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LONGITUDINAL STUDY OF AGE-RELATED DIFFERENCES IN THE PSYCHOLOGICAL IMPACT OF CONFINEMENT AS A CONSEQUENCE OF COVID-19 IN A SPANISH SAMPLE

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Abstract

This research aims to analyze age-related differences in the psychological impact of the Covid-19 confinement situation in a Spanish sample. A longitudinal study (*N*= 1,041) was conducted through an online survey with two measurements: at two and five weeks after the declaration of the alarm state in Spain. Post-traumatic stress disorder (PTSD), anxiety and depressive symptoms, spiritual well-being and perceived loneliness were evaluated by screening tests. Means and their confidence intervals (95%) were calculated for all variables in the study, for the three age groups: 18-30, 31-59, 60-80. Linear mixed models with random slopes (Time nested to Subjects) were calculated for each variable. The results indicate that the psychological impact caused by the pandemic persists over time, and even increases in some of the variables studied. The older age group (60-80 years) shows the least impact and the greatest well-being. They presented less depressive, anxious and PTSD symptoms and less loneliness. These results may be explained by the greater resilience of this group to recover from adverse situations, in addition to having a greater number of coping strategies.
KEY WORDS: *age, Covid-19, loneliness, mental health, spiritual well-being.*

Resumen

Se analizan las diferencias relacionadas con la edad en el impacto psicológico del confinamiento a consecuencia de la Covid-19 en una muestra española. Se realizó un estudio longitudinal (*N*= 1.041) mediante una encuesta *online* con dos mediciones: a las dos y cinco semanas de la declaración del estado de alarma en España. Se evaluaron mediante cuestionarios de detección los síntomas de trastorno de estrés postraumático (TEPT), ansiedad y depresión, bienestar espiritual y soledad percibida. Se calcularon las medias y sus intervalos de confianza (95%) para todas las variables del estudio, para los tres grupos de edad: 18-30, 31-59, 60-80. Para cada variable se calcularon modelos lineales mixtos con pendientes aleatorias (tiempo anidado a los sujetos). El impacto psicológico persiste a lo largo del tiempo, aumentando en algunas de las variables. El grupo de mayor edad

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muestra menor impacto y mayor bienestar. Presentan menos síntomas de depresión, ansiedad y TEPT y menos soledad. Estos resultados pueden explicarse por la mayor resiliencia de este grupo para recuperarse de situaciones adversas, y el mayor número de estrategias de afrontamiento.
PALABRAS CLAVE: *edad, Covid-19, soledad, salud mental, bienestar espiritual.*

Introduction

Covid-19 has been a global pandemic with devastating social and health consequences. On March 14, a state of emergency was declared in Spain, and in the same way as in other parts of the world, drastic quarantine measures were established for all Spanish citizens. This exceptional situation of confinement was an experience with enormous psychological implications, including higher levels of stress and anxiety, psychological distress, insomnia and irritability, symptoms of post-traumatic stress disorder (PSTD), depressive symptoms, among others (Balluerka Lasa et al., 2020; González-Sanguino et al., 2020; Ko et al., 2020; Losada-Baltar et al., 2020).

Regarding the impact of the pandemic in terms of physical health, the older population, both those living in their homes or in a residence, has suffered the greatest impact of Covid-19, with higher morbidity and mortality rates. At the time of this study was conducted of the 20,527 people who had died from Covid-19 in Spain on May 21, 2020, 1,820 were aged 60-69; 4,884 were aged 70-79; and 12,839 were over 80. As for hospitalizations, 20,772 were between 70-79 years old and 25,000 over 80. It is important to note that in Spain only 2,191 of those admitted between 70-79 years of age and 383 of those over 80 years of age were placed in Intensive Care Units (ICU) (Health Ministry, 2020). Additionally, and as a reaction to the effects of the pandemic, older people have had to face different types of discrimination, such as those carried out in social media (e.g. #BoomerRemover), as well as the lower priority for medical care, with gerontologist claiming the use of alternatives to chronological age to personalize prognosis and treatment choices in contrast to age-based screening to make decisions about who has priority for a ventilator and an ICU bed (Le Couteur et al., 2020). Covid-19 has changed how older people are treated (Ayalon et al., 2020; Boreskie et al., 2020) and it seems that with the pandemic there has been a parallel outbreak of ageism. The negative responses toward older adults may have contributed to the image of older people as vulnerable, helpless, and unable to contribute to society (Monahan et al., 2020). These image of old age and Covid-19 may be internalized by older people themselves and can adversely affect their health, with a recent study showing how health and aging concerns are positively associated with anxiety symptoms, which are higher in older adults, showing the particular vulnerability of this population group (Bergman et al., 2020).

