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"THE PSYCHOLOGICAL AND SOCIAL IMPACT OF THE COVID-19 PANDEMIC ON THE ELDERLY IN THE COMMUNITY"

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Abstract: Introduction: Societies are aging. In Portugal, the number of elderly people has been rising, which has led to an increase in institutionalization. The Covid-19 pandemic has brought with it a range of challenges that are considered significant at a global level, affecting all aspects of daily life. Compared to other groups in society, older people face increased health risks and a sense of social isolation. Specifically, in Portugal, as in other countries, the elderly have been one of the central themes in both social and health policies. **Objective:** This study puts the onus on the elderly in the community, with the aim of knowing the demographic profiles and gauging the psychological and social impacts resulting from the pandemic experienced, providing insights into how these factors contribute to well-being. **Method:** We opted for a mixed methodology, selecting 16 elderly people from the community, who were given different assessment instruments (GDS, UCLA, Spirituality Scale and Hope State Scale), as well as semi-structured interviews. This made it possible to collect sociodemographic information and thus ensure a more varied wealth of information. **Results:** The findings show that it affected activities of daily living and social relationships, leading to feelings of fear, worry and lack of affection. Faced with adversity, the elderly resorted to spirituality and adaptation as their preferred coping strategies, contributing to the creation of a community project to promote health literacy and concomitantly reduce the loneliness they felt. Emphasizing the importance of quality of life for this vulnerable group.
Keywords: Aging, community-dwelling elderly, Covid-19, coping

The aging process can be considered a continuous, progressive, irreversible, heterogeneous, individual, universal process with the presence of both physical and psychosocial changes (Lima, 2013).

AGING PROCESS

Ageing is a physiological, psychological and social process that is more than just the sum of the years of life, it is holistic, universal, gradual and irreversible. It is therefore a process characterized by transformations that take place throughout the life cycle. At the same time, it is recognized as a cumulative process, compromising the cognitive abilities of the elderly (Paúl & Ribeiro, 2012).

Ageing entails a loss of autonomy and/or functionality (Sousa et al., 2014), and active ageing is therefore a concept that should promote participation, quality of life and safety. The concept presented above covers not only health, but also socio-economic, psychological and environmental factors. There is therefore an urgent need for the community to take responsibility for ensuring quality of life for the elderly.

BIOLOGICAL AGEING

The aging process leads to the appearance of physical changes that begin with the decline of bodily functions, appearing at physical maturity, between the ages of 18 and 22.

With regard to skeletal changes resulting from the ageing process, at a structural level there is a loss of trabecular bone, loss of cortical bone, loss of bone mass, as well as loss of calcium and a lower capacity to produce material for the intrabecular bone, which ends up weakening it. The fibrocartilage becomes drier and thinner, respectively, causing compression of the vertebrae (Salech M. et al., 2012).

In turn, at a physiological level, there is a decrease in height and a more curved posture due to changes within the vertebral discs, more flexed knees, widening of the pelvis and hips, as well as lengthening of the nose and ears due to the continuous growth of cartilage. During the ageing process, there is a decrease in height and a concomitant loss of body balance (Nigram & Knight, 2017c).

The joint changes resulting from the ageing process at a structural level can take the following forms: reduced synovial fluid and thinner cartilage. In this way, and taking into account the structural changes mentioned above, at a physiological level we can find shorter and less flexible ligaments leading to a reduction in range of motion, leading to changes in gait (Salech M. et al., 2012; Nigram & Knight, 2017a).

After a certain age, women undergo hormonal changes due to the menopause. The drop in oestrogen and progesterone production can cause emotional and physical problems. Among the physical ones is osteoporosis, which is characterized by a decrease in bone mass and an increase in bone marrow cavities and spaces, which leads to increased bone fragility and is more susceptible to fracture (Cunha et al., 2007). In men, there is a decrease in testosterone production and they can present physical problems, including osteoporosis, just as in women (Cunha et al., 2007).

