 respectively), which was statistically significant (P-value=0.002 & <0.001 respectively). A slight positive correlation

(Correlation Coefficient=0.419 & 0.359 respectively) was observed between the scores for "my physical health has been affected for the worse since the pandemic started" and "the novel coronavirus makes me feel helpless" and the score depression, which was statistically significant (P-value<0.001 in both cases). Then, a slight negative correlation was found (Correlation Coefficient=-0.485 & -0.495 respectively), which was statistically significant (P-value< 0.001 in both cases). A very slight negative correlation (Correlation Coefficient=-0.241) was found between the scores for "my health and mood has not changed compared to last year" and the depression score, which was statistically significant (P-value=0.001).

Examining the association between the scores for "my sleep has been affected because of the pandemic", "the novel coronavirus makes me feel very close to me" and "the novel coronavirus makes me feel like I'm thinking about it all the time" and the depression score, a very slight positive correlation was observed (Correlation Coefficient=0.244, 0.236 & 0.243 respectively), which was statistically significant (P-value=0.001 in all cases). Also, between the scores for "the novel coronavirus makes me feel that it is spreading quickly" and "the novel coronavirus makes me feel that the media is not exaggerating" a very slight positive correlation was found (Correlation Coefficient=0.165 in both cases), which was statistically significant (P-value=0.019 in both cases). Finally, a very slight positive correlation was observed between the scores for "the novel coronavirus makes me feel anxious", "I am afraid that hospitals will not be able to cope with increased demand" and "the novel coronavirus makes me feel lonely because of it"» and the depression score (Correlation Coefficient=0.163, 0.160 & 0.251 respectively), which was statistically significant (P-value=0.021, 0.024 & <0.001 respectively). No other statistically significant association was found.

A very slight negative correlation was observed between the domains of employment status, lifestyle, number of roommates, existence of chronic problems, receiving treatment, monthly income and the depression score (Correlation Coefficient=-0.201, -0.297, -0.288, -0.286 & -0.269 respectively), which was statistically significant (P-value=0.004 in the first, <0.001 in the others). In contrast, a very slight positive correlation was observed between the domains of gender, housing conditions, income adequacy and the depression score (Correlation Coefficient=0.175, 0.178 & 0.261 respectively), which was statistically significant (P-value=0.013, 0.012 & <0.001 respectively). Subsequently, a slight positive correlation was found between the year of birth and the depression score (Correlation Coefficient=0.479), which was statistically significant (P-value<0.001). On the contrary, a slight negative correlation was found between the educational level and the depression score (Correlation Coefficient=-0.489), which was statistically significant (P-value<0.001). Finally, a very slight negative correlation (Correlation Coefficient=-0.286) was shown between receiving treatment and the depression score, which was statistically significant (Pvalue<0.001). *Table 2*

Table 2: Correlation between depressive symptomatology and socio-demographic characteristics of the sample

Depression Score (total GDS)			
Correlation of depression symptoms with socio-demographic characteristics of the sample	Gender	Correlation Coefficient	0,175
		P-value	0,013
		N	200
	Year of Birth	Correlation Coefficient	0,479
		P-value	<0,001
		N	200
	Educational Level	Correlation Coefficient	-0,489
		P-value	<0,001
		N	197
	Job status	Correlation Coefficient	-0,201
		P-value	0,004
		N	200
	Monthly income	Correlation Coefficient	-0,269
		P-value	<0,001
		N	200
	Living Conditions	Correlation Coefficient	-0,297
		P-value	<0,001

	N	200
Number of Roommates	Correlation Coefficient	-0,288
	P-value	<0,001
	N	199
Living conditions	Correlation Coefficient	0,178
	P-value	0,012
	N	200
Income sufficiency	Correlation Coefficient	0,261
	P-value	<0,001
	N	200
Existing chronic problems	Correlation Coefficient	-0,286
	P-value	<0,001
	N	200
Under Medical Treatment	Correlation Coefficient	-0,286
	P-value	<0,001
	N	199

CONCLUSIONS

The women in the sample appeared to have higher percentages than the men in the family domain, in particular widowhood, loneliness, multi-morbidity and limited personal time. They also had a higher score in the domain of fear caused by the pandemic and the domain of changing their daily life and social habits in order to comply with the new protection measures. 40.5% of the sample was male and 59.5% female. The mean age was 75.70 years ($SD\pm 6.29$) and the mean value for education was 5.62 years ($SD\pm 2.81$). The mean value for GDS-15 was found to be 5.97 ($SD\pm 3.07$), while the comparison of depressive symptoms showed that women, lonely people and the elderly with chronic health problems are more vulnerable to the development of depressive symptoms. In relation to covid-19 and depressive symptoms there was a positive correlation with fifteen factors