Despite the fact that the elderly are at a higher risk and are being more severely punished by the pandemic, a majority of the studies published highlight that younger people are showing a greater psychological impact, in measurements that reveal symptoms of depression, anxiety or post-traumatic stress (PTSD), (González-

Sanguino et al., 2020; Moreira et al., 2020; Nwachukwu et al., 2020; Qiu et al., 2020; Wang, Pan, Wan, Tan, Xu, Ho, et al., 2020; Wang, Pan, Wan, Tan, Xu, McIntyre, et al., 2020; Zhang & Ma, 2020). Another psychological consequence has to do with perceived loneliness, where the few studies available agree that confinement greatly aggravates these feelings (Losada-Baltar et al., 2020; Okruszek et al., 2020), also with greater impact on young people (Losada-Baltar et al., 2020). Additionally, the psychological variable "spiritual well-being" has also been studied to a lesser extent, and it was found to be a protective factor against psychological impact in the confinement situation (González-Sanguino et al., 2020), showing also values that indicate a lower wellbeing in younger people (López et al., 2020).

On the other hand, a recent study conducted in the US also supports these results, revealing that older people had a perceived higher risk of dying if they got Covid-19, but also a perceived lower risk of getting Covid-19, being quarantined or running out of money, as well as less depression and anxiety (Bergman et al., 2020). These data support the hypothesis that younger people seem to be a more vulnerable group in relation to mental health in the situation of confinement generated by Covid-19 compared to older people, who seem to cope better with the psychological impact, despite presenting more risk of illness and suffering its consequences.

Although we have data showing the effects on mental health of Covid-19, as well as the differences found according to age, no specific longitudinal studies have been published on age-related differences in the psychological impact (mental health, loneliness and spiritual well-being variables) of confinement in Spain. The aim of this longitudinal study is to examine the role of age in the psychological impact (mental health, loneliness and spiritual well-being) of the Covid-19 pandemic in Spain at two different moments in time, after two and five weeks of quarantine.

Method

Participants

The sample (*N*= 1041) contained a majority of women (81%), 29% of whom were aged 18-30, 64% 31-59 and 7% 60-80. The average age was 39.39. Moreover, 56% of the participants declared that they had a partner and shared their home with them. 44% of the participants had children and 38% had university studies. Table 1 shows the sociodemographic characteristics of the sample.

In the first evaluation, recruitment consisted of sending requests for participation to people belonging to databases of different institutions: students and workers in public organizations such as the Complutense University of Madrid and the academic Chair Against Stigma, and private organizations such as the company Group 5. These databases contain sufficient data to perform reasonable sampling of the Spanish population. To increase the sample size as much as possible participants were asked to help with its dissemination by sending the survey through various social network channels (email, Twitter, distribution through WhatsApp lists, Facebook…) and on the website www.contraelestigma.com. The percentage of people recruited in this way was small, estimated as less than 5%. The final sample

for the first evaluation contained 3,480 people. For the second evaluation, those people who had agreed to participate in the study were directly contacted by email, with a final sample size of *N*= 1041.

The inclusion criteria were: 1) To be over 18 years old, 2) to be living in Spain during the Covid-19 health emergency, and 3) to have agreed to participate in the second evaluation of the study.