According to Osório (2010), alterations to the nervous system at a structural level can include: the loss of neurons in the brain and spinal cord, a reduction in the number of nerve conduction fibers, a decrease in cerebral blood flow, neurochemical losses, a structural decrease in the neocortex, a structural decrease in the hippocampus, a structural decrease in the basal nuclei and a decrease in the total weight of the brain. There a reduction in the cortical layer, a deposition of lipofuscin in nerve cells, as well as amyloid deposition in blood vessels and nerve cells and the appearance of senile plaques (Ciechanowski et al., 2013).

SOCIAL AGEING

According to the WHO (2015), ageing goes beyond biological and psychological processes; it is also a cultural and social process. Old age, as a stage in the life cycle, is characterized by various changes at the most diverse levels of the individual and human experience. It is therefore a period in which there are losses and disconnections, not only on a personal level but also on a social level. When we talk about social roles, we are referring to the set of functions, norms, behaviors and socially and culturally defined rights that a person is expected to fulfill or exercise, taking into account their acquired or attributed social status. As we get older, these roles change, and as we get older, society forces the individual to abandon some of the roles they have played all their lives. This new situation leads to a panoply of social and psychological changes in the individual.

SOCIAL CHANGES

According to the state of the art, there are numerous theories that attempt to explain the psychosocial changes that occur with the ageing process and the origin of these changes.

From the summary in the table below, it is possible to draw the following conclusions: the decrease or absence of social activity does not appear suddenly in older people. It is usual for activity to gradually decrease over time.

As the frequency of social relationships decreases, the value is reinforced and they become more rewarding, in which more time is devoted to strengthening them. It also appears that the quality of any interaction is a more decisive factor than the quantity, respectively.

PSYCHOLOGICAL AGEING

The aging process can be considered a continuous, progressive, irreversible, heterogeneous, individual, universal process with the presence of both physical and psychosocial changes (Lima, 2013).

Taking all these factors into account, according to Paiva (2013), cognitive functions are the greatest achievement that human beings can have, since it is through memory, language, gnosia, praxis, executive function and visual-spatial function that everyone interacts with their peers and the world, in order to find meaning in life.

Memory is characterized by the processing of information and has three stages: encoding, which is the input of information, storage, which consists of the consolidation and maintenance of information in the memory system, and recall, which allows access to and production of information that has already been stored (Charchat & Moreira, 2008). Studies show that there is a decrease in memory performance throughout the ageing process, when it is necessary to perform tasks that require greater efficiency and control mechanisms to support this performance.

The memory difficulties experienced during the ageing process are a complex issue and can be divided into short-term memory1 and long-term memory2. (Paiva, 2013; Park & Festini, 2017)

Linguistic ability is a cognitive function that allows human beings to interact with those around them by simply sharing feelings and information, whether through sounds, signs or gestures. These are maintained with age in phonological, semantic and syntactic knowledge. However, errors in naming tasks increase with age, associated with errors such as the semantic association of naming and location (Paiva, 2013), as shown in the study by Moreno and Adrados (1999), which reported that there is a significant decline in the production of semantic categories as a function of age, i.e. the older the child, the less linguistic ability they have.

Verbal fluency is also influenced by ageing, specifically in the capacity for focused attention, processing speed and speech production speed, respectively. In this way, the elderly person's fluid intelligence and ability to respond quickly gradually decreases. On the other hand, intelligence and prior learning show a slight increase. There is a decline in attention span with increasing age. It is assumed that the elderly are slower to perform many tasks (Paiva, 2013). Studies state that fluid intelligence tends to decrease with the ageing process and is related to physiological and neurological characteristics (Lopes, 2010). As Damasceno (1999) states, normal ageing leaves vocabulary and syntactic processing intact, but alters word recall.

DEMOGRAPHICS - THE CASE OF PORTUGAL

In the specific case of Portugal, due to the sharp drop in the gross fertility rate and the gross reproduction rate in recent years, together with the increase in the mortality rate, the number of elderly people in Portuguese society has risen considerably.

