Loneliness, COVID-19, and Music: Experiences of Older Adults in a Nursing Home

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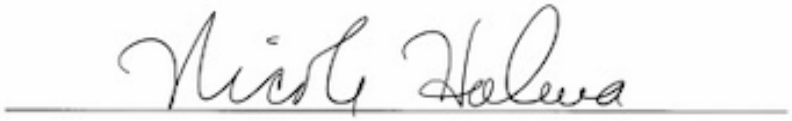

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Abstract

This thesis explores the experiences of older adults during the lockdown due to the COVID-19 pandemic. While this research is about a specific time in history, the information that has been gathered from it is has been relevant for decades. In this study, fifteen individuals residing at a nursing home where I worked, as a music therapist working in the activities department, share their experiences of loneliness during lockdown that resulted from the COVID-19 pandemic. This study was conducted by gathering data both qualitatively and quantitatively. Each participant completed a loneliness scale questionnaire and took part in a semi-structured interview. Questionnaire data were analyzed using descriptive statistics. The interview content was coded using descriptive coding and grouped into themes and analyzed. Themes emerged to coincide with Elisabeth Kübler-Ross's 5 Stages of Grief. These themes were Not Feeling Any Different/Nothing Has Changed, Feelings of Frustration/Feeling Restricted, Wishing Things Were Different, Feelings of Loss, and Feelings of Acceptance, Hope, and Faith. Additionally, a theme centered around the role of music in participants' lives. Discussion of the of the implications of the results of this study, as well as limitations and recommendations for future research were explored.

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I would like to thank Dr. Hadley for being an inspiration to do the work. There is great value in not only the concept of being with someone as a whole person, but also of experiencing them (and yourself) in their wholeness. Your encouragement has helped me to see myself in my wholeness, and others in theirs. Thank you for creating this program.

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To Dobra Tea in Pittsburgh, where I did most of the studying, reading, and writing for my MMT graduate coursework till March of 2020. I promised you a shout out.

To my grandparents in Heaven.

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Introduction

Situating the Research

I became a music therapist in October of 2018, as a nontraditional student. While I also hold a degree in music education, I have always been drawn to working with older adults. As I approach the age of 40, like the older adults I worked with I have accumulated memories, knowledge, preferences, and connections from a number of decades. Yet unlike me, many of the people I worked with experience chronic pain, mobility challenges, and sometimes cognitive challenges. Many times, residents have quipped, “do me a favor – don’t get old.”

In February of 2019 I began working in the activities department of a nursing home. The home is run by a congregation of Catholic nuns. The sisters are dedicated to their mission to welcome needy elderly and serve them with dignity until they are called home to God. The home is one of many like it in the US, with half of the building devoted to skilled nursing care for up to 48 residents, and the other half consisting of apartments for independent living residents.

The residents I worked with live on the nursing home side of the facility. Certified nursing assistants (CNAs) serve residents needing assistance with any combination of activities of daily living such as mobility, eating, toileting, and bathing. Nursing staff assist residents with management of medication and other medical needs. The activities department in which I worked, strives to address cognitive, social, and emotional needs of residents. I aimed to know the resident in their wholeness and tailored activities to their specific preferences. My background in music therapy and music education helped me to learn the residents’ preferred ways of interacting and ways of assisting them to do what they enjoy. I worked at this facility for one year before the lockdown due to the COVID-19 pandemic began in that March of 2020.

The nursing home is comprised of four units, two upstairs and two downstairs, called households. Each resident on a household has their own room with windows and a private bathroom. There are twelve rooms per unit. Six rooms flank either side of the hub of the household, an open common space created to portray a more home-like feel. Each household includes a pantry/kitchen, dining room, and living room. A nurse's station is tucked away nearby so that the living and dining areas are the main focus for the residents in their households. The home is fortunate to have this setup, because I believe it helped the residents to stay safe during this strange time.

A physical therapy gym is down the hall from the second-floor households. Residents receive restorative, physical, and occupational therapy, as well as heat for treatment for pain. There is a chapel located on the first floor. Mass is held every morning at eleven. Sisters, as well as the residents who choose to attend mass, worship here. Also, on the first floor, there is a reception area, where all guests must be buzzed in by the receptionist; a café area for residents, staff, and volunteers; the activities office and activities room; and, a large auditorium with an attached porch overlooking the grounds.

Before what we referred to as the "lockdown" due to the COVID-19 pandemic began, volunteers, family members, and even staff members on their day off would come to church. For residents unable to attend in person, there was a closed-circuit television station (CCTV), so residents could participate in mass from their rooms or households. Residents who were unable to come to the chapel in person for mass and wanted to receive the Host would be delivered holy communion on their household by a sister and a volunteer. In addition to daily mass, rosary was said twice a day. Special masses such as feast days and funerals were celebrated several times a

year. A mass of Christian burial in the home's chapel was performed after the passing of each of the many residents over the years whom had arranged for this to be so.

When the lockdown began, funeral masses stopped; as did communion delivery. The CCTV proved to be an excellent resource for some residents to stay connected to daily mass while social distancing. Volunteers and family no longer were allowed into the chapel or building. Before the lockdown, volunteers were active in participating in daily activities, group outings, and various other jobs in the facility. Bingo was held five times a week – twice in the activities room, three times on various households, and always called by a volunteer. In addition to the caller, at least two other volunteers helped residents with their cards, gave out prizes, and escorted residents to and from the activity. Volunteers also helped escort residents and distribute cookies and milk for a monthly "Tunes with Tots" intergenerational music program held in the activity room. The activity department counted on the help of volunteers for outings, to escort residents to vehicles, assist residents with transportation, meals, other needs such as counting money, carrying shopping bags, and getting to the restroom.

Residents who wanted to participate in monthly outings were escorted to dine out at local restaurants, shop at a large chain store or the local mall. During special seasonal outings, residents traveled to our city's local flower conservatory in the spring, to the community park for a picnic in the early summer, and went on a riverboat luncheon and tour in late summer. They enjoyed a baseball game in early fall, and bundled up in the winter to board the facility bus and take in a Christmas light display while adding a stop for hot cocoa. We even went to our local amusement park in the summer just to ride the train, eat lunch, and experience the thrill of the park. When residents have something to look forward to, it enhances their mental health (Morley et al., 2021).

Gatherings and parties were always important to the sisters who run the home, as they believe it brings joy and companionship to the residents. The facility is fortunate to have an auditorium for many of the gatherings. This was often where I saw residents from the independent living apartments and nursing home residents co-mingle. Our biggest programs were for Mardi Gras, St. Patrick's Day, and Christmas. The ukulele club and chime choir would perform and everyone was encouraged to sing. Family members and volunteers attended. Staff members watched in person or on CCTV from their households and remarked to performing residents, "I saw you in the auditorium on the TV!"

We were practicing for the St. Patrick's Day play when we first heard rumors of the Coronavirus coming to the United States and to our region. Mardi Gras had just taken place a couple weeks before, and with the limited amount of outings in winter, excitement was starting to build for the next auditorium event. It was my second St. Patrick's day at the nursing home and I had written the play for that year. We finished rehearsal for the day and agreed to have one more practice before the St. Patrick's Day performance. The next day I was facilitating horse races. Residents enjoyed participating in this activity two to four Fridays a month. Nursing home residents would be escorted to one household's living room, in the same way that many activities such as sing-alongs, hymn sings, trivia, table-bowling, bingo, and word games would often take place. A tape of horse races was played on TV and residents picked their favorites in each race. The horse races provided friendly competition, reminiscing, and socialization. During this activity, I got a call from the assistant director of nursing. She said, "No residents are to leave their units, we are on lockdown." I told her that I would help the residents back to their households calmly after the next race and cancel that afternoon's activities. "Does this mean no

one can go to church?" I asked. That was a tender subject to many, but the answer for that day, the next two weeks, and longer was, "Yes."

I remember that day helping residents who usually participated in mass to tune in on CCTV. I remember that my biggest concern was keeping people safe, which I knew the nursing staff would be on top of, and my next biggest concern was fighting boredom. I found four shallow storage bins from the rummage room in the basement and filled them with playing cards, crayons and colored pencils, coloring pages, word searches, magazines, large print books, puzzles, and DVD's. I took a box to each household with a note attached to it explaining what was in the box and suggested to staff that if residents were bored, these activities could be done with the staff members or independently. My hope was that we could promote engagement with other people on the individual households, even within restrictions of the lockdown.

To minimize cross contamination, the activity director, the activity aide, and I each took one household to work with as our primary "home base." On the household where I primarily was, by request we said the rosary every morning after either music, book club, or exercise. In the afternoons, I facilitated bingo and residents kept and cleaned their own cards for the next time. Or we played musical baseball, or I spent time with residents individually, in between making video calls and eventually social distance visits with friends and family. We went outside on the household's porch every time the weather was nice enough to do so. We painted rocks and canvases. We planted seeds and cared for plants. It was meaningful, but strange.

The atmosphere of the home changed. Masked staff struggled to speak with residents with poor hearing. All staff members had to enter through the front doors with temperature checks, use of hand sanitizer, answering the questions about if we had COVID-19 symptoms, and the date and time of entry. All rooms were cleaned and disinfected after every use. We were

extra concerned because of how deadly we were being told the virus was for elderly people in nursing homes. We focused on keeping things as normal as possible for the residents. Routine is important to older adults and especially individuals living with dementia (Zisberg et al., 2010). At first, we believed this would be for just two weeks. We worked diligently to keep the residents safe, engaged, and on as regular of a routine as possible. The lockdown, and dealing with working within it, has continued for more than a year at the time of this research.

During that time, the staff was spread thin with responsibilities. The home was no longer buzzing with activity, yet the workers were busier than ever. We quickly found out how much we had relied on the companionship of the volunteers and families. The staff call-offs, which had been happening for years, continued as usual. A situation like that meant there was just one CNA working per household, when there were usually two, caring for all 12 household residents.

In an effort to connect residents with family members, the activity department immediately reached out to family members about video calls. Schedules were made for each household: when the call would take place, who the call was with, and the preferred app over which the call would be made. Some children or loved ones of residents had to make arrangements with younger friends and family who had smart phones and devices that permitted video connection. Some families said they would like to do this, but did not have smart phones or the technological knowledge to do this.

We were fortunate to have iPads donated to each household. The responsibility of dialing the family and connecting the resident to their family was on the activity department. CNAs and nursing staff were encouraged to call resident families. Most staff would assist with these calls. Often, they were unable to do so as they were assisting another resident, were unfamiliar with the technology, or did not want to learn how to do so. A few residents were given the iPad and then

some privacy to speak with their family, as they could manage without supervision. They would ring their call bell and wait to be assisted to disconnect the call, and then the iPad could be charged or used by another resident. For some residents, physical limitations with vision or hearing or cognitive capability proved to be a challenge to have a meaningful connection through technology with family. Along with some other staff members, I helped to facilitate connection in these situations, such as when a non-speaking resident was connecting by iPad with their family. My role as a music therapist working in an activities department shifted to a facilitator of connecting families.

By Mother's Day of 2020, about six weeks into the lockdown, it became more than apparent that the nursing home and entire facility was not opening up any time soon. Arrangements were made for family members to schedule times to meet residents at one of the four windows at street level off of the auditorium porch. The windows were far enough apart that the family outside and the residents inside were socially distanced. Residents wore masks, visitors outside wore masks. Telephones and headphones were provided to the residents inside, and loved ones outside used their cell phones to communicate through the window. Visits were limited to one hour and the spaces, inside and outside, were disinfected before and after each visit.

The summer brought hours of facilitating visits outside on the porch, six feet apart, reminding people to cover their noses and mouths with masks. Phones were provided to residents so that the loved one could call from their cell phones communicate across the six foot table. This still proved to be challenging for, and between, those with hearing limitations, soft speaking voices, and dementia. Some residents became upset when they did not understand why their loved one was not coming in for lunch or taking them out for a ride as they so often did before.