Table 1
Socio-demographic characteristics of the sample

Variables	*n* (%)
Gender	
Man	200 (19)
Female	841 (81)
Age	
18-30	305 (29)
31-59	669 (64)
60-80	69 (7)
Education	
Elementary	15 (1)
High school	148 (14)
Vocational training	126 (12)
University	399 (38)
Posgraduate	355 (34)
Children	
No	579 (56)
Yes	464 (44)
Professional area	
Administration	94 (9)
Commercial	55 (5)
Education	179 (17)
Social-health	348 (33)
Other	367 (35)
Marital Status	
Single	541 (52)
Married	385 (37)
Divorced	82 (08)
Separate	28 (3)
Widower	7 (1)
Relationship	
Single	264 (25)
Couple no sharing	195 (19)
Couple sharing	584 (56)

Instruments

a) *Sociodemographic Questionnaire*. Questions developed *ad hoc* allowed data collection on age (subsequently grouped into clusters: 18-30, 31-59, 60-80);

gender identity; relationship (single, couple not sharing house, and has couple and shares housing); educational level (elementary studies, high school, vocational training, university, postgraduate); profession (social-health, education, administration, commercial and others such as transport, communications or tourism) employment situation (working, unemployed, student, retired, unpaid domestic work, other situation); economic situation (subjective perception from very bad to very good); importance of religious beliefs; presence of medical diagnosis (psychiatry and mental health, cardiovascular, neurological, respiratory or other diseases).

b) *UCLA Loneliness Scale* (UCLA-3; Russell, 1996), Spanish version by Velarde-Mayol et al. (2016). Assesses perceived loneliness in the last 15 days. It includes the following items: 1) Since March 15 (or, in the second survey "In the last 15 days"), how often do you feel that you are short of company? 2) Since March 15 (or, in the second survey "In the last 15 days"), how often do you feel excluded? 3) Since March 15 (or, in the second survey "In the last 15 days"), how often do you feel isolated from others? The three items in Likert-type format with three possible responses (1 rarely, 2 sometimes, 3 often), address three dimensions of loneliness: relational connectedness, social connectedness and self-perceived isolation. A single item of loneliness is also included (Campaign to End Loneliness, 2015), "For the past week, have you been feeling lonely?": Hardly ever (for example, less than 1 day); Sometimes or a small part of the time (for example, 1-2 days); Quite a long time (for example, 3-4 days); and All the time (e.g. 5-7 days).

c) *Functional Assessment of Chronic Illness Therapy Spiritual Well-Being* (FACIT-Sp12; Cella et al., 1998), Spanish version by Galiana et al. (2016). Assesses spiritual well-being, understood as a personal search for meaning and purpose in life, in connection with a transcendent dimension of existence, and the experiences and feelings associated with that search and that connection (Zinnbauer et al., 1999) was evaluated through the FACIT-Sp12. This scale explores three dimensions of spiritual well-being: meaning, peace and faith. These dimensions come together in two subscales: meaning/peace and faith. We selected 4 items from the meaning/peace subscale. The answers were Likert type from 0 (nothing) to 4 (a great deal). Higher scores indicate greater well-being. For the meaning/peace subscale, Cronbach's α was .88.

d) *Patient Health Questionnaire 2* (PHQ-2; Kroenke et al., 2009), Spanish version by Diez-Quevedo et al. (2001). Brief self-report questionnaire that addresses the frequency of depressive symptoms. It consists of 2 Likert-type questions ranging from 0 "never" to 3 "every day". Higher scores indicate more symptomatology, providing a severity score of 0.6, and establishing the cut-off at >3 points as a possible case of depression (Muñoz-Navarro et al., 2017). The original scale presented a sensitivity of .90 and a specificity of .61 (Kroenke et al., 2009).

e) *Generalized Anxiety Disorder Scale* (GAD-2; Spitzer et al., 2006), Spanish version by Garcia-Campayo et al. (2014). The GAD-2 Questionnaire includes the first 2 items of the GAD-7 Likert format, with a maximum score of 6 points. The cut-off point in this case is 3, from which the possibility of detecting possible cases

of anxiety is indicated (Muñoz-Navarro et al., 2017). The sensitivity of the original test was .88; with a specificity of .61.