The demographic changes that began in the 19th and 20th centuries and continue into the 21st century are changing the world. The years added to life expectancy and the fall in fertility are causing clear changes in the structure of society as a whole. The consequences of an ageing population bring immense opportunities and challenges for society as a whole.

According to Rosa (2012), the Portuguese population will continue to age and may even do so very intensely, as can be seen in figures 10 and 11, respectively. Even if fertility levels increased slightly and migration balances remained positive, in the future, in 2026, the Portuguese population could still be close to 10 million inhabitants, but it will still be much older than it is today, since:

- The number of people aged 65 and over could be almost triple the number of young people (ageing index 271);
- One in three residents in Portugal (32%) could be aged 65 or over;
- The population aged 80 and over could be equivalent to 1.4 million people.

- people and represent around 13% of the resident population in Portugal;
- The number of working-age people per elderly person, currently one slightly more than three, it could be less than two;
- The working-age population under the age of 40 may decrease, but it will increase,

on the other hand, the number of people in the upper working ages (especially those aged 55 and over).

AGEING IN PLACE

Ageing in Place (Fonseca, 2018) means the ability to continue living at home or in the community over time, safely and independently. Thus, according to the WHO (2015), active ageing is advocated, corresponding not only to the possibility of reaching old age in good health, but also improving Quality of Life. Since, until now, we have been referring to "Healthy Ageing" as the goal to be achieved according to the World Health Organization (2015). *Ageing in Place* means having the health and support you need to live safely and independently, at home or in the community, as you get older (WHO, 2015). This concept presupposes the ability to adapt both the physical and social environment to everyday life, maintaining, as mentioned above, quality of life over time. It therefore reflects the desire to grow old in a familiar environment that adapts to growing physical and/or functional limitations.

Burton et al. (2011) state that, as people get older, they strengthen their emotional and psychological relationships, given their greater vulnerability to the environment around them. This process translates into an environmental adaptation mechanism that requires social, psychological and environmental challenges (Albuquerque et al., 2018).

According to the WHO (2015), ageing in place is not an option, but a necessity given the limitations of the social security system and support services and the consequent shortage of institutional alternatives. The needs assessed with regard to the maintenance and modernization of the housing stock should include updating and infrastructures that present spatial constructive quality and provide comfort in order to guarantee safe and comfortable use, while obeying the accessibility principles previously outlined (Albuquerque et al., 2018).

METHOD

PARTICIPANTS

It can be seen that 68.8% (n=11) of the interviewees are between 65 and 79 years old, the first three age groups. In turn, 31.2% (n=5) were between 80 and 95 years old. The subjects in our sample are spread across six age groups. 25% of the participants were between 65 and 69 years old.

The sample of sixteen individuals, in terms of gender, is made up of 81.3% female and 18.8% male, 56.3% of the sample was married (n=9). This was followed by widowhood, with 37.5%, while 6.3% were divorced.

Analyzing marital status by gender, it can be seen that the distribution is very noticeable, with a predominance of married women and widows, with a frequency of n=6, respectively. In contrast to the information shown above, it can be seen that the male participants (n=3) are married and cohabit with their spouse.

The gender of the participants shows that 9 have between 1 and 11 years of schooling (as opposed to 1 man) and 3 have more than 11 years of schooling.

In terms of higher educational qualifications, it can be seen that they have a degree (n=1). On the other hand, only 1 man has a doctorate.

COLLECTION INSTRUMENTS

SEMI-STRUCTURED INTERVIEW

Based on the object of study and the objectives outlined for this intervention project, an interview script was drawn up. The same script was submitted to two judges in order to ensure content validity, as well as to assess the relevance and appropriateness of its content. The data collection process was carried out using a semi-structured interview, which allows the interviewer to develop each question freely, directing each question in the way that seems most appropriate.

In this way, an interview script was drawn up. This consists of the following units of analysis: 1) sociodemographic characterization of the participants; 2) psychological and social impact of the Covid-19 pandemic on the elderly in the community, which can be divided into the following categories: literacy of the elderly, quality of life, psychological implications, social implications and strategies adopted, respectively.