While some of the restrictions eased when vaccines had been administered, they continued and returned with positive COVID tests, and were never fully lifted at the time of this writing.

For the duration of the lockdown due to the pandemic, residents and staff have all been holding onto hope of going out on outings, having musical performances in the auditorium, welcoming back loved ones – especially children, reuniting with volunteers, allowing for co-mingling between the apartment residents and nursing home residents, and gathering all four households together for activities inside and outside the facility. Because of the nature of a nursing home facility, depression due to loneliness is inherent (Harper Ice, 2002). These activities and events add hope and life to the lives of the elderly residents, and staff who support them. As I noticed and was contemplating the impact of the COVID-19 lockdown on the daily lives of the residents, I began to wonder whether this had an impact on their experiences of loneliness. I also wondered how older adults perceive the role that music has played in their lives during this unique time. I decided to conduct a study exploring this.

Literature Review

Older Adults and Loneliness

Whether one chooses to be alone or is alone due to circumstances beyond their control, the human relationship to loneliness is something that everyone is capable of experiencing. Social isolation may also be a choice or become forced due to a situation. Smith et al. (2020) defined social isolation as "the 'relative absence of social relationships.' It is an objective measure that describes a physical separation from people" (p. 2). While loneliness and social isolation are different concepts, they are often sited together, although differentiated, throughout the available literature. Dykstra (2009) defines social isolation as an objective condition of not having ties with others, and loneliness as a subjective and negative experience. One does not

have to be socially isolated to feel lonely, and one does not necessarily feel lonely when socially isolated.

The experience of loneliness could happen to a person of any age. The tendency toward loneliness becomes more prevalent as one advances in age. Loneliness is especially prevalent for older adults over the age of 80, of whom 40 to 50 percent report that they are "often" lonely (Dykstra, 2009). As one ages, various types of losses may be experienced by an older adult such as: death of a spouse, companions, friends and other family members; separation from a familiar home; the decline in degrees of sight, hearing, and mobility; and possibly a reduction in feeling joy.

Barg et al. (2006) conducted a study on depression in multiple phases. In an initial phase, loneliness was a salient theme, prominently given by respondents of the study as a component in their view of depression. When asked to describe a depressed person, non-depressed participants responded "lonely" most frequently. Additionally, depressed persons in the study tended to provide social isolation as the cause of their depression. This complication provoked a conclusion that "clinicians need to recognize that loneliness may be a manifestation of a depression, and not merely a precursor" (Barg et al., 2006, p. 337).

Wherever loneliness may stem from, it could manifest physical effects in the body. Social relationships play an important role in the health outcomes of older adults. In addition, "the quality of our interactions with others have profound effect on our psychological, behavioral, and physiological functioning" (Seeman, 2000, p. 367). Negative physical effects of loneliness have shown to include high blood pressure, cardiovascular disease, disability, cognitive decline, and depression (Gerst-Emerson & Jayawardhana, 2015). Similar to the research on obesity and health effects several decades ago, the risk of negative health outcomes are trending upward into the

future (Holt-Lunstad et al., 2015). In a study about the relationship between loneliness and functional decline, Perissinotto et al. (2012) found that loneliness persisted not only as an aspect of functional decline, but also occurred in conjunction with a large number of confounding conditions such as severe illness and depression.

Loneliness has a mortality risk "comparable to well-established risk factors such as cigarette smoking and even exceeding the influence of physical activity and obesity" (Gerst-Emerson & Jayawardhana, 2015, p. 1013). Though it is less acknowledged, loneliness has been found to be a risk for premature death. Holt-Lunstad et al. (2015) found that "individuals lacking social connections (both objective and subjective social isolation) are at risk for premature mortality" (p. 235). In addition to functional decline, Perissinotto et al. (2012) found that the association between loneliness and death was strong.

The social well-being of older adults may not have received as much attention as medical issues, but the impact of their loneliness on society is prevalent. Holt-Lunstad et al. (2015) noted that, "researchers have predicted that loneliness will reach epidemic proportions by 2030 unless action is taken" (p. 236). The effects of older adults experiencing loneliness could be felt not only by the person experiencing loneliness, but also by those whom with they come into contact. For example, Gerst-Emerson & Jayawardhana (2015) conducted a study to determine if loneliness is associated with a higher utilization of healthcare. They found that older adults visited physicians for not only medical reasons, but also to meet their own personal needs of socialization.

For decades, nursing homes have been aiming to meet the medical care needs of older adults. As older adults age, it may be increasingly difficult for them to be motivated or physically able to set themselves up for physical and psychosocial activities of their choosing (for example,

sitting at the piano, baking, or knitting). In addition to the nursing home environment meeting physical needs, quality of life was brought to the forefront in 1987 by an act of congress. Referencing this act of congress, Harper Ice (2002) noted the "nursing home reform act section of the Omnibus Budget Reconciliation Act of 1987 (OBRA '87) addressed the quality of life of nursing home residents" (p. 347). This may have given way to activity departments creating activities which are specific to an individual resident's preferences, as well as therapeutic goals.

Paque et al., (2018) interviewed 11 residents between the ages of 74-92 who lived among three Dutch nursing homes. They concluded that experiencing loneliness was strongly associated with losing self-determination or autonomy as a result of institutionalization. Similarly, 22 residents in two care homes in Australia were interviewed through a socioeconomic lens. In their study, Barbosa Neves et. al (2019) found,

> On the one hand, professional staff meant adequate care and new social ties; on the other, living in a care home meant missing out on regular contact with relatives and friends, dependency, routinization, and a compromised sense of self and identity (p. 81).

The prospect of older adults' use of technology to enhance their wellbeing is known as "gerontechnology." It has become prominent in literature pertaining to older adults and is especially tied in to the relief of social isolation and loneliness. There is a significant push to get the elderly to use technology in ways that younger people do. Haufe et al. (2016), stated that government agencies for health and welfare around the world, "have been encouraged by the World Health Organization to adopt policies to make living places more age friendly. Within this policy framework, the promotion of gerontechnology has become increasingly important" (p. 2).

Even before the lock down due to the pandemic, Hasan and Linger (2016) created a study which explored the possibility of reconnecting older adults to their family, friends, and

community to improve wellbeing through various types of information technology. Reasoning that few elderly citizens have the capability to stay connected through technology, researchers sought to connect friends and family and "improve their social wellbeing and enable them to remain productive members of society" (Hasan & Linger, 2016, p. 754). Use of devices and participation in lessons were provided to 30 individuals in two agreeing nursing homes. After discussions and meetings to collect data, the researchers identified a set of themes which included connection, self-worth and personal development, productivity, occupation (of time), self-sufficiency, being in control, and enjoyment. How much more important and relevant are these themes through gerontechnology now, in the time of COVID-19 isolations and precautions. In research connecting older adults to school students through Skype, Zamir et al. (2021) found that video calls with students increased socialization for older people. However, the support and assistance of dedicated care staff to facilitate the calls was needed in order to be successful. The availability of staff to complete calls can vary. Technology equipment has been important, but it is the assistance from staff that has played an essential role in connecting families during a time of isolation.

Music Therapy and Older Adults

Music therapy research has explored various topics that focus on older adults. Many studies (Astuti et al., 2019; Biasutti & Mangiacotti, 2017; Chu et al., 2014; Gök Uger et al, 2016) are randomized control trials, having taken place in a medical setting, and measured some type of increase or decrease in what is being studied in the mind or body. Rhythmic imitation exercises along with vocal improvisation were shown to improve cognitive functioning in an experimental group of 18 older adults, and show no change in the control group of 17 older adults (Biasutti & Mangiacotti, 2017). A decrease in systolic blood pressure was demonstrated

by participants after receiving music therapy sessions in 8- and 10 -week studies. (Astuti et al., 2019; Gök Ugur et al., 2016). Group music therapy impacted a randomly assigned group from 104 older adults with dementia who were found to have improvement of depression symptoms and delay of cognitive decline over 12 weeks of 30 minute music therapy sessions (Chu et al., 2014).

There are also qualitative and mixed methods studies that seek to find meaningfulness in music for older adults. Hays & Minichiello (2005) sought to study the personal aspects for older adults regarding the meaning of music. In-depth interviews that placed emphasis on the life experiences of participants were held with 52 individuals between the ages of 60 and 98. Themes of identity and understanding of self, connection, well-being, emotions, and motivation emerged. Their findings included that "music helped people to initiate movement in their mental states and cue them towards feeling more positive about life" (p.445). In research that was more specifically focused on spiritual care and older adults living with dementia, Kirkland et al. (2014) created a mixed methods study. They found that weekly gatherings by older adults in a program of spiritual music yielded a positive social impact, especially in relationships with others. Along with this was a significant and sustaining contribution to personhood and hope.

Psycho-social needs and aspects can be reached through music therapy. The positive effects of the impact of group therapeutic singing in a Parkinson's choir were found to include fellowship and engagement (Stegemöller, 2018). Similarly, group singing led by a music therapist as a non-pharmological intervention was shown to be the only type of intervention out of television watching, music listening, and the group singing, that led to significant improvement in quality of life (Cho, 2018). Music therapy with older adults has demonstrated an effectiveness in the management of depression symptoms, and in decreasing anxiety levels

(Onieva-Zafra et al., 2018; Verrusio et al., 2014). Given that loneliness is often accompanied with depression, these findings regarding the positive impacts of music therapy are relevant to the present study.

Music Therapy, Older Adults, and Loneliness

In the music therapy literature, there has been a substantial amount of research with older adults in nursing homes. More specifically addressing older adults and loneliness, Creech et al. (2013) stated that music provides social cohesion, is spiritually refreshing, and is empowering. In the context of active group music making, powerful enhancements of health and well-being for older adults took place. Music was shown to provide senses of belonging, of being valued, of benefitting from a routine, and opportunities for self-expression (p. 88). Compared to others participating in non-music making activities, those who participated in active music making were found to have more positive responses, especially in community contexts (Creech et al., 2013, p. 90).

Group music therapy learning provides opportunities to socialize. "Music learning also appears to have the potential for facilitating new social interactions beyond the immediate music learning context" (Perkins & Williamon, 2014, p. 560). Use of familiar and preferred music, especially from their teenage and early adult years, has been used with music therapists to reduce anxiety and provide a channel for communication in older adults with dementia. Sung et al. (2012) explored an individualized music intervention for agitation theory, which hypothesized that when music therapy experiences presented pieces that matched chosen preferences, groups of older adults with dementia could experience a reduction in anxiety and agitation. An experimental group received 2 music therapy sessions per week for 6 weeks that consisted of 5 minutes of breathing warm-ups, 20 minutes of active participation with percussion instruments,

and 5 minutes of stretching to cool-down. A control group received usual care with no music therapy. They concluded that group music therapy has the potential to reduce anxiety and improve well-being (p. 626).

Reducing anxiety and agitation through social connections are important to the well-being of older adults and those who are caring for them. Technology in music therapy has been utilized with younger aged groups, and is becoming more frequently explored to support older adults in staying socially connected. In 2015, Engelbrecht and Shoemark studied the acceptability of iPads in music therapy to support wellbeing. They postured that, "It seems inevitable that technology will be incorporated into music therapy sessions alongside traditional methods, thus mindful development will ensure the safety and success for our older adults" (p. 67). It is important to note that both of the female participants, ages 83 and 97 in their study had a desire to learn to use the iPad for music apps, which contributed to success. Video music therapy (VMT) has also been researched with positive results, but only for older adults with mild to moderate dementia. For those with early stage dementia, the data on video music therapy suggest that it can "increase contact with other people (friends, caregivers, and other patients), improve communications and contribute to individuals' ability to interact socially." (Rubbi et al., 2016, p. 34).