f) *Civilian version of the Post-traumatic Stress Disorder Checklist* (PCL-C; (Weathers et al., 1993), Spanish version by Reguera et al. (2021). This questionnaire was used to detect post-traumatic symptoms. A reduced version was chosen (Lang et al., 2012; Lang & Stein, 2005) with two Likert-type items which ask about the presence of certain phenomena related to the traumatic experience and how it affected them. The answers range from 0 (nothing) to 4 (a great deal).

Procedure

The longitudinal study took place between March 21 and April 27 and consisted of two measurements, one from March 21 to 29 and the other from April 13 to 27. A survey was developed to be completed online using the Google Forms platform with the aim of reaching the maximum population possible. Since face-to-face interviews were not possible due to confinement, data was collected online. The survey contained 80 questions and the average time for completion was about 7 minutes. At the end of the first survey an independent section was included informing the respondents that they could participate in a second evaluation, if they were willing. Those who agreed completed the second evaluation. In both cases, the signature of the informed consent and acceptance of the data protection laws were included. The study was conducted in accordance with the Declaration of Helsinki and the protocol was approved by the Deontological Commission of the Faculty of Psychology of the Complutense University of Madrid with reference "pr_2019_20_029".

Data analysis

Means and their confidence intervals (95%) were calculated for all variables in the study, for the three age groups: 18-30, 31-59, 60-80. Linear mixed models (LMM) with random slopes (Time nested to Subjects) were calculated for each variable in the study in order to analyze the effect of longitudinal measures, and the interaction with age. The estimation method was maximum likelihood (ML) and results provide the effect of fixed terms and random effects. The analyses have been performed using R (v3.5.6) with the nlme package.

Results

Age and mental health

The representation of means and their confidence intervals (95%) for the age groups in the Mental health variables are found in Figure 1. Table 2 shows the means and differences in the scores of the variables at the two measurement intervals, indicating their significance.

Linear mixed models showed a significant change between the two temporal measurements (T0 and T1) for the depression variable (PHQ-2), $F(1, 1040)= 59.94$,

p< .001; but not for anxiety (GAD-2), *F*(1, 1040)= 0.10, *p*= .751 or PCL-C, *F*(1,1040)= 1.69, *p*= .193. The standard deviation for random and residual terms were Time= 1.04, Residual= 0.53; Time= 1.18, Residual= 0.60 and Time= 1.48, Residual= 0.72, for each model.

Figure 1
Means and their confidence intervals (95%) as a function of age for the mental health variables: depression (PHQ-2), anxiety (GAD-2) and PTSD (PCL-C)