The interview script for the elderly is divided into themes. The first theme refers to the literacy of the elderly, which includes aspects related to the pathology of Coronavirus, etymology, symptoms and care to be taken in order to reduce these infections. This part of the interview allows us to understand how the knowledge presented by the elderly person affects changes in their lives. The second theme of the interview is related to the impact on quality of life of the pandemic, in which elderly people are forced to make psychological and social changes, as well as their impact on their quality of life.

With regard to the last theme presented, it serves to understand how and what older people resort to when they encounter a stressful moment in their lives.

GERIATRIC DEPRESSION SCALE

The Geriatric Depression Scale (GDS) was developed by Yesavage (1988 cit in. Apóstolo, 2012) as a screening tool for detecting the existence of depression in the elderly, designed as a self-administered scale. To this end, the scale does not include items referring to somatic symptoms or sleep disorders, as these are more frequent in the older population, regardless of the presence or absence of depression. On the other hand, the scale does have items referring to cognitive changes, namely memory changes, which often accompany depression in the older population.The original scale was designed with thirty items to measure depression in people aged 65 and over.

The authors paid particular attention to the wording of the items in an attempt to make them easy to understand and easy to answer for this target population. Hence the choice of a dichotomous response format (yes/no). The scale used in this research was the 15-item version, which was translated, measured and adapted to the Portuguese population by Veríssimo (1988 cit in. Apóstolo, 2012).

LONELINESS SCALE (UCLA)

Ferguson's (1978) UCLA loneliness scale, translated into Portuguese by Neto (1989 cit in. Pocinho, 2010; Fonseca & Medeiros, 2019), is a hetero-administered scale that aims to assess subjective feelings of loneliness or social isolation. The questions asked on the scale are presented in a negative way, in which the elderly person indicates how often they experience feelings of loneliness, on a scale ranging from never (1 point) to often (4 points). This means that the higher the final score, the greater the level of loneliness or social isolation felt by the elderly person. The study adapting this scale to the Portuguese reality was developed by Barroso (2008 cit in. Fonseca & Medeiros, 2019). This scale comprises a total of eighteen items, measured on a four-point multiple-choice scale, from 1- never, 2- rarely,

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3- sometimes and 4- often. Given this range of responses, participants select the answer that best reflects their feelings. It is understood that the higher the final score, the greater the level of loneliness.

SPIRITUALITY SCALE

The Spirituality Scale was developed by Pinto and Pais-Ribeiro (2007) to assess spirituality. It consists of a scale that is quick and easy to administer, made up of five questions that quantify agreement with spirituality. The answers are given on a four-point Likert scale, namely: 1) "don't agree", 2) "agree a little", 3) "agree a lot", 4) "agree completely" (See Appendix IV).

This instrument reflects a positive outlook on life, encompassing characteristics such as: hope, optimism, satisfaction and appreciation of life. The same scale has two sub-scales: Beliefs (referring to the attribution of a meaning or sense to life), visible in questions 1 and 2, respectively, a vertical dimension of spirituality.

The second subscale refers to hope/optimism and consists of three questions (4, 5 and 6), reflecting the horizontal dimension of spirituality. As far as the score is concerned, higher spirituality scores indicate greater agreement with the dimension being assessed.

As Pinto & Pais-Ribeiro (2007) point out, the internal consistency of this instrument was analyzed, as well as the sub-scales belonging to it, namely beliefs and hope, using Cronbach's Alpha, with the following values: 0.92 (beliefs) and 0.69 (hope), giving an overall internal consistency of 0.74.

HOPE SCALE STATE

The State Hope Scale (SHS) is considered to be an instrument for self-assessment of hope, applied to a population of adults (see Appendix III). They conceptualize hope in a dynamic way, reflecting on the importance of cognitions for them to be able to achieve their goals, considering that thinking oriented towards achieving a certain goal is based on two interrelated components, Agency and Pathways. Action (consists of the determination to achieve the goals) and Direction (the strategic plan designed to achieve the goals).