Older Adults and COVID-19

The COVID-19 pandemic began for the United States in early 2020. "By March 17, the outbreak had expanded from several isolated clusters in Washington, New York, and California to all 50 states and the District of Columbia" (Omer et al., 2020, p. 1767). Emphasis was placed on the vulnerability and fragility of older adults. "The COVID-19 coronavirus pandemic is the main global health disaster of our time. Older people are more susceptible to COVID-19

infection, caused by a defective immune response to infectious challenges" (Benksim et al., 2020, p. 122). The importance of protecting older adults from loneliness and social isolation seemed to take a back seat to the effort to keep older adults alive. Describing this time, Dahlberg (2021) states:

> In order to minimize the spread of COVID-19, many countries have enforced restrictions on physical social contacts, ranging from recommendations to keep a physical distance from others to lockdowns of communities and even whole societies. Older adults have been identified as being at higher risk of poor outcomes if infected and in many countries have been subjected to greater restrictions on their physical contacts with others. (p. 1161)

Core principles of COVID-19 infection prevention were provided for individuals in nursing homes to follow. These included putting into practice hand hygiene, face coverings or a mask covering mouth and nose, screening of those entering and in facility, cleaning and disinfecting surfaces, restriction of visitors, social distancing at least six feet between persons, cancellation of communal dining, and cancellation of group activities (Center for Medicare and Medicaid Services, 2020).

By March 8, 2021, twelve months later, the Worldometer measurement tool (2021) indicated that 7,314,083 United States citizens were infected with COVID-19 and 544,076 individuals had died from COVID-19. Of the 544,076 deaths, a clear number was not available on the number of deaths of older adults. In state data, older adults in nursing home COVID-19 deaths were lumped with staff worker deaths. According to Long Term Care Tracker (2021) website there is no federal dataset about the impact of COVID-19 on older adults nor uniform method for states to report standardized data:

> Some states report cumulative cases and deaths, while others report only current outbreaks. Every state defines an outbreak in a different way. Despite these variations, we've done our best to represent the scale and scope of the pandemic within these communities. (Long Term Care COVID Tracker, 2021)

However, also according to the Long Term Care COVID Tracker:

> Using state and federal data, we can estimate that as of March 2021: About 8% of people who live in US long-term-care facilities have died of COVID-19—nearly 1 in 12. For nursing homes alone, the figure is nearly 1 in 10. (Long Term Care COVID Tracker, 2021)

Older adults are most certainly a population that is disproportionately affected by the COVID-19 pandemic. According to The Heritage Foundation (2021), drawing from data from the Center for Disease Control, COVID-19 is deadliest among older populations. They state on their website, "In fact, through February 17, 93 percent of COVID-19 deaths nationwide have occurred among those ages 55 or older. Only 0.2 percent were younger than 25. This trend can also be found on the state level."

A considerable amount of research on older adults and the COVID-19 pandemic has been published in the last year. This research included the joys and stresses of the COVID-19 pandemic, addressing mental and physical well-being, the use of technology, and the paradox of social distancing with a population vulnerable to loneliness. A study which conducted an online survey with 825 older adults (Whitehead & Torossian, 2020) explored the stresses and joys of the pandemic. The researchers noted,

> Sources of stress tended to reflect specific aspects of the COVID-19 experience, such as worry about the future, restrictions, and social isolation; sources of joy, on the other hand, tended to be resources, relationships, or activities that pre-dated the pandemic (p. 44).

Krendl & Perry (2020) conducted a study on the impact of sheltering in place on older adults' social and mental well-being. When 93 older adults were surveyed by telephone, they answered questions about their social network and closeness, if their social life has been negatively affected by COVID-19, the eight-item Patient Health Questionnaire, and the three-item UCLA Loneliness Scale. The researchers found,

> The majority of older adults 79% (*n* = 69) said their social life had decreased/ been negatively affected by COVID-19 and more than two thirds 69% (n = 60) reported spending somewhat or much less time with people they cared about. However, 60.9% (n = 53) reported spending somewhat much more time reconnecting or catching up with people they cared about, and 78.2% (n = 68) were using some form of internet technology to keep in touch during the pandemic. (p. 55)

A significant amount of research focused on technology, connectedness, and well-being of older adults in regard to COVID-19. According to Smith et al. (2020), older adults already experiencing social isolation and loneliness before social distancing was put into place were at greater risk for limited connectedness (p. 3). While technology reduces isolation, for older adults it requires support from others in close physical proximity to use it. Speaking to this, Smith et al. (2020) wrote,

> While obviously helpful to prevent exposure to the spread of COVID-19, limited physical interactions with others directly softens (or negates) ongoing efforts to reduce social

> isolation and improve connectivity among older adults. Herein lies the basis of the COVID-19 Social Connectivity Paradox. (p. 2)

Increased risk for one factor diminishes the risk for another, and vice versa.

Seifert et al. (2020) stated physical or cognitive limitations may prevent some older adults in long term care facilities from being able to utilize and navigate technology on their own. Assistance from staff would be needed to operate technology and successfully connect to others. Furthermore, focusing on digital events only, could potentially perpetuate ageism (p. 100). The literature on older adults and technology held additional cautionary factors for becoming reliant on technology during the pandemic. Kotwal et al. (2021) warned against

> an overreliance on technology-based solutions for facilitating medical or social interactions because these may not be inclusive of many older adults with limited comfort access to these options. In these circumstances, clinicians may need to take the lead on making exceptions to allow in-person interactions for older adults. (p. 27)

Berg-Weger & Morely (2020) posit that "In the future, we may see more social worker interactions carried through digital connections along with increasing use of "Alexa" and a variety of health robots to help alleviate loneliness" (p. 457). However, Kotwal et al. (2021) make an important point that "it is important to access who the interventions aim to serve, who may be left out, and how to address these gaps" (p. 28).

The review of literature I have compiled will probably already have been substantially expanded. New studies about COVID-19's medical and societal effect on older adults continue to be published. A few additional relevant topics include immunological implications of physical inactivity (Damiot et al., 2020; Sepúlveda-Loyola et al., 2020), reduction in levels of social

support (Giebel et al., 2020) and violence against older adults in Brazil (Leite de Moraes et al., 2020).

Older Adults, COVID-19, and Loneliness

It has long been established that the number of older adults experiencing loneliness is an issue (Holt-Lunstad et al., 2015; Harper Ice, 2002). Politicians have spoken out about this. "By 2017, calling it a 'loneliness epidemic', US Surgeon General Vivek Murthy proclaimed loneliness and social isolation among the world's older adult population was a global pandemic" (Berg-Weger & Morley, 2020 p. 456). Older adults in long term care faced additional burdens during the COVID-19 pandemic. The prevalence of use of technology for connection and communication during the lockdown has been discussed above. "Despite the positive digital participation outcomes for people worldwide during the COVID-19 pandemic, older adults risk feeling doubly excluded, first from physical contact and second by digital exclusion from a digitally dominated society" (Seifert et al., 2020, p. 100). In a study that examined open-ended responses directly from 151 community-dwelling older adults in the San Francisco Bay Area during the lockdown, "several participants reported successful use of technology to sustain connections with community activities and loved ones, and that their relationships with technology changed during the pandemic as more services and interactions moved online or they were provided help" (Kotwal et al., 2021 p. 24). However, it was found that participants in that same study had difficulty accessing and interacting with smart technology. Additionally, this study concluded that to meet the unmet relationship needs of those experiencing persistent loneliness, additional steps would be needed.

Telephone contact has also been found to be an important factor in reducing the experience of isolation for older adults. Arpino et al. (2020) studied older adults in France, Italy,

and Spain to find out if those who increased or maintained the amount of non-coresident, individuals with whom they were in non-physical (via telephone or mobile phone) contact with led to a lower risk of perceived depressed feelings. “Comparing those who increased nonphysical contacts with older people who did not change their frequency, our analyses indicate that those who maintained their level of nonphysical contacts have suffered less in terms of increased perceived depressive feelings” (Arpino et al., 2020 p.184).

The importance of interpersonal relationships for older adults, especially in nursing homes, is discussed by Sepúlveda-Loyola et al. (2020). They state:

> As a preventative measure during the COVID-19 pandemic, community organizations have closed. Old people are constrained from visits with family members, therefore the social participation have been restricted. Thus, the decreasing of social interaction produced by social distancing could have a negative impact on mental and physical health in older people, since it has limited the social participation in community organizations and family activities. (p. 1)

During the pandemic, in order to limit the spread of infection, interaction with professionals was more limited. This has been found to have a negative effect on older adults. In a study by van Tilburg (2020) well known risk factors for loneliness in 404 older adults aged 74-96 were studied to see if these limitations led to further increases in loneliness. They found that loneliness did increase for almost all older people in the study. They noted that, “Various personal losses and non-fulfilled need for (professional) support were associated with increased social and emotional loneliness and mental health problems” (p. 5).

Music Therapy and COVID-19

At the time of this publication, several topics about music therapy and COVID-19 have been covered. In order to frame the scope of ideas being studied, a few examples were mentioned here. Mina (2021) explored the use of community music therapy in an emergency homeless shelter serving mostly Black, Indigenous and People of Color (BIPOC), Negrete (2020) examined the effect of interactive parent-child virtual music therapy classes to provide developmental support and connectedness in a neonatal intensive care unit (NICU), Knott and Block (2020) explored the development of virtual music therapy services to best meet patient/client needs, Mastnak (2020) explored expected child mental health outcomes and music therapy's rectification of them, Giordano et al. (2020) explored the effectiveness of clinical staff receiving music therapy while working with COVID-19 patients in an emergency situation, and Cabedo-Mas et al. (2021) explored ways in which Spanish citizens used music (listening, singing, dancing, playing instruments, to relax, to escape, to enhance mood, to keep company) during the lockdown period. Research through two surveys included a qualitative and quantitative survey for Neurological Music Therapy (NMT) clinicians providing telehealth (Cole et al., 2021), and a survey on the impact on employment, service delivery, stress and hope for music therapists in the United States (Gaddy et al., 2020). In another use of the creative arts, more generally, Gupta (2020) provided an art therapist's account of continued expression and connection through the arts during a time of extreme social distancing.

Music Therapy, COVID-19, and Older Adults

Two music therapy research studies about older adults and COVID-19 were published at the time of this writing. Molyneux et al. (2020) had been facilitating a choir for several years for people with dementia and their caregivers in the UK. When the lockdown due to the pandemic

began, they moved online. They describe that, "the project began in 2017. Therefore, a significant investment in relationships and a strong sense of belonging already existed and had been expressed in the project evaluations and focus group meetings" (p. 7). They went on to say that this research was, "an opportunity to share the team's experience of adapting the project to offer online sessions in response to the impact of the global COVID-19 pandemic" (p. 2). Weekly sessions, held on their usual day, brought a stability in a time of uncertainty. Technology brought limits. They said, "With online delivery, the opportunities for musically rich group improvisations are limited as the technology does not allow groups to play or sing together synchronously" (p. 9). However, the therapists were creative and used this experience to imagine what it was like to be on the other side of the screen, or not joining at all.

> For some, it may be that they do not have the capacity to learn the new technology required to access the sessions or may not have the necessary equipment. Offering technical support, including individual opportunities to trial the online technology, has resulted in some participants joining the sessions. For other participants, the emotional impact of not being able to continue to meet in-person informed their decision to not join the online sessions. (p. 10)

Implications offered by the researchers of this project due to the unique platform included:

> Accessibility for participants beyond the time they are able to physically attend sessions in the community, an online bank of recorded resources, increased connection with guest musicians, and the possibility of live-streaming sharing events to increase access to those unable to join in-person. (Molyneux et al., 2021, p. 15)

Another similar resource, a 6-episode television program, was created by a music therapy intern for their internship site during the lockdown (Wong, 2021). Wong stated that it

"was designed and produced for isolated older adults in need of mental and emotional support" (p. 2). Wong went on to say that because "In the context of the pandemic, the older adults in long term care facilities comprise a community of persons experiencing social exclusion and isolation to a degree" and because "varying forms of participation, including virtual, are required to maintain community engagement" (pp. 14-15), this research was conducted. The television program, which included music for older adults, games, and discussions centered around themes was effective in decreasing loneliness in residents at the facility where it aired. However, "Although residents received fliers informing them of the television show, many did not seem aware of it. Those who did know about it either did not have enough interest to watch it or did not have the necessary knowledge to know how to access it" (Wong, 2020, p. 31).