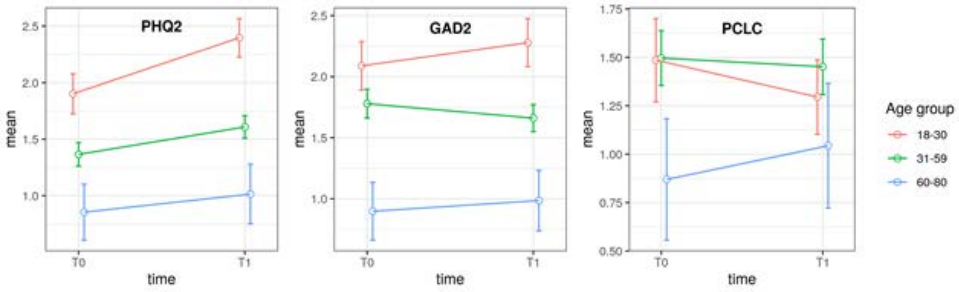


Table 2
Descriptives and results for mental health variables

		Depression (PHQ-2)		Anxiety (GAD-2)		PTSD (PCL-C)	
Age group	N	T0	T1	T0	T1	T0	T1
18-30	305	1.90 (1.58)	2.40 (1.52)	2.09 (1.76)	2.28 (1.76)	1.49 (1.91)	1.30 (1.71)
31-59	669	1.37 (1.37)	1.61 (1.32)	1.78 (1.56)	1.66 (1.46)	1.50 (1.87)	1.45 (1.89)
60-80	69	0.86 (1.05)	1.01 (1.12)	0.90 (1.00)	0.99 (1.05)	0.87 (1.33)	1.04 (1.37)
Fixed terms							
Time		*F*= 59.94, *p*< .001		*F*= .10, *p*= .751		*F*= 1.69, *p*= .193	
Age		*F*= 43.78, *p*< .01		*F*= 26.84, *p*< .001		*F*= 3.30, *p*< .05	
Interaction		*F*= 4.49, *p*< .05		*F*= 4.83, *p*< .01		*F*= 1.36, *p*= .255	
Random terms							
Time		1.04		1.18		1.48	
Residual		0.53		0.60		0.72	

AGE AND DEPRESSION: For the depression variable (PHQ-2), significant differences were also found for the age groups, *F*(2, 1040)= 43.78, *p*< .01 and for the interaction with the two time measurements, *F*(2, 1040)= 4.49, *p*< .05. Figure 1 shows how the means decrease with increasing age of the participants, showing a greater increase in depression between the T0 and T1 measurements for the younger age group (18-30 years), being less pronounced, and equivalent, for the rest of the age groups (31-59 and 60-80).

AGE AND ANXIETY: A significant effect of age and its interaction with longitudinal measurements was also found in the anxiety variable (GAD-2), *F*(2, 1040)= 26.84,

p< .001 and *F*(2, 1040)= 4.83, *p*< .01. The graph in Figure 1 shows significantly higher values of the variable for the 18-39 group compared to the other groups. However, the change between the two measurements presents the same slope for the 18-30 and the 60-80 groups, being different for the 31-59 group, which shows hardly any change between them, or a negative one.

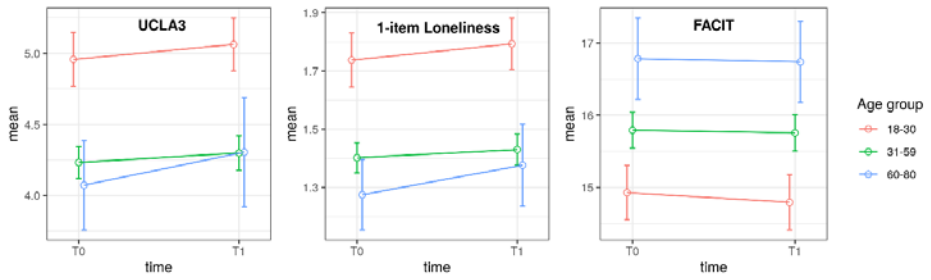
AGE AND PTSD: The PCL-C measurement shows a significant effect for age, *F*(2,1040)= 3.3., *p*< .05 but not the interaction with the two time measurements *F*(2, 1040)= 1.36, *p*= .255. The graph shows significant differences between the two younger age groups (youth and adults) versus the older one, with the latter showing lower scores.

Age and loneliness

The representation of means and their confidence intervals (95%) for the age groups in the Loneliness variables are found in Figure 2.

Figure 2

Means and their confidence intervals (95%) as a function of age for the other variables in the study: Loneliness (UCLA-3 and Single item of Loneliness), and spiritual well-being (FACIT-12)



Models similar to the previous ones were calculated for the variables of Loneliness UCLA-3 and Single item of loneliness showing a change between the T0 and T1 measurements for UCLA-3 *F*(1, 1040)= 4.43, *p*< .05 and Single item for Loneliness, *F*(1,1040)= 4.53, *p*< .05. The standard deviation for random and residual terms was Time= 1.09, Residual= 0.57; and Time= 0.49, Residual= 0.26, for each model.