According to Snyder et al. (1991 cit in. Snyder et al., 1996), Hope can be defined as "a cognitive set that is based on reciprocally- derived sense of successful agency (goal - directed- determination) and PathwaIS (Planning to meet goals).

There is a cognitive predisposition towards hope on the part of individuals who are motivated to expend energy on triggering and maintaining the efforts needed to achieve their goals. In this way, individuals who are less hopeful are also less likely to experience success and memorize success sequences in life.

The SHS was created by Synder et al. (1991 cit in. Snyder et al., 1996) and, as previously mentioned, it is an instrument that aims to carry out a self-assessment of dispositional hope. The SHS is made up of 6 positively oriented items, consisting of a Likert scale, in which each item can be classified into eight categories (1= Definetely False; 8= Definetely True), with a minimum score of 6 points and a maximum of 48 points.

Respectively, the items are presented by means of an introduction, stimulating the individual to two specific moments:

1) Briefly reflect on yourself and what is happening in your life at the moment;

2) Once you have defined the present state in which you find yourself (through a self-assessment of life here and now) you will move on to answering the respective scale.

With regard to the version of the scale validated for the Portuguese population, the 6-item version was carried out by Faria (2000), referring to a study carried out in 1997 and 1998. Through the factor analysis carried out by the aforementioned author, two initial factors were obtained, as well as an alpha of 0.78, thus allowing this scale to be applied in the field of psychology research.

PROCEDURES

With regard to the analysis of qualitative data, in order to process the data previously obtained through the interviews, content analysis will be used according to the categories presented in the conceptual map previously presented. In other words, the content of each interview will be explored according to the categories presented.

Firstly, the interviews were recorded, with the prior authorization of the interviewees, and lasted an average of 45 minutes.

This was followed by the full transcription of the interviews with the participants, which was a long and time-consuming process, enabling a meticulous analysis of the information gathered during the interviews.

With regard to the quantitative analysis, the results obtained through the application of the scales were subjected to a set of descriptive statistical operations carried out using the SPSS program (version 26), from which graphs and tables will be drawn up to facilitate a clearer and quicker reading. It should be noted that quantitative analysis was used to complement the information obtained from the qualitative data and to gain a deeper understanding of the impact of the pandemic on the elderly in the community.

PRESENTATION OF RESULTS

When asked what their main concern is at the moment, 25.1% (n= 4) consider the Coronavirus pandemic to be at the forefront of their minds. This was followed by health, which accounted for 18.9% (n= 3). As we are going through a pandemic period, in addition to the concern about the pandemic itself, health is one of the constructs on participants' minds, both from their own perspective and that of their family members.

Like their children and grandchildren, their family also plays a significant role in their concerns (12.5%) and only 12.6% (n=2) say that the pandemic ranks second in their hierarchy of concerns.

From the participants' assertions, that as a result of the pandemic they have experienced, in terms of activities of daily living, they have undergone changes in their routine, as can be seen in the recording units below.

Another category arising from the "Psychological Implications" is "Loneliness", a construct listed in different recording units.

"Affectivity", another category that completes the dimension under analysis "Implications at a psychological level", that one of the negative signs of this pandemic from the point of view of the elderly people participating in this study is the lack of affection, human warmth, or simply the lack of visits from people who were significant to them.

With regard to "Resignation", another category that makes up the Implications dimension at a psychological level,), she is resigned to the adverse and uncertain period we are in, and "...it will only be what God wants", as she herself said.

The table below shows fourteen recording units, in which it is necessary to point out that most of them have led to changes in social relations.

The table below shows that five of the elderly people turn to God to give them the strength to carry on

with your life.

With regard to the Spirituality Scale, it can be seen from the table below that the majority of participants perceive their beliefs as positive (Q1 - 75% fully agree, a result that is also visible in Q2). With regard to the Hope/ Optimism dimension, it should be noted that 100% (n=16) fully agree with the statement "I have learned *to value the little things in life*". It should be noted that in the other two questions, the responses were very positive, as can be seen in the data presented later.