Music Therapy, COVID-19, Older Adults, and Loneliness

While the Molyneaux et al. (2020) and Wong (2021) studies did briefly touch upon social aspects such as loneliness and isolation, there is a need to hear directly from older adults about their experiences. This study examined the COVID-19 pandemic with older adults, studied their experiences of loneliness, and placed attention to how music played a role at this time. A recent National Academy of Sciences, Engineering, and Medicine report (2020) concludes that one of the major aspects of the current overall evidence base regarding older adults, social isolation, and loneliness is "to target research to major gaps" (p. 219). My study is the first known study to explore music therapy, COVID-19, older adults in nursing homes, and loneliness.

This research added to the decades long understanding that there is a high prevalence of loneliness experienced by older adults (Holt-Lunstad et al., 2015; Harper Ice, 2002). COVID-19 magnified these concerns. While the literature highlighted that isolating older adults from others was said to be necessary for health, a paradoxical impact was faced concerning wellbeing (Smith

et al., 2020; Krendl & Perry, 2020; Kotwal et al., 2021). There is limited research on music therapy and older adults to address loneliness and the needs expressed directly by older adults. Given the need to address loneliness during COVID-19, the purpose of this study was to directly hear about the experiences of older adults in one nursing home during the time of lockdown due to COVID-19. The aim was to explore how isolation and resulting feelings of loneliness have effected participants as individuals, and what has been provided at their skilled nursing long term care facility in order to help to alleviate feelings of loneliness. Additionally this study examined whether music has played a role in reducing feelings of isolation and loneliness since the lockdown due to the pandemic began. The main research question in this study was, in what ways do older adults in a nursing home experience isolation and feelings of loneliness during the time of lockdown due to COVID-19? A sub-question was, in what ways did music play a role for study participants during this time?

Method

Theoretical Framework

Convergent parallel design is a mixed methods research design which analyzes and combines qualitative and quantitative data in order to see the ways in which the data converge or diverge. Burns & Masko (2016) described the convergent parallel design more specifically. "This design involves collecting quantitative and qualitative simultaneously, analyzing each strand separately, and merging the two data sets for final interpretation. Each strand is independent and equal in priority" (p. 602). There have been a few music therapy studies that use convergent parallel mixed methods design (Fredenburg & Silverman, 2014; Rickson et al., 2016; Verstegen, 2016). Creswell & Creswell (2018)'s description of this type of research further informed the methodology of this study as an examination of outcomes through the lens of

intent. Outcomes are "shaped by the intention behind including and integrating both qualitative and quantitative data" (p. 236). I chose to examine both qualitative and quantitative data in order to paint a richer picture through both experience descriptions and measurements of loneliness.

Instrument

Quantitative data was gathered through four questions that measured loneliness. These four questions were taken from the National Indicator of Loneliness' Community Life Survey in the Campaign to End Loneliness (Siddorn, 2020). The UK-based campaign aims to bring together a community of support for all ages. Their choice to use these three loneliness measurement questions with adults came from combining a short Three Question Loneliness Scale (Hughes et al., 2004) that had been created from the 20 question UCLA Loneliness Scale (Russell, 1996), along with a direct measure of loneliness - a fourth question added by the UK's Office of National Statistics (see Appendix A).

These same 4 quantitative questions I asked in the loneliness measurement scale were used to determine how often the respondent felt lonely by assigning each answer point values. The first 3 questions' answers were scored as *hardly ever or never* (1), *some of the time* (2), and *often* (3). The fourth question's answer was scored as *often or always* (5), *some of the time* (4), *occasionally* (3), *hardly ever* (2), and *never* (1). The higher the total amount of points scored, the greater the respondent is experiencing loneliness (Russell, 1996; Hughes et al., 2004). Total scores indicated that the respondent *was not lonely* (4-6), *was somewhat lonely* (7-9), *was severely lonely* (10-12), and *was very severely lonely* (13-14). I chose the shorter questionnaire as opposed to the original 20 question UCLA loneliness scale because I did not want to overwhelm the respondents with a longer questionnaire, and wished to focus on their qualitative semi-structured interview answers.

Qualitative data was gathered through semi-structured interviews (see Appendix B). The semi-structured interviews allowed for open-ended conversation, relationship, and an engagement between the respondent and interviewer. Questions I asked in the interview were predetermined, with the exception of the follow-up questions. In a semi-structured interview, dialogue follows the respondents interests and concerns. Depending on the flow of the interview, the order of the questions could be altered. Smith & Osborn (2003) stated that "In this relationship, the respondents can be perceived as the experiential expert on the subject and should therefore be allowed maximum opportunity to tell their own story" (p. 31). The measurement of loneliness scales and the semi-structured interviews were conducted in the same sitting with each of the fifteen respondents between February 23 – March 5, 2021.

Recruitment and Pre-interview Procedures

Individuals who participated in this study were living at the nursing home where I worked and were affected by the lockdown due to the COVID-19 pandemic. Because of my ongoing relationship in working closely with the residents, and the rapport that had been established over time, I was able to consider which residents would be capable of participating in the study. I asked residents who were able to converse, able to make informed decisions, and able to make their needs known. I approached 15 possible participants and asked them if they would be interested in participating in a research study. As each participant that volunteered agreed, I went over the IRB-approved consent and audiotape release forms with them (see Appendix C) in order to further explain the study and confirm their willingness to be involved. We read the form together which explained that this study was focused on the time during the lockdown, experiences of loneliness, and whether or not music played a role in reducing

experiences of loneliness. I answered any questions the residents had in relation to the research. All fifteen residents signed the forms voluntarily.

Participants Demographics

The study took place in a nursing home run by Catholic nuns located within the city limits of the second-most populous city in a state in the Mid-Atlantic region of the U.S. The participant group ($N = 15$) consisted of 12 women and 3 men, all of whom were white and spoke English. Participants ranged in age from 73-103 years old. Three residents had lived in the home just 3, 4, and 5 months, respectively. They had come to the home from congregate care settings: the facility's apartments, the VA, and another long term care facility. The other 12 residents lived in the nursing home ranging between a year and a half (18 months) and 6 and a half years (79 months) at the time of the study (See Table 1).

Table 1

Resident Interviews February 23-March 5, 2021

Pseudonym:	Gender:	Race:	Age:	Months Lived in Home at Time of Interview:	If in Home Under 6 Months, Where Resident Previously Lived:	Interview Duration in Minutes:
Ada	Female	Race	94	59		7
Bill	Male	White	92	26		6
Claire	Female	White	80	4	Apartments	6
Debbie	Female	White	103	34		7
Ellen	Female	White	97	79		36
Frank	Male	White	74	54		4
George	Male	White	78	3	VA	34
Helen	Female	White	90	24		27
Ida	Female	White	91	18		11
Joyce	Female	White	75	5	Another LTC	12
Kim	Female	White	73	16		36
Lily	Female	White	88	36		34
Marie	Female	White	92	66		18
Nina	Female	White	95	38		18
Olive	Female	White	92	16		25

Data collection

Due to COVID-19 protocols in the facility, I wore a mask covering my nose and mouth during each interview and washed my hands prior to entering the resident's room. Residents were not required to wear masks in their own living space (they were only required to do so if they left their household). Each participant and I sat socially distanced six feet apart. A Tascam recorder was used to record the audio for each interview. I let the resident know when the Tascam was being turned on and turned off. Additionally, a laminated piece of paper with the possible answers to the quantitative loneliness measurement scale was brought to each interview. Thirteen participants chose an answer they read from the laminated sheet, and two participants with low vision chose an answer after hearing them from the list I read to them.

Ethical considerations

The Informed Consent and Audiotape Release forms (see Appendix C) had IRB approval (see Appendix D). While some participants said that I could use their real name, I decided not to do so due to HIPAA. Instead, pseudonyms were chosen for each participant using the first 15 letters of the alphabet. Due to the sensitive nature of the content of this study, and my rapport with the residents, offering resources in the nursing home for support were made available to the resident, if needed. The audio data of the interviews recorded with the Tascam was uploaded to GarageBand on my password protected computer and deleted from the Tascam. Each interview was transcribed into a Word document, which was saved to a password protected folder. Names were not included, only initials, and then eventually initials were changed to pseudonyms as identifiers. Audio files of each interview were deleted from the Tascam, and from GarageBand. The Word document with transcription of the interviews is to be kept for three years and then deleted.

Data Analysis

I read through the transcripts one at a time. I completed an entry in my research journal after each interview as a way to reduce bias and as a way to immediately note things that seemed important to come back to and to reflect upon. Journaling also helped me to discover what I did well and did not do well as part of the process and influenced how I conducted the next interviews. After reading through the transcripts, I journaled again for further reflection and considered possible themes emerging from the data. The qualitative data document with the transcription of the semi-structured interviews was added to Atlas.ti, a coding program. I went through the process of the Constant Comparative Method (Creswell & Creswell, 2018) while coding. These steps included transcribing the interview recordings raw data, reading the transcripts, comparing segments of data with each other and creating codes that connect them, comparing codes with other codes to create categories that connect them, and comparing categories. With guidance and consultation of my professor, themes and sub-themes emerged. I also created a chart with the answers, points (see Table 2 in Results), and results of the quantitative data from the loneliness scales (See Table 3 in Results). Then I took a general look at how the participants rated themselves on the loneliness scale, and how it corresponded with what they said in the interview.

Results

Quantitative Data

The purpose of this study was to directly hear from older adults about their lived experience in their nursing home during the time of lockdown due to COVID-19. The aim was to explore how isolation and loneliness have effected them as individuals, and to examine whether music has played a role in reducing feelings of isolation and loneliness since the pandemic began. Quantitative data was collected through the administration of the Loneliness Scale that

was adopted from the National Indicator of Loneliness' Community Life Survey. The first 3 questions (How often do you feel that you lack companionship? How often do you feel left out? How often do you feel isolated from other people?) were scored using the same point system. These 3 questions' answers were scored with *hardly ever or never* (1), *some of the time* (2), and *often* (3).The fourth question was a direct measure of loneliness (How often do you feel lonely?). This question's answer was scored with *often or always* (5), *some of the time* (4), *occasionally* (3), *hardly ever* (2), and *never* (1). Table 2 shows each participant's results of the Loneliness Scale, listed by pseudonym, and converted into points.

The total lowest possible score of the Loneliness Scale was 4, and the total highest possible score was 14 (4:14). Total point scores indicated that the respondent *was not lonely* (4-6), *was somewhat lonely* (7-9), *was severely lonely* (10-12), and *was very severely lonely* (13-14). There were 5 participants of 15, or one third (Bill, Claire, Debbie, George, and Lily), who fell into the not lonely category. Of the 15 participants, 8, or over half (Ada, Ellen, Frank, Helen, Kim, Marie, Nina, and Olive), fell into the somewhat lonely category. No participant scored within the severely lonely category. There were 2 of 15 participants, just over ten per cent (Ida and Joyce), who fell into the very severely lonely category.