The variable UCLA-3 showed a strong effect of age *F*(2, 1040)= 30.36, *p*< .001. The graph shows higher values of loneliness for the younger age group (18-30), followed by adults (31-59) and finally the older group (60-80). An increase in loneliness seems to be slightly higher in the youngest group compared to the other two, but the difference is not enough to show a significant effect of the interaction with the longitudinal measures, *F*(2, 1040)= 0.42, *p*= .617.

The measure of loneliness based on a single item presents results very similar to those obtained with ucla3, showing a significant effect for age but not for interaction, *F*(2, 1040)= 33.45, *p*< .001 and *F*(2, 1040)= 0.54, *p*= .581. The groups

of adults and older people seem to obtain more similar measures among themselves than with the group of young people.

Age and spiritual well-being

The representation of means and their confidence intervals (95%) for the age groups in the Spiritual well-being variable are found in Figure 2.

Models similar to the previous ones were calculated for the spiritual well-being variable showing no change between the T0 and T1 measurements for FACIT variable $F(1, 1040)= 0.79$. $p= .372$. The standard deviation for random and residual terms was Time= 1.81, Residual= 1.10, for this model.

Spiritual well-being (FACIT) shows clear differences between the three groups (Table 3), with older people showing significantly greater well-being, followed by adults and ending in youth, $F(2, 1040)= 15.09$, $p< .001$. The graph shows great stability between the two measurements for the three groups, finding no effect of the interaction, $F(2, 1040)= 0.17$, $p= .839$.

Table 3
Descriptives and results for Loneliness and spiritual wellbeing variables

Age group	*n*	Loneliness (UCLA-3)		Single item of loneliness		Spiritual wellbeing (FACIT)	
		T0	T1	T0	T1	T0	T1
18-30	305	4.96 (1.69)	5.06 (1.65)	1.74 (0.83)	1.79 (0.79)	14.93 (3.34)	14.80 (3.40)
31-59	669	4.23 (1.49)	4.30 (1.59)	1.40 (0.68)	1.43 (0.70)	15.79 (3.25)	15.76 (3.31)
60-80	69	4.07 (1.33)	4.30 (1.63)	1.28 (0.51)	1.38 (0.60)	16.78 (2.38)	16.74 (2.37)
Fixed terms							
Time		$F= 4.43$, $p< .05$		$F= 4.53$, $p< .05$		$F= .79$, $p= .372$	
Age		$F= 3.36$, $p< .001$		$F= 33.45$, $p< .001$		$F= 15.09$, $p< .001$	
Interaction		$F= .42$, $p= .617$		$F= .54$, $p= .581$		$F= .17$, $p= .839$	
Random terms							
Time		1.09		0.49		1.81	
Residual		0.57		0.26		1.10	

Discussion

As far as we know, the study presented here is the first to show the different psychological impact over time of Covid-19, as a function of age, on mental health, loneliness and spiritual well-being variables, in a Spanish sample.

Data shows that in the first measurement (after two weeks of confinement) the youngest age group (18-30 years) was the one that suffered the greatest impact from all the variables studied and the worst spiritual well-being. In the second measurement (after five weeks of confinement), data shows how, over time, depressive symptomatology increases significantly, while anxiety and PSTD do not

show statistically significant changes. In all age groups, levels of loneliness increase and spiritual well-being decreases, even if the changes are not significant. The older age group (60-80 years) was the one that presented less depressive, anxious and PTSD symptoms, less loneliness and greater well-being in both measurements. The youngest age group (18-30 years) was the one that suffered a greater impact from prolonged confinement in all the studied variables.

The longitudinal results are consistent with previous studies which indicate that younger people are more affected both by measures of mental health (González-Sanguino et al., 2020; Moreira et al., 2020; Nwachukwu et al., 2020; Qiu et al., 2020; Wang, Pan, Wan, Tan, Xu, Ho, et al., 2020; Wang, Pan, Wan, Tan, Xu, McIntyre, et al., 2020; Zhang & Ma, 2020), measures of loneliness (Losada-Baltar et al., 2020) and psychological well-being (López et al., 2020). Moreover, the results are also consistent with a cross-sectional study conducted in the north of the country, where they found that in a sample of people over 60 years reported no significant levels of symptoms of anxiety, stress or depression (Gorrochategi et al., 2020).