($p < .05$), with the most important ones being fear for the health of their family, sleep disorders, the feeling of loneliness and the feeling of not being able to deal with the virus. Regarding social support, the mean value for the social network (SSQ-1) was found at 12 people ($SD \pm 5.26$) and the mean value for perceived social support was at 28.14 (SSQ-2, $SD \pm 2.92$). The comparison of mean values for social support between men and women showed a statistical difference only in terms of the size of the social network, as women appeared to have a larger social network compared to men (Mann-Whitney $U = 3,885,500$, $p = .019$). Finally, a positive statistical correlation emerged between perceived social support and educational level ($r = .150$, $p = .035$), as well as monthly personal income ($r = .181$, $p = .010$).

The research results showed that in the sample the elderly had a moderate level of depression. Compared with an earlier study before the start of the pandemic in Crete on a corresponding sample of seniors from another Municipality, the results of the present study did not show a difference in terms of the average value. In contrast, the mean value for GDS-15 in the present study was twice as high compared with another corresponding study at the beginning of the pandemic on a sample of seniors in an urban setting. It seems, therefore, that the reality of the pandemic affected the depressive symptoms of the elderly in the sample, as seen in the relevant question, where 15 factors emerged out of a total of 24 that were associated with high depressive symptoms. In particular, there is a negative correlation with the question item "I am optimistic about how I will manage", which reflects a low "attitude" in relation to the threat of the pandemic. Moreover, the study showed that people who live alone face a much greater risk of developing depressive symptoms, while regarding the level of social support, both the size of the social network and the perceived social support had low corresponding average values compared to corresponding studies. In addition, the correlations of the study showed that the emotional mood during the pandemic affected the social support (SSQ-2), the physical health and the feeling of fear for the health of other family members (SSQ-1).

DISCUSSION

The overall study results showed moderate depressive symptoms and low social support among the elderly participants from Phaistos, Crete. The COVID-19 pandemic seemed to have negatively affected the mood of the elderly in the sample, as it limited their social contacts, while at the same time it increased their concern on various matters involving their own health and that of their wider family. According to the results, social care and health units should be mobilized and actions should be planned to protect the emotional mood of the elderly, as they appeared to present moderate depressive symptoms and great uncertainty about the future. Acute social isolation, health risks, and other life disruptions caused by the COVID-19 crisis can be stressors, especially for older adults who are at an increased risk of severe morbidity and mortality due to COVID-19 and may need to isolate themselves more intensively than the younger population groups. In this respect, Eastman et al., 2021, report that poor mental health in the elderly associated with the

COVID-19 pandemic may lead to the use of various coping behaviors, including alcohol use. In a sample of 6,548 people, the researchers concluded that one in ten experienced an increase in alcohol consumption during the quarantine period, compared to their usual pre-COVID-19 alcohol consumption. Since the onset of the pandemic mental health symptoms were associated with increased alcohol consumption with the most common being that of depression (Eastman et al., 2021). In another study (González et al., 2020), with a sample of 2,992 seniors, the majority of whom were women with a mean age of 70 years, the results showed that women had higher levels of COVID-19 concern than men. Participants also showed higher levels of anxiety and depression as they were more affected by the situation accompanying the pandemic. Increased levels of anxiety and depression were also seen in older women who had already been diagnosed with a serious health problem. Brooks et al., (2020), conducted a review of various findings in similar events and found that the pandemic and the concomitant quarantine caused a range of negative psychological effects, including symptoms of post-traumatic stress, anger, confusion, fear, anger, pain and anxiety. An important finding of this study was also that many of the older participants reported that they experienced severe insomnia and an uncontrollable anxiety (Brooks et al, 2020).

An important issue raised by Khademi, et al., (2021), in a recent study, was the fear and anxiety of death. People's perception of death is shaped by the death events they see in their environment, the developmental characteristics of the age period and the personal experiences associated with the religious and cultural values they believe in. Thus, during the Covid 19 period, older adults showed increased levels of anxiety due to fear of death. This was largely attributed to the fact that the majority of recorded deaths involved people over the age of 65. The pandemic of COVID-19 increased the need for an even greater number of social support structures. Clearly, in a crisis social support is necessary for the elderly, their families and the professionals providing care and services (Serafini et al., 2020). To that end, the COVID-19 pandemic is a reminder that older people, as a vulnerable group, need to be empowered and supported at every level, especially the emotional level. Negative emotions such as loneliness, social isolation, loneliness-related anxiety and death anxiety have increased significantly in the last year and a half. In this sense, expanding older people's communication networks by improving their individual skills also on the use of technology (new info?) is extremely important for the prevention of the feeling of isolation.

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