Table 2

Raw Scores for Loneliness Questions: UCLA Scale and Direct Measure of Loneliness

	How often feel lack companionship	How often feel left out	How often feel isolated from others	How feel lonely (Direct Measure of Loneliness)	Loneliness Total Score
Ada	1	1	2	3	7
Bill	1	1	1	2	5
Claire	1	1	1	1	4
Debbie	1	1	1	2	5
Ellen	2	2	2	3	9
Frank	1	1	2	3	7
George	1	1	1	2	5

Helen	2	1	2	2	7
Ida	3	2	3	5	13
Joyce	3	2	3	5	13
Kim	1	1	1	5	8
Lily	1	1	1	1	4
Marie	1	1	1	4	7
Nina	2	1	1	3	7
Olive	1	1	1	4	7

Within individual scores, it is notable that Ida's and Joyce's direct measure of loneliness score was the highest possible. They each were also the only participants who scored the highest possible points on two out of the first three questions. Ida and Joyce were the only participants to have a total score that fell into the severely lonely category. Kim scored the highest possible on the direct measure of loneliness, but lowest possible on the first three questions. Similarly, Marie and Olive scored second highest possible on the direct measure of loneliness, but the lowest possible scores in the first three questions. Claire's and Lily's scores were consistently the lowest possible for all questions. They scored the lowest possible total scores and fell into the not lonely category. Ellen's choices were the middle answer for each question and her total score fell into the high end of being somewhat lonely. Each of the other 8 participants' answers varied in scores among the four questions.

Table 3

Mean Scores for Loneliness Questions: UCLA Scale and Direct Measure of Loneliness

Quantitative Interview Questions	*M*	*SD*	*Min*	*Max*
UCLA 3 Question Loneliness Scale (range 1-3)				
How often feel lack companionship	1.46	0.74	1	3
How often feel left out	1.2	0.42	1	2
How often feel isolated from others	1.53	0.74	1	3
Direct Measure of Loneliness (range 1-5)				
How often feel lonely	3.06	0.74	1	5
Total Scores (range 4-14)	7.2	2.76	4	13

Table 3 paints a picture of where an average participant in this study places on the loneliness scale. It is noticeable that many participants generally seem to not feel left out. While scores varied in feelings of lacking companionship and feeling isolated from others, participants mostly seemed to score low. Scores also varied on the direct measure of loneliness question, but the average appeared to be the middle possible score. The average score seemed to be on the low end of the somewhat lonely category, with standard deviation accounting for a few outliers.

Qualitative Data

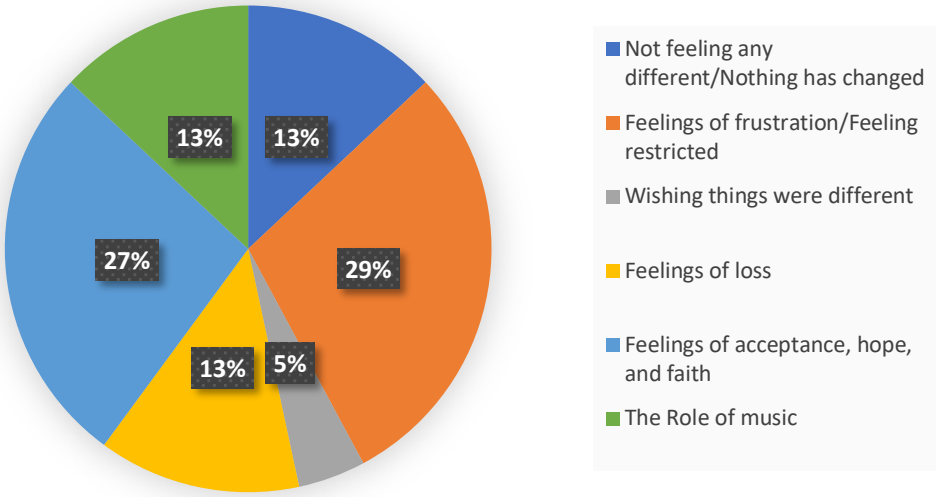
Qualitative data consisted of experiences and opinions shared by participants during the time of the lockdown due to the COVID-19 pandemic. Participants' verbal expressions came about through responses that were generated from the following questions:

- Since the pandemic/virus/lockdown started, have you noticed a difference in how many people you interact with? In the same physical space, face to face (at window or iPad)?
- Since the pandemic/virus/lockdown, has the frequency of visits from family/friends changed?
- Please tell me about how this has impacted you emotionally?
- Tell me about anything that we do here that has helped you to feel less lonely?
- Please share any story about how music has played a role in your life since the pandemic/virus/lockdown started?

There were 6 main themes and 30 sub-themes that emerged from the data. The 5 main themes included: (1) not feeling any different/nothing has changed, (2) feelings of frustration/feeling restricted, (3) wishing things were different, (4) feelings of loss, and (5) feelings of acceptance, faith, and hope. An additional sixth theme centered around the role of music (See Figure 1).

Figure 1

Emergent Themes



This qualitative data was quoted directly from the residents' words and stories at the time of interviews. Each of the 15 participants contributed to the data in the qualitative results of this study. The 6 themes and their corresponding sub-themes will be shared in this section, along with quotes provided as examples. Each participant has been given a pseudonym in order to maintain confidentiality. An example quote pertaining to each of the 6 themes from a participant can be found in Table 4.

Table 4

Experiences of Lockdown Example Quotes

Theme	Example Quote
Not feeling any different/ nothing has changed	"I just continue thinking, and going along as I usually do, so I don't notice anything different." -Claire
Feelings of frustration/ feeling restricted	"My fingers are pretty hard uh to manage. I could do some, but to really communicate by mail or that, is a little bit hard. I'm a little bit too old to have good – uh, my eyes are failing and all of that." -Ellen

Wishing things were different	"But I don't like it on (makes a square with fingers) (gesture for device with screen) (pause) I like personal." -Lily
Feelings of loss	"I'm just not there, when the girls call me, if any of them are there, she'll put them on the phone but they - they call me Deda for grandma, they know Deda, but they don't really know me. They know, 'talk to Deda,' but other than that they really don't know me." -Ida
Feelings of acceptance, hope, and faith	"It's been an isolation, but at the same time, it has taught me to think in a different direction and it has uh, (pause) uh… opened up paths that I really would never even considered." -Helen
The Role of music	"Well it helps, music does. Picks you up, makes you feel better… well when, we have like, when you sing the songs, ya know, like that – makes ya feel good." -Frank

Not Feeling Any Different/ Nothing Has Changed

This theme had 29 codes, represented in parentheses. The 5 sub-themes in this category included: use of television (8), telephone usage (7), acquiescence (6), baseline minimal visits (5), and unbothered (3).

Use of Television. The television has been a familiar piece of technology for decades in the lives of older adults. CCTV (closed circuit television) for the chapel and in-house programming, as well as normal cable TV, made it possible to continue life as usual. Ellen said, "if I want to go to chapel, uh, I have my TV here. Whenever they have a special program, or I could get the prayers from the chapel today. But I usually have EWTN." She went on to reference the TV when asked about music. "Oh, music, okay. Well, when I can, I'll get this, oh

what is it 957 or something like that." George talked about it, too. "This music channel, I practically listen to it 24 hours a day." He went on to remark on the chapel channel, as well. "956 does all the religious stuff. I pay close attention to that." Debbie shared that in her free time she will "put the radio on or television, hon."

Telephone Usage. Some residents felt that it did not make a difference if they were in person or on the phone with their loved ones. Ada said, "I feel that, that I… I've – I'm in touch. My nieces. They (staff) always call them, or talk to them, and let me know - or let them know - how I'm doing or how they're doing." In regard to phoning family rather than visiting in person, Kim said, "it's just as simple to talk to them." Olive casually said, "yeah, we talk, they call me, (grand daughter's name) calls me and the kids are all on the phone." Marie said, "but we still talk on the phone so that's the same thing, so I don't feel isolated." George's comment seemed to speak to not only the lockdown, but being in a nursing home in general. When asked if the frequency of visits had changed for him, he shared, "well because of where I am it'd be less. But I communicate by telephone with my closest relatives," and "now at least the ones that want to talk to me, it's easy to call me. Or leave me a message and I'll call them back."

Acquiescence. Some residents commented on coming to compliance without protest to the situation. Ellen said, "it's on our mind, but we can't do nothing about it, so," and went on to say about the separation from family, the foot doctor, and the eye doctor, "you just have to deal with it, eh. You know they're not coming." Lily talked about how she would like to be able to hug her family but, "you make do with what you have." When I said that sounded like a motto, she replied, "well no sense crying over it, or worrying about it, I'm just the kind that takes things and I go with it." Similarly, Marie stated, "What else can you do? It only makes it worse if you grieve."

Baseline Minimal Visits. Three participants shared that the frequency of family visits seemed to be the same as usual. When asked about this, Ada remarked, "hmm… same" and that it has always been "just my family on my birthday." Bill said, concerning no difference in the nature of interaction with others, "I never, since I've been here – I haven't interacted on a day-to-day basis with anybody." Marie felt the frequency of visits with family were, "about the same, but we talk on the phone twice a week. Both of my daughters."

Unbothered. When asked how the lockdown has impacted them emotionally, some participants answers consisted of what they thought about the situation, or rather did not think. Ada shook her head as she shared, "uh, I don't think about it." Claire said, "I just continue thinking, and going along as I usually do, so I don't notice anything different." Bill casually said, "I don't think I've even given it a thought."

Feelings of Frustration/ Feeling Restricted

This theme emerged from 65 codes. The 5 sub-themes in this category included: restriction of visits (38), decrease in visits (10), confinement to a small space (8), annoyance (5), and physical limitations (4).

Restriction of Visits. The way in which family members, and really anyone, could visit with residents was restricted due to the lockdown, and participants brought this up. "I think it's a question of them being allowed, rather than them not wanting to," Bill said. "They would like to be here more often but they're not allowed 'cause of the lockdown," he continued. The restriction of time was prevalent for most. "The main thing is, it has to be scheduled," said Ellen. That didn't always work out. "(Niece's name) said she wanted to come at one o' clock. (Staff member name) said no way, not at that time," adding that doctor visits, if at all, were the same way. "You ask, when is the eye doctor? They can't just come in any time. They have to be

scheduled. Lockouts are serious business, you know." Olive said that a family member, "called on the weekend and wanted to come. She's real busy through the week and her hours didn't clench with what the hours were here. She called me and said, 'Nana, I'm so frustrated. I want to come but I can't get a time that works.'" The time for visits was set. "She can stay an hour, which is also the appointment time," said Kim. "An hour we get, but it's like 15 minutes and it's over," said Ida. She brought up a restriction of interaction, "you hardly get to exchange things and it's over." Kim said, "truthfully it's just too much work! Ya know, when you gotta do all these things just to get a visit from your granddaughter for an hour." When family was present, there were also limitations. Olive shared a story. "(Great grandchild's name) said to his mother Sunday, 'why is Nana sitting way over there?' He wanted to come over to me. And she says, '(great grandchild name), you know why.' And he says, (in a low, disappointed-sounding voice) 'COVID.'" The feeling of getting together had changed for residents. Joyce said, pertaining to visits, "the intensity of them's different. Before, it was just kind of… you were just loose and glad to see each other. You didn't worry about time. And they were right there with you. You could touch them, you could kiss them." Kim commented on visits, "it's very rigid."

Decrease in Visits. Seven participants said that their families came less. For example, Bill said, "oh, certainly less," and Olive said, "oh much less," while Frank simply put it: "less." Three people said their families do not come at all. Nina remarked, "yeah cause they don't come, because of this virus stuff." Debbie said, "no, no, they don't come, honey. We just got on the phone." Ellen brought up the decrease of in person doctor visits, "the foot doctor and eye – well the eye hasn't been here with me."