The greater psychological impact on the younger population could be explained by the great losses that confinement entails for them in terms of a drastic loss of face-to-face social relationships which, in this age group, are usually numerous, and include uncertainty regarding their academic, professional and economic future, among others. In a recent study of the effect of Covid-19 on a sample of students, the delay in academic activities, the effects on day-to-day life and the effects on the economy were associated with an increase in the anxiety suffered as a result of the pandemic (Cao et al., 2020). Perhaps these factors were also determining factors in this age group, which contained mostly students.

The lower psychological impact on the older population could be explained in part by factors such as resilience and the coping strategies characteristic of this age group. The older population has probably suffered over the years from a greater number of stressful life events (loss of loved ones, illness, etc.) that may have provided opportunities to develop resilience and other coping strategies (Browne-Yung et al., 2017; Fernández-Ballesteros & Sánchez-Izquierdo, 2020; Gooding et al., 2012; Hayman et al., 2017; Kok et al., 2018; López et al., 2020; Rubio et al., 2016; Windle, 2011). It should be noted that the older Spanish population has lived through a war and a post-war period, as well as a 40-year dictatorship, which has served as a scenario for overcoming adverse situations (Díaz Gandasegui et al., 2018).

On the other hand, Lopez et al. (2020) found that Covid-19 has meant that some older adults experience a time of growth and personal discovery. These authors point out the need to develop strategies in this population such as resilience, gratitude and acceptance, in order to improve psychological well-being. In this sense, Browne-Yung et al. (2017) identified the following as elements of resilience in older people: Adapting to aging-related physical challenges; changing social networks; continuity in the sense of identity to maintain unity and life's purpose; and redemptive capacity to cope positively with life challenges. In addition, coping strategies protect older people from suffering from depressive symptoms (Meléndez et al., 2012; Xie et al., 2010), which may partly explain the results of this study.

Along these lines, Gooding et al. (2012) found that the older adults were the more resilient group especially with respect to emotion regulation ability and problem solving. According to these authors, these results highlight the importance of maintaining resilience-related coping skills in both young and older adults but indicate that different psychological processes underlie resilience across the lifespan. Complementarily, Hayman et al. (2017) point out that very late life is characterized by a unique balance between losses, associated with vulnerability and resource restrictions, and potential gains based upon wisdom, experience, autonomy and accumulated systems of support, providing a specific context for the expression of resilience.

As the main limitations of the study we found that, despite the recruitment effort, the resulting sample is not exactly equivalent to the Spanish population, with a higher proportion of women and younger people. This fact does not distort the results found, since the objective is not to provide epidemiological information or prevalence data but to compare the averages obtained by various social groups in the variables of interest and to analyze the differential change between temporal measures. In this sense, as long as the sample meets the requirements of the statistical tests used, we believe it is valid for the study. However, it is necessary to be careful in the interpretation of the results and understand that they are limited by the characteristics of the sample obtained. Furthermore, in the group of older people the average age was 64.85 and the oldest in this group are under-represented, perhaps because they did not have access to the online form for its completion, as they are one of the groups most affected by technological illiteracy. Additionally, the number of men and older participants was lower than that of women and younger participants, with these groups being under-represented.

As conclusions of the present research, it is possible to establish that the psychological impact caused by the pandemic persist over time, even increasing in some of the variables studied, being able to identify as the most vulnerable age group the one between 18-30 years old. The older age group (60-80 years) shows the least impact and greater spiritual well-being than the other groups, which remained stable over time. Although the Covid-19 has had a strong negative impact on our lives, with a particularly high risk for older people who have suffered the effects of the disease to a greater extent, we would like to rescue the possibility of maintaining a positive view of the lived experience, trying to promote the capacity of recovery, taking our elders as an example, without forgetting their important role in our society.

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