Dimension	Category	Registration Units
Quality of Life	Changes in Daily Activities	"The only thing I do is stay at home and go out as little as possible. It's affected my quality of life. So I spend more time at home than out and about." (E2)
		"Oh what changes, at the same time there are so many, and many activities that I used to do for fun, which I don't do at the moment. For example, I'm in the parish registry office, as you know, and this has changed everything." (E5)
		"It's so complicated. Going to the supermarkets and disinfecting my hands, going home and disinfecting my feet with water and bleach, disinfecting my hands, disinfecting the groceries I bring." (E7)
		"Look, I was always partying, I'd go for coffee, my family would pick me up to go for coffee, but that's it. Coffee had to be at home. In the morning, I'd do my shopping or something very quiet, and in the afternoon, I'd visit people who were ill, so the people at the conference. Then I had meetings to prepare for Faith and Light and conference meetings to take minutes. That didn't happen any more, so what I dedicated myself to at the time was reading, going deeper and deeper with a sense of depth first thing in the morning, starting my life at 11am listening to Mass, not exactly the whole Mass, but listening to the word." (E9)
		"Then I had to limit my freedom to go out a lot. Going out and socializing with friends and family. Yes, definitely." (E14)

Dimension	Category	Registration Units
Psychological implications	Loneliness	"I don't know, I see it so dark, I see it so dark. Everything is so different from what it was. ... I feel a bit alone. "(E3)
		"Yes, it's very complicated. Just being here alone, I spend days not seeing my granddaughters, not seeing my children. It's very complicated. Very lonely. It's like this, I can call my children, but it's really not the same as being with them, them coming here and being with me. Many days I feel very alone and I cry." (E7)
		"I've been suffering a bit because my children haven't been coming to my house since the beginning of the year... I feel lonely, yes, I feel lonely, because I used to go to the neighbors' houses. There are lots of houses here, not everyone has their own area, and I used to go to their houses and now I don't. So we're a bit isolated. So we're a bit more isolated." (E11)
		"Oh yes, sometimes I do... Now when it's rainy and it's raining and I have to be at home, cooped up in the house, you really do feel a bit lonely, but bear with me. I keep my son coming here all the time." (E13)
		"It's totally different. It's not like it used to be, before COVID. We were at ease, we went here and there at ease, it's not like that anymore. I feel like I need more socializing." (E15)

Dimension	Category	Registration Units
Psychological implications	Affectivity	"But to feel human warmth, you don't seem to feel it." (E5)
		"I miss having visitors. I always had a lot of them. I'd love them to come, but people defend themselves, don't they?" (E6)
		"Everything, very complicated. A lot, because it's all very complicated and just having my granddaughters and my children come to my house and me not being able to kiss them and hug them has already affected me a lot." (E7)