Confinement to a Small Space. Various types of restrictions were brought up by participants. Helen mentioned that within the building there hasn't been get-togethers, "Well I

don't, uh, we don't intermingle (puts hands together with fingers interlocked). There's no intermingling." Kim felt restriction in the way that she never "feels better" for a whole day. "But I'll tell ya, there's never a whole day and I think that's because we've been in this (slaps the bed she's sitting on) stupid building." She went on to say, "I mean it's been, 9 months? 10 months?" When confirmed that it had been 11 months, Kim continued, "and I've only been out one day, I mean, I haven't even been allowed to go out for a ride." Olive was quarantined to her room for a few days after going out of the facility to the hospital for an emergency doctor's appointment at the time of interview. "Like right now, with me sitting in this room it's driving me crazy (laughing)." She was toward the end of her quarantine at the time we talked, and continued, "yeah, tomorrow, I'm allowed out."

Annoyance. Lily generalized her annoyance from something specific to the pandemic to the more general experience of living in a nursing home, saying, "of course I – ya know, when you're with people like this (gestures around) you always have problems." Joyce said, "it (motions an explosion with hands) everything, everything is exacerbated" and went on to say, "and I can't think that COVID helped that situation." Kim remarked on noticing others family visits, "people get upset when other people have a whole bunch of family, and they don't get anybody." She also commented on the limited space, "so many activities we do are plopped in the middle of everybody else and that annoys me, it really annoys me."

Physical Limitations. Nina expressed the difficulties in physical limitations about getting older in general. "We used to go out quite often like that. And I miss that. Ya know but uh when you get older you know, you get up there in age, you just can't do that no more. And that was nice!" Ellen spoke matter-of-factly about limitations in terms of not being able to see her loved ones in person and how physical declines in function made it difficult to replace that.

"I can't… I can't no longer hear too good on the phone to call my other nieces or nephews or write," she went on to say, "my fingers are pretty hard uh to manage. I could do some, but to really communicate by mail or that, is a little bit hard. I'm a little bit too old to have good – uh, my eyes are failing and all of that." Olive said that she saw her son when he was dropping off supplies, but the glass barrier made it frustrating. "But he's out in the vestibule and I'm in the lobby. I can't hear him through the window."

Wishing Things Were Different

This theme emerged from 10 codes throughout 4 sub-themes. Sub-themes included: feels like a burden (3), doesn't like technology (2), a barrier to technology (2), and worry (2).

Feels Like a Burden. Ida expressed guilt about sharing her feelings on the situation. "I'm sorry to lay this on you… I hate to impose on people," she said. Ida also did not want to take up too much time, with staff spread so thinly, "I know you're busy, there's not just me. There's all of us."

Does Not Like Technology. Lily said, "But I don't like it on (makes a square with fingers) (pause) I like personal." Several activities, visits, and meet-ups were held on the iPad. "I do not like the, ya know (gestures as square), whatever they call that."

Barrier to Technology. A great emphasis had been placed on technology during the time of the lockdown. Kim talked about her experience with it. "Not too many of us are (breathes out and laughs) hooked up to Zoom or anything." She went on to express gratitude for staff that helped with devices. "Yeah, tech support, that's very (pause) that's very important to me."

Worry. Ellen said, "it does worry me that it's not coming to an end and that I would like it to." She went on to say, "so (staff member name) said, too, 'no don't worry'… and uh… then I often thought with this virus thing, if we get it, will they put us out?"

Feelings of Loss

This theme emerged from 30 codes. The 4 sub-themes in this category included: negative emotional impact (13), missing hugs, touch, and being in proximity to family (9), missing trips (4), and missing grandchildren and great grandchildren (4).

Negative Emotional Impact. Frank said he felt, "sad," and "not good." "I think it's terrible, that's all," expressed Debbie. Kim said, "there have been weeks where it's all too much. It's very depressing." Ida shared her feelings, "I'm down in the dumps most of the time. That's why I don't even like talking about it, 'cause I start crying right away."

Missing Hugs, Touch, and Being in Proximity to Family. "I miss them a lot. Yes, yes. See, the two nieces and a nephew," said Ada. She went on to say," You know it feels like, uh, you wish they were here." "I miss my visitors, I miss my family," said Helen. Ida put it like this, "nothing can help me but to see my children come in my room and I can hug them. And I know it's not gonna happen right now, and it's hard for me to conceive that, ya know." Lily stated matter-of-factly, "I mean… I'd like to be able to give her a hug, and my family hugs, but we're not allowed to, so." Olive talked about the importance of hugs, "that means a lot, just getting a hug, ya know."

Missing Trips. Some residents used to attend every bus trip they could. "You don't get out and see people," Frank said, "Ya don't see as many people." "Oh don't even mention the casino, I can't wait to get there," shared Lily.

Missing Grandchildren and Great Grandchildren. Helen said, "well, uh I'm older and I'm more forgetful and uh as a result, if I'm not talking to family, nobody reminds me, ya know, of the things I should be remembering but can't." Ida said, "Yeah, I think of my family, I have 14 great grandchildren who I don't get to see (pause) and they're growing up and getting older

and I'm not there." Also from Ida, "I'm just not there, when the girls call me, if any of them are there, she'll put them on the phone but they - they call me Deda for grandma, they know Deda, but they don't really know me. They know, 'talk to Deda,' but other than that they really don't know me." Olive put it this way, "It makes me, in one respect - I'm very blessed that none of my family has gotten anything and they're all fine. And I'm glad for that. But, I… I miss them all so much. I mean there's so many of them. And I really sometimes feel lonely."

Feelings of Acceptance, Faith, and Hope

This theme emerged from 60 codes. The 10 sub-themes included: meditation (13), feeling content (10), gratitude (9), acceptance (8), feeling comfortable (6), faith (4), hope (4), everyone is experiencing this (2), seeking mental help (2), and increase in family visits (2).

Meditation. This sub-theme emerged for just one participant, but was quite prevalent in their interview. Helen, who shared this was the first year she had ever spent alone, said, "To stop and think about all kinds of things, like, the very fact that life is eternal…I woulda never thought this deeply if I had not been sitting here." She shared, "insights that I woulda never had, never had crossed my mind." Helen declared conclusively, "it's been an isolation, but at the same time, it has taught me to think in a different direction and it has uh, (pause) uh… opened up paths that I really would never even considered."

Feeling Content. Some participants expressed that they felt content at this time. "I read my books. And I have a list of movie stars," said Ada. "I can only say that I'm perfectly satisfied with the situation," said Bill who went on to share, "I mean, I don't have anything that I'm thinking I need or want." Lily said, "I just came with my little suitcase (chuckling) and I've been happy ever since. I'm content with that." Marie said, "I'm just contented in my room. I just sit here and (laughing) observe"

Gratitude. Residents expressed gratitude for the facility and staff. “The thing that I like most here is their professionalism. And their ability to follow schedules,” said Claire. “And you’re gonna get washed in the water, in the bathroom, so we have everything our own: own private bathroom, room, bed,” said Ellen. George said, “Well (pause) where I was before here was (name of facility), it truly was, I’d call that hell and this heaven.” Kim shared, “Well you know that I appreciate you very much…not only for the music and stuff, but you do a lot of (pause) (gestures to her wall hangings and her laptop) this kind of stuff for us, too.” Olive said, “Well I think the fact that the activities people have so many things going on for us, it helps to keep you busy in a day.”

Acceptance. “I pretty much follow my own methods” said Claire. “It hurts to know that the doors are locked but at the same time, we’re not deprived of stuff, ya know,” shared Ellen. Helen said that, “I’ve gotten used to being alone.” She continued, “It took an adjustment, it did take an adjustment.” “I just accept it, because it’s for the best,” said Marie.

Feels Comfortable. Several residents commented on their comfort with the facility in general. “They make me feel very good here,” shared Claire. “I feel wanted here… I’m given almost - I’m given just really - taken care of, ya know. I’m getting really good care,” said Ellen. “I love it here,” expressed Lily. George said, “I feel at home… I’m telling you, this place is unbelievable.”

Faith. Coping through faith was brought up by two participants. “How to put it – you’re never alone,” said Helen. She also said, “it’s as though no matter where I go or what I’m doing, God’s listening. Ya know, He hears what I’m saying.” Olive said, “Thy will not mine. But I hope it comes around.”

Hope. Thinking about the brighter side and wondering "what if" took place. "There's a part of me that truly believes that it'll be over and we can get back to normalcy," said Joyce, "I'm just trying to take it one day at a time." Ida shared a similar feeling, "I keep telling myself things are gonna get better… it just takes time, God willing, it will."

Universality. The difficulty of the lockdown was expressed, but paired with the narrative that everyone was experiencing this time collectively, as a way to cope. Olive said, "so it's hard, for everybody. It's evenly distributed (laughing)." Kim expressed that the ongoing annoyance gets to her. "Uhh, but like my son says, Mom, everybody in the world is feeling like you feel (chuckles) right now."

Seeking Mental Help. Joyce commented on mental health, "I certainly am in touch with my own feelings that I know how it affects me." Kim spoke further into the subject. "It's just too much, so that's why I'm calling on (name of app for virtual doctor visits) (laughs)." She continued to say that she was aware of her feelings, "and that's when I know I need to do something about it. That's all there is."

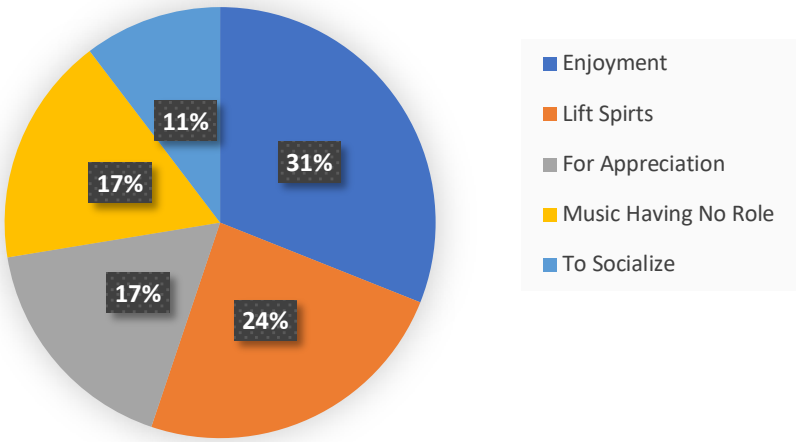
Increase in Family Visits. An increase in family visits was noted by two residents. Kim said, "my granddaughters have come almost every week since we're on this lockdown, so that's a lot more visits." Nina connected with distant family members through the iPad, "More, yeah."

The Role of Music

The theme titled the role of music emerged from 29 codes. Sub-themes included: enjoyment (9), lift spirits (7), for appreciation (5), music having no role (5), and to socialize (3). Participants seemed to answer not just how music has played a role at this time, but how they felt towards music in general, throughout their lifetime (See Figure 2).

Figure 2

The Role of Music



Enjoyment. Marie remarked on music in the nursing home, "well I enjoy the guitar playing." Olive also spoke to music in the home "when you play your guitar and sing *old* songs, that – that's nice." She specifically brought up music in the chapel, "even like, when Mother (Superior and organist) plays hymns that I don't know, and my eyes are working against me 'cause I can't read the words or the music when she plays a song (pause)… I liked yesterday, 'cause every hymn she had - I knew." Other participants responded by talking about their feelings toward music in general. "I love to listen to music," said Debbie. "I like the music. I like music period," said Ellen.

Lift Spirits. Joyce shared, "I listen to music a lot, I keep the music going all the time," and "the music just makes me happy to hear it." Olive expressed, "I just like music, it makes me feel good, it makes my heart warm, if you can understand what I mean." Frank shared how the sing-alongs made him feel, "well it helps, music does. Picks you up, makes you feel better… well when, we have like, when you sing the songs, ya know, like that – makes ya feel good."

For Appreciation. Kim mentioned tuning in to music documentaries on her television through a subscription service her son set up. "Yeah, it did the Beach Boys and all the documentary stuff, not just them playing one – playing one – playing one… it's… you know, the *stories*." Ellen and George had previously commented on how the in-house CCTV had been accessible and enjoyable. George spoke to how music has played a lifelong roll, as well as the specific role music played at this time. He said:

> *Nothing has really changed, 'cause - I've **been** a music guy since my, (pause) at one stage of my life, I was strictly classical music, so I had appreciation. Somehow I got turned to this uh, country and western music, which is kinda like my favorite now. But nothing new with the pandemic. (Pause) Other than I listen to it more than I did before, but it's just the freedom of paying attention to the, how do you say it, uh (pause) this music just makes it warmer than without music. And the pandemic I guess has people paying more attention to the music and the words, ya know.*

Ellen took a similar approach to explaining music's role at this time and her appreciation:

> *music was always important to me (pause) we did have one of those… with just the big horn… (gestures an arc with her arm and hand) and just the little box (gestures little box) and you put a record on it and then put a little, uh, needle on, and it play! But most of the music, we could… people gave us. Like our godmother. And then like was uh (pause) polkas or mostly just a dance around or make noise (small chuckle). Yes, yes, but it means a lot they have music.*

Music Having No Role. When asked how music has played a role at this time, Bill said, "I don't think anything worth nothing." Lily expressed, "well, I don't dislike music, but I don't have to have it all the time." Some participants expressed that music had no role throughout their

lifetime. Nina shared, “I can’t say too much about music, cause I don’t know nothing ‘bout music. I can’t sing. I don’t know a note from anything. I don’t have a voice for music. I never (pause) I don’t know what to say with that. I never could sing. In fact, there was 9 of us and I don’t think one of us could sing a note.” Claire said, “I’m not a musical person.”

To Socialize. Music for socializing seemed important to Ada. She expressed her feelings toward music in the nursing home and said, “I look forward to the sing-alongs when they’re scheduled… most of my friends from here go.”

Discussion

The current study sought to explore how older adults felt in terms of feelings of loneliness during the COVID-19 lockdown due to the pandemic, and whether music was helpful to them at this time. Research questions investigated how often participants felt lonely, as well as how the lockdown had impacted them, and how music played a role for them at this time. Participants provided answers to how often they felt lonely in a quantitative survey. They also provided spoken answers during semi-structured interviews that focused on their feelings at this time of lockdown.

Revisiting the Research Questions

In this thesis, the following questions were explored: In what ways do older adults in a nursing home experience isolation and feelings of loneliness during the time of lockdown due to COVID-19? And, in what ways did music play a role for study participants during this time?

In the current study, just 1 participant over the age of 80 responded that they were “often” lonely. This was inconsistent with Dykstra’s (2009) findings that 40-50% of older adults surveyed stated that they were “often” lonely. This discrepancy could possibly have been due to a smaller sample size. Answers may have been softened as an attempt to protect the staff

member and researcher who was asking the questions. It is also possible that participants did not want to appear vulnerable or stigmatized by admitting that they often felt lonely (Taylor, 2019, p.149).

Barbosa Neves et al. (2019) found that older adults in their study appreciated the care from professional staff in the nursing home. Which was supported in this study's findings. Claire said, "The thing that I like the most here is their professionalism. And their ability to follow schedules." Gratitude for the direct care staff's professionalism was also commented on by George, Ellen, and Marie. At the same time, residents, consistent with previous findings by Barbosa Neves et al., also felt that they missed having regular contact with relatives and friends as they once did, and felt they needed to be dependent on the staff for care.

Staying connected through technology for well-being was a prominent topic in the literature, but in this study, participants seemed somewhat overwhelmed by it. Hasan and Linger (2016) found that technology with older adults was used to "improve their social wellbeing and enable them to remain productive members of society" (p.754). However, the technology users in their study were not learning and relating to new equipment under the pressure of a pandemic. Perhaps the forced new pathway to connection, brought on due to visitation restrictions, and abruptly needed to replace face-to-face interaction, was the reason that technology was not more praised by participants in this study. Just two residents had something to say about smart device usage. Lily shared that she did not like the iPad, stating, "I don't like the, ya know (gestures a square), whatever they call that."

A digital divide was certainly apparent. I personally connected many calls over video chatting platforms in the nursing home. This was consistent with the findings of Zamir et al. (2021), who found that staff support was needed to facilitate the calls. Kim expressed gratitude,

"Not only for the music and stuff, but you do a lot of (pause) (gestures to her wall hangings and her laptop) this kind of stuff for us, too. Tech support. And that's very (pause) that's very important to me." Additionally, it is important to note that while staff assisted with technology, many older adults in a nursing home do not have the accessibility and engagement with technology that younger folks who are digital natives do. Kotwal et al. (2020) questioned who technology-based interventions serve, and who may be left out. As Kim put it, "not too many of us are (breathes out and laughs) hooked up to Zoom or anything."

Time with people cared about was researched by Krendl and Perry (2020), who found that more than two-thirds of older adults in aged care facilities who participated in their study reported spending somewhat or much less time with people they cared about (p.55). This was consistent with the result that two-thirds (10) of participants in the current study also experienced a decrease in family visits. The duration of the lockdown also played a factor. Krendl and Perry found that because fatalities were said to be higher for older adults, "shelter-in-place orders in most states were longer and more critical for this population and may have thus been perceived as particularly isolating" (p. 57). This was particularly true because of the need for social distancing. Ida, Helen, Lily, and Olive each mentioned especially the distance from the younger members of their families. "Yeah, I think of my family, I have 14 great grandchildren who I don't get to see (pause) and they're growing up and getting older and I'm not there," said Ida. Additionally, a non-fulfilled need for professional support (van Tilburg et al., 2020, p. 5) was expressed by Ellen, who said, "they can't just come any time," pertaining to the eye, ear, and foot doctors she depended on.

In contrast to frustration were sources of joy. Whitehead and Torossian (2020) found that sources of joy for older adults during the lockdown due to the pandemic tended to be resources,

relationships, or activities that pre-dated the pandemic (p.44). For Helen, her relationship with God seemed to play an important role, noting, "you're never alone." She said, "it's as though no matter where I go or what I do, God's listening." And, "Ya know that He hears what I'm saying." Music was also an established as part of life that pre-dated the pandemic for the research participants.

The role of music is varied for older adults. In a study with older adults, Hays and Minichiello (2005) found that music provided a sense of identity, provided connection, wellbeing, and helped people to feel positive. My findings were consistent with these concepts. What was apparent in this research was "how music is related to identity" (Hays & Minichiello, 2005, p.439) and how that played a role for the participants. "I've *been* a music guy," said George. Yet, for Claire, she stated, "I'm not a musical person." Regarding music providing ways of "being interested and motivated in life" (Hays & Minichiello, 2005, p.449), the presence of music during the lockdown period was meaningful to Ellen. "It means a lot; they have music" she said. Kim spoke about her interest in "the stories" of musicians, and not just listening to one song being played after another. The sustainability in motivation was prominent for Joyce, who often put on music to move about her room in her electric scooter doing self-directed activities, "I listen to music a lot, I keep the music going all the time." Another finding that was consistent with Hays and Minichiello's study was that music helped participants to move toward feeling more positive about life. Debbie, Ellen, Joyce, Marie, and Frank specifically mentioned these feelings. Frank said, "well it helps, music does. Picks you up, makes you feel better… well when, we have like, when you sing the songs, ya know, like that – makes ya feel good."

In their study, Hays and Minichiello (2005) found that "Music provided the participants with ways of knowing, understanding emotions, self, others, and expressing their spirituality" (p.

449). In the current study, ways of knowing were described by Olive and George. Olive knew and could name for herself what made her feel good, "I just like music, it makes me feel good, it makes my heart warm, if you can understand what I mean." George shared, "music just makes it warmer than without music." These findings are similar to findings from Kirkland et al. (2014) in their study on togetherness and spiritual music. They concluded that "providing opportunities for participants to remain in relationship with others is a significant contribution to sustaining personhood" (p.31). Although getting together for participation in spiritual music was provided in-person or through the Closed Circuit TV, Ellen, Olive, and George mentioned that it was the music that was played daily during services in the chapel that was of great importance. Various themed music sessions, including spiritual music, were held in each household of the facility. Music provided a "source of enhanced social cohesion" (Creech et al., 2013, p.88) in these various types of music groups. Related to this, Ada noted, "most of my friends from here go."

Connecting the Emergent Themes to Stages of Grief

An unexpected outcome was the emergence of two themes that could be likened to the widely known Five Stages of Grief (Kübler Ross & Kessler, 2014). After interviews were conducted, and themes emerged, it became apparent that the participants were in various stages that corresponded quite closely to the Five Stages of Grief that were delineated by Kübler Ross. In recent scholarly literature, I found that older adults were experiencing different stages of grief in reaction to the pandemic (Durak & Durak, 2020). Furthermore, Mortazavi et al. (2020) found that each of the 5 stages could be inhibited by quarantine policies. In this study, the two themes that emerged strongly in the data were Feelings of Frustration/Feeling Restricted and Feelings of Acceptance, Hope, and Faith, which have close resemblance to the stages of Anger and Acceptance, respectively, in the Five Stages of Grief.

Anger

The theme of Feelings of Frustration/Feeling Restricted, which I associate with the Anger stage, came up in many ways for the participants. Things that were already difficult about living in a nursing home were amplified. Things that were newly challenging due to the lockdown were brought to light. As Joyce said, "everything is exacerbated." Limitations and restrictions were new, and the loss of the freedom to visit with friends and family was a frequent topic in this theme. "Anger surfaces once you are feeling safe enough to know you will probably survive whatever comes" (Kübler Ross & Kessler, 2014, p.10). While some residents said that they understood that restrictions were to keep them safe, there was often frustration being expressed that they were nearing the ends of their lifetime, and they wanted to spend it with family, to hold grandchildren, to go on outings, when it seemed that the virus was not having an effect in the nursing home.

Acceptance

The theme of Feelings of Acceptance, Hope, and Faith, which I associate with the Acceptance Stage of Grief, was also a common theme for participants. "It has been forever changed and we must readjust" (Kübler Ross & Kessler, 2014, p. 25). This was exemplified by what Helen shared about her adjustment. "It puts life into perspective," she said. Helen, who spent a great deal of time in daily prayer and meditation, also said, "It took an adjustment, it did take an adjustment." It appeared that gratitude also helped. George expressed gratitude, "I couldn't ask for any more. In my condition and age." Learning to live with the losses also meant having hope. "Thy will, not mine, but I hope it comes around," said Olive. This kind of acceptance in the face of adversity may be related to the participants not wanting to be a burden on others.

The concept of being a burden was noted to be prominent for older adults in a study which focused on how the process of care affects their well-being. Cahill et al. (2009) studied 355 respondents by semi-structured interviews. Though the interview questions did not include anything related to being a burden, this concept was raised spontaneously by the participants while the interviews were being conducted. To the older adults in the study, being a burden meant being a disruption to the daily routines, socially-based relationships, and the other activities of family members (p. 307). Cahill noted that the inability to reciprocate care can undermine an older person's morale. They came to the conclusion that it sounded like the older adult wants their adult child, spouse, or caregiver to be there, but did not want them to go too far out of the way. For example, not wanting the adult child to go out of their way when dealing with situations such as a demanding work schedule and difficulties with teenagers, which an older adult may not have faced when they were their adult child's age taking care of a parent. Participants in this study particularly discussed feelings of guilt in relation to burdening families and seemed to not want family to be inconvenienced or limited by their illness. In the interest of not bothering family members, and to possibly protect themselves from experiencing a decrease in morale, some participants may have just bucked up and took it on the chin, so to speak.