Dimension	Category	Registration Units
Social implications	Changes in social relations	"(...) the worst thing is our little grandchildren, who used to be with us every day, and now they're not. It's all running away, all running away. I pick them up on the run, take them to the study room, here or there, but it's all running away and always with masks. No hugs, no kisses. None of that." (E1)
		"No, I'm completely apart from that because I have family in Chamusca and I hardly go to visit them because of the parties." (E2)
		"(...) I talk to my grandchildren, so poor things. I don't give them kisses... Sometimes I give them kisses on the back (Henrique, give me a kiss on the back). In the old days it was on the cheek, not now." (E3)
		"I talk to my grandchildren, so poor things. I don't give them kisses... Sometimes I give them kisses on the back (Henrique, give me a kiss on the back). In the old days it was on the cheek, not now." (E4)
		"The changes I have are that I can't socialize with my family, for example..." ... "It affects not being able to talk at ease, not being able to go and give a hug to a friend who needs it or is distressed." (E5)
		"Look, it's changed. The level of having the house always full as it was... Because they defend themselves," (E6)
		"I go to see my sister at the nursing home, but it's like this, it has to be with a glass and 3 meters of being in the nursing home, and I talk to her, I see her, but I can't have any contact with her, I can't give her a kiss or anything. It's the same with my granddaughters, if they come to my house I put the mask on straight away and I can't give them a kiss or a hug or anything." (E7)
		"They didn't suffer at all. Because I don't have any neighbors either. The only thing I have is my children, that's all. I don't have anything else." (E8)
		"Saturdays and Sundays, which used to be my meeting point for lunches at my house, no longer took place with my immediate family. So it was a total change." (E9)
		"Well, we're practically isolated. Everyone, even family members, I don't know how this is going to be maintained." ... "Neither is socializing, even on a family level, which I think has been more pronounced." (E10)
		"Yes, my children come here, but they don't come into my house. I go outside and stay away from them, we're apart, so we also have to be sensible." ... "The changes that can cause me are my children, not being with my children..." (E11)
		"I'm not going to visit my children and grandchildren who are in Évora and Lisbon." (E12)
		"With my grandchildren, yes, because they've never kissed me, it's from a distance. They come here, but it's from a distance, because it's changed. Well, it's really changed, because they can't reach each other, they have to be one meter apart, now they talk about two meters. And they also wear masks, it's like that, it's different from before COVID." (E13)
		"With my granddaughter, look, I've never kissed her, I hug her back and kiss her neck. That's all I do. I've never kissed her on the cheek or hugged her like that, I'm afraid." (...) "I don't kiss my daughter either, I turn my head like this and my daughter kisses me sometimes on the head and on the back of the neck and so on. And I never gave it to her either. That's the difference I make. I'm scared, I'm scared. You never know if there's something wrong, I'm scared." (E16)

Dimension	Category	Registration Units
Strategies adopted	Spirituality	"I cling to God our Lord, I'm so tired of asking him. This is such a big battle. Such a big, big battle. I don't see it, but I'm always thinking about it. We have to get through this ordeal, but it's hard. Now I watch Mass on TV, say the rosary on the radio or TV and crochet so I don't think about what's happening." (E3)
		"(...) I cling to prayer a lot, I see the rosary every day in Fatima, I pray a lot, I cling to God our Lord a lot and to my little saints that I have a lot of faith in. I pray a lot because that's what we all have to do." (E7)
		"I try to accept it because I think that if all events, even if they're bad, we have to conclude that if we have faith, we're going to get something good out of it. So I just have to accept, your will be done. And this is the world that also deserves God's will." (...) "Shutting myself in my room and praying, never forgetting that for me my Lord and my God, if everyone is against me, is always for me. He is never against me, just as he is never against others. That's what's always waiting for the prodigal son." (E9)
		"Look, I'm not much of a pray-er either, but I ask God, look, I ask God for the courage to take this away from me because there's nothing I can do, I'm the one who has to." (E11)
		"To God to give me strength." (E13)

			Frequency	Percentage	Valid percentage	Cumulative percentage
Beliefs	My spiritual/ religious beliefs give meaning to my life	Little agreement	1	6,3	6,3	6,3
		I agree	3	18,8	18,8	25,0
		I fully agree	12	75,0	75,0	100,0
		Total	16	100,0	100,0	
	My faith and beliefs give me strength in difficult times	I agree	4	25,0	25,0	25,0
		I fully agree	12	75,0	75,0	100,0
		Total	16	100,0	100,0	
Hope/ Optimism	I see the future with hope	Don't agree	3	18,8	18,8	18,8
		Little agreement	6	37,5	37,5	56,3
		I agree	7	43,8	43,8	100,0
		Total	16	100,0	100,0	
	I feel my life has changed for the better	I disagree	1	6,3	6,3	6,3
		Somewhat agree	2	12,5	12,5	18,8
		I agree	13	81,3	81,3	100,0
		Total	16	100,0	100,0	
	I learned to value the little things in life	I fully agree	16	100,0	100,0	100,0

DISCUSSION OF RESULTS

According to the data obtained, in this same study, changes in daily activities are evident in the participants' statements, referring to the inability to lead an independent life within the community in which they live, having worsened during this pandemic period.