The Importance of Being with Someone Where They Are

Social isolation is objective and loneliness is subjective. Not everyone experiences loneliness in the same ways. Noticing how someone is reacting to social isolation, as well as loss, is a way to support them. In noticing, and not judging or assuming, one has a greater sense of getting to know what is important to an individual. Taylor (2019) posits that, "It is important to emphasize clients' sense of self-determination in understanding and assessing their social isolation and loneliness" (p. 149). What drives an individual, no matter who is around, is the

essence of who they truly are. The social isolation from the lockdown due to COVID-19 accelerated some losses and exacerbated the effects of others. Individuals dealt with the losses differently, through determining what was important to them. It is important that music therapists refrain from assuming what the older adult is experiencing and engage with the person to help them express themselves through various types of musical and possibly non-musical experiences, if preferred.

Older adults need to be provided spaces to express challenging emotions like anger and frustration. Music lends itself to this. Hays and Minichiello (2005) noted that their participants stated that music could provide ways of expressing and feeling emotions that are not always culturally accepted by society in a legitimate way. Additionally, spaces where older adults can have control over their lives and not feel the need to accept adverse circumstances are necessary. Music helps to provide a structure of time and for emotions to be controlled within that structure.

The paradox of the mortality rate for older adults and COVID-19 *and* the need for connection forces music therapists to be more creative in ways to build connections. Knowing that older adults are not digital natives is important for music therapists who are creating new experiences and connections with technology usage to keep in mind. Patience is needed when setting up experiences with smart phones, tablets, and computers, and it is important to recognize that interaction with these devices for older adults is not as intuitive as it might be for younger people. Taking the reins and leading where you excel technically in setting up experiences will assist older adults in music therapy to be free to express creativity where they excel – in being experts on their lives.

There is value in being a music therapist that knows that people experience loneliness and grief in different ways. Connecting older adults to what is important to each

of them in their lives as individuals, through the nexus that the music therapist can facilitate, could mitigate loneliness.

Limitations

A limitation of the study was that the experiences here were of a small convenience sample at one location. COVID-19 precautions did not allow for in-person visits to other nursing homes, to ask questions about how they were experiencing this time of lockdown, and how music may have played a role. While it was helpful and meaningful that I knew all of the participants in the study, and had worked with them in the nursing home before the study was conducted, this may have potentially influenced participants' willingness to share openly due to not wanting to appear negative and not wanting to make anyone feel bad. While steps were taken to avoid coercion, knowing me may also have influenced whether or not participants agreed to participate in the study and/or their level of participation.

Other limitations were related to the survey length and the wording used in the semi-structured interviews. The longer 20 item questionnaire may have elicited more information from participants. However, the shorter questionnaire was chosen to be considerate of participant time. A longer quantitative survey with more pointed questions may have assisted in honing in on feelings of loneliness in the present moment, and could have better set the tone for the qualitative portion of the interview. Some of the interview questions were worded in ways that did not make it clear that the focus was on the time of lock-down specifically and so some of the answers were about their feelings more generally. This was particularly evident when answering questions about the role of music in their lives. Expansive responses that encompassed a lifetime were more common than the idea of just sticking to talking about this particular moment in time.

Recommendations for future research

An unexpected outcome of this study was the ways in which older adults talked about long ago musical experiences and their relationships to music pertaining to the present moment. Further research could explore how one's relationship with music over their lifetime influences its role in their life as an older adult. This type of suggested study would be a narrowing of the concept that Hays and Minichiello (2005) provided in their recommendations for further research, "Studies might also compare whether older people use music in the same way as younger people" (p. 450). An additional study could examine whether those who bring past musical experiences to the present moment deal with loneliness differently than those who do not, and in what ways reactions to loneliness guide music therapists' work.

Another possibility for future research could be on how participating in music might impact an older adult's experiences of loneliness. Using the loneliness questionnaire and scale, before and after music therapy sessions, could provide us with valuable information, especially if also paired with a subjective response about how connected they felt with others when engaging in the musical experiences. The sessions could include movement to music, improvisation, reminiscing, and songwriting. Finally, a study examining the different generations could yield interesting results about the role of music in mitigating loneliness among adolescents, adults, and older adults. Participants of different socioeconomic statuses could be interviewed, and from different cultural backgrounds, for more richness of content, a broader range of stories, and the ability to find more patterns in a larger set of data.

Conclusion

The residents in this study did not come to the nursing home to wait to die, they came to live while alive. Whether it be family, faith, independence, or music, the residents in this study

did not fear death, rather they focused upon what they live for. The lockdown due to COVID-19 put limitations on how they could do that. They were further isolated, and this reduced their time with their loved ones. In striving to understand how individuals cope with loneliness and social isolation, what is important to older adults in dealing with loss, and the role that music plays in their lives, perhaps loneliness can be mitigated.

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Appendix A

Three Question Loneliness Scale:

- How often do you feel that you lack companionship?
- How often do you feel left out?
- How often do you feel isolated from other people?

Direct Measure of Loneliness:

- How often do you feel lonely?

Appendix B

- Since the pandemic/virus/lockdown started, have you noticed a difference in how many people you interact with? In the same physical space, face to face (at window or iPad)?
- Since the pandemic/virus/lockdown, has the frequency of visits from family/friends changed?
- Please tell me about how this has impacted you emotionally?
- Tell me about anything that we do here that has helped you to feel less lonely?
- Please share any story about how music has played a role in your life since the pandemic/virus/lockdown started?

Appendix C

Professor Susan Hadley, PhD, MT-BC
Music Therapy Program Director
Graduate Music Therapy Program Coordinator

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Approved
February 1, 2021
Slippery Rock University
Institutional Review Board

CONSENT TO PARTICPATE IN RESEARCH

Loneliness and COVID-19:
Experiences of Older Adults in a Nursing Home

Susan Hadley, Ph.D, MT-BC; susan.hadley@sru.edu
Rhiannon Rieger, MT-BC; Rhiannon.rieger@gmail.com

Invitation to be Part of a Research Study

You are invited to participate in a research study. In order to participate, you must be a resident of the Little Sisters of the Poor, Saints Peter and Paul Home. Taking part in this research project is voluntary.

Important Information about the Research Study

Things you should know:

- The purpose of the study is to understand the impact of loneliness and isolation in a nursing home during the COVID-19 pandemic and hear from residents about their coping strategies and experiences. If you choose to participate, you will be asked to complete an interview in your room under social distance procedures, at a time of your choosing, and be audiotaped. This will take approximately 30 minutes.
- There are no anticipated risks or discomforts as a result of participating in this study. There is a minimal chance that the experience may cause emotional discomfort as they discuss feelings in regard to the current pandemic situation.
- A possible benefit of participating in the study is that it may be good to discuss your feelings around the impact of the pandemic on your feelings of loneliness. Additionally, the findings may benefit future residents in nursing homes in terms of how to prevent loneliness and isolation.
- Taking part in this research project is voluntary. You do not have to participate and you can stop at any time.

Please take time to read this entire form and ask questions before deciding whether to take part in this research project.

What is the Study About and Why are We Doing it?

The purpose of this study is to directly hear from residents experiencing isolation due to COVID-19 in an assisted living long term care facility in finding out how isolation affects them and ways in which they cope. Isolation and loneliness can affect older adults. With this further exacerbated at this time, understanding feelings and how to work with preventing isolation and strengthening community is the aim of the study.

What Will Happen if You Take Part in This Study?

If you agree to take part in this study, you will be asked to participate in an interview about your feelings, beliefs, experiences, and attitudes toward the current pandemic situation. It will be at a time that you agree upon as convenient. We will follow social distance procedures in your room, I will wear a mask, and will wash my hands and use hand sanitizer upon entry of your room. The interview will take about 30 minutes.

How Could You Benefit From This Study?

By participating in this study, you may benefit from discussing your feelings regarding this time of greater isolation. You will also be contributing to a study that may benefit other older adults who experience isolation while living in assisted living facilities by helping us to recognize ways to prevent loneliness and isolation.

What Risks Might Result From Being in This Study?

We do not anticipate any risks or discomforts as a result of participating in this study. There is a minimal chance that the experience may cause emotional discomfort as you discuss feelings in regard to the current pandemic situation. Sometimes it can be difficult to talk about feelings of loneliness. If you feel emotional, we will let the staff know and someone will come and spend time with you.

How Will We Protect Your Information?

The researcher(s) will keep audio recordings of the interviews in a password-protected folder on their password-protected computer(s). They will be transcribed and then destroyed. Interview transcriptions will contain your demographic information but not your name. At the conclusion of this study, we may publish the findings. No names will be included in publications or presentations. Your demographic information may be included but will be synthesized with the demographic information of other participants to further conceal your identity.

What Will Happen to the Information We Collect about You after the Study is Over?

We will not keep your research data to use for future research or other purposes. Your name and other information that can directly identify you will be kept secure and stored separately from the research data collected as part of the project. Research materials will be kept for 2 years and then destroyed.

How Will We Compensate You for Being Part of the Study?

There is no compensation for this study. It is completely voluntary.

Your Participation in this Research is Voluntary

It is totally up to you to decide to be in this research study. Participating in this study is voluntary. Even if you decide to be part of the study now, you may change your mind and stop at any time. You do not have to answer any questions you do not want to answer. If you decide to withdraw before this study is completed, the audiotapes of your interview will be destroyed by erasing the file from the researcher's Tascam recorder.

Contact Information for the Study Team and Questions about the Research

Please contact Rhiannon Rieger here at [redacted] or Susan Hadley at susan.hadley@sru.edu, if you have any questions about this research. We are happy to answer any questions you have about the study, including background and rationale, procedures, and implications.

Contact Information for Questions about Your Rights as a Research Participant

If you have questions about your rights as a research participant, or wish to obtain information, ask questions, or discuss any concerns about this study with someone other than the researcher(s), please contact the following:

Institutional Review Board
Slippery Rock University
104 Maltby, Suite 008
Slippery Rock, PA 16057
Phone: (724)738-4846
Email: irb@sru.edu

Your Consent

By signing this document, you are agreeing to be in this study. Make sure you understand what the study is about before you sign. Please print this email attachment, sign, and scan this document and return it via email to the co-researcher, Rhiannon Rieger. You will be given a copy of this document for your records. We will keep a copy with the study records. If you have any questions about the study after you sign this document, you can contact us using the information provided above.

I understand what the study is about and my questions so far have been answered. I agree to take part in this study. I understand that I can withdraw at any time. A copy of this signed Consent Form has been given to me.

_____	_____	_____
Printed Participant Name	Signature of Participant	Date

By signing below, I indicate that the participant has read and to the best of my knowledge understands the details contained in this document and have been given a copy.

_____	_____	_____
Printed Name of Investigator	Signature of Investigator	Date

Audiotape Release Form:

We request the use of audiotape/videotape material of you as part of our study. We specifically ask your consent to use this material during the study, as we deem proper. Regarding the use of your likeness in audiotape/videotape, please check one of the following boxes below:

☐ I do...

☐ I do not...

give unconditional permission for the investigators to utilize audiotapes of me.

_____	_____	_____
Printed Participant Name	Signature of Participant	Date

Appendix D

SlipperyRock University of Pennsylvania

TO: Dr. Susan Hadley
Music

FROM: _____
Ann Romanczyk, Ph.D., Chairperson
Institutional Review Board (IRB)

DATE: February 1, 2021

RE: Protocol Approved

Protocol #: 2021-026-56-A
Protocol Title: Loneliness and COVID-19: Experiences of Older Adults in a Nursing Home

The Institutional Review Board (IRB) of Slippery Rock University has conducted an administrative review of the above-referenced protocol under the "exempt" category.

You may begin your project as of February 1, 2021. Your protocol will automatically close on January 31, 2022 unless you request, in writing, to keep it open.

Please contact the IRB Office by phone at (724)738-4846 or via e-mail at irb@sru.edu should your protocol change in any way.