The **difficulty of mobility** is also associated with the loss of functionality and the period of confinement required to control the Sars CoV -2 pandemic.

Awareness that health is a resource for the elderly to live a quality life, increasing the critical awareness of people and the community and involving them in choices regarding their own health or that of those around them, is something really pertinent, so that they can achieve their previously defined goals. Increasing quality of life should be seen as a goal for modern society.

The loss of quality in emotional relationships refers to the negative perception of the changes considered important to the elderly person themselves in the emotional relationships associated with ageing. These **changes in social relationships and interactions** had a negative impact on the involvement and participation of the elderly person, due to the simple limitation of relationships with their family, community or social organizations.

The category "Psychological implications" involves nine indicators: view of life, fear, worry, loneliness, affectivity, resignation, sadness and reintegration of life. During the ageing process, the recapitulation of life as well as the approach of death results in a spiritual approach, which puts the meaning of life into perspective as well as death itself (Amaro et al., 2021).

Faced with the pandemic that is ravaging us, **sadness** is another indicator that can be highlighted from the different interviews conducted in order to understand the implications on a psychological level. The sadness felt by the elderly people under study is related to the changes that have had to occur in their daily lives.

As Goiás (2020) discusses in his article, **loneliness** was already a problem before the pandemic emerged. Nowadays, this issue has taken on a new perspective since the majority of the elderly population has had to make certain changes to their daily activities, with the aim of staying at home, in order to try to mitigate the spread of the virus.

There is therefore an urgent need to **reflect** on life itself, especially at this stage of the life cycle, given the proximity of death. This moment can be understood from the quotes below, where the elderly person ends up questioning their own existence, which is not only pertinent to overcoming the various inner crises that exist, but also to developing their personality (Oliveira & Silva, 2013).

Coping strategies differ from person to person, as can be seen from the statements above. Thus, coping strategies can be problem-centered (describing cognitive restructuring, interaction with the environment and help from people), and emotion-centered (adopted when emotion regulation, emotional ventilation is involved). In the Covid-19 pandemic, it can be understood that the most used strategies were problem-centered.

Another strategy adopted by the elderly themselves when faced with adversity **is to value the little things in life**. This strategy is very relevant at this time of trial, as we urgently need to learn to value the simple.

Nevertheless, it can be seen that significant positive correlations were found between Spirituality and Quality of Life. As mentioned, activities as well as spiritual beliefs (namely prayer, trust in God, positive spiritual connections) trigger survival strategies in times of greater distress, leading to more favorable results in terms of Quality of Life, as can be seen in the statements below.

Thematic areas	Categories	Indicators
The psychological and social impact of the Covid - 19 pandemic on elderly people in the community	Older people's literacy	- Knowledge of the disease (E1, E3, E4, E5, E6, E7, E8, E9, E10, E11, E12, E13, E14, E15, E16) - Unfamiliarity with the disease (E2, E9)
	Quality of life	-Changes in daily activities (E2, E5, E7, E9, E14) - Suffering (E11) - Mobility difficulties (E13) - Concern (E16)
	Psychological implications	- Vision of life (E1, E12, E13) - Fear (E1, E3, E5, E8, E12, E13, E15) - Concern (E1, E12, E13, E15, E16) - Loneliness (E3, E7, E11, E13, E15) - Affectivity (E5, E6, E7) - Resignation (E11) - Sadness (E13) -Reintegration of Life (E14) - Reflection (E14, E16)
	Social implications	- Changes in social relationships (E1, E2, E3, E4, E5, E6, E7, E8, E9, E10, E11, E12, E13, E15, E16) - Use of ICT in communication (E4)
	Strategies	- Coping (E1, E4, E5, E6, E7, E12, E15, E16) - Valuing things in life (E2) - Spirituality (E3, E7, E9, E11, E13) - Family support (E8, E10, E14) - Ignoring the problem (E11)

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