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Article

Telling Tales (Tails): Factors Associated with Older People's Anxiety Symptom Positioning after COVID-19

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Abstract: This study sheds light on personal characteristics of and the coping strategies that older Canadians self-identifying as severely anxious post-COVID-19 were more and less prone to gravitate to. Our studied sample consisted of 606 older people residing in 10 Canadian provinces. Participants completed the Geriatric Anxiety Scale – 10 and a personal checklist of everyday coping strategies for mitigating anxiety. Severely anxious older Canadians tended to be in their 60s, and in poor to fair health. They were not significantly more likely to be women or to be chronically ill, nor to self-identify as non-binary or as having a life partner. Older Canadians experiencing severe anxiety were, however, far more likely to normalize their fear and anxiety, challenge their worries, and to relax or meditate. They were less inclined to decrease other sources of stress in their lives, to stay active, and to get enough sleep. We offer anticipatory guidance for mental health program planners and practitioners, and researchers, fruitful avenues of inquiry.

Keywords: anxiety; coping behaviors; older adults; survey; logistic regression

1. Introduction

Aging is not merely biological; it is a social construct shaped by cultural norms around what constitutes 'old' and older people's characteristics and contributions to society at large [1]. In the early stages of COVID-19, 'old' centered around illness and death [2,3] and social isolation [4] and loneliness [5]. The tale being told was one of older people as being an anxiety-riddled demographic. Anxiety can however act like a natural alarm system, motivating people to take remedial action [6]. Older people leverage years of life experience to build a cadre of resources and strategies to better their mental health [7,8]. Advancing age was found to be a protective factor in large-scale observational studies in Canada [9,10] and abroad [11]. Other older people spoke of silver linings [12] and upsides [13] to social lockdowns.

Anxiety characterized by excessive fear and worry and behavioral disturbances can impair everyday functioning [14]. Very early in the COVID-19 pandemic, 10% of older Canadians reported experiencing moderate to severe symptoms of anxiety [15]. During the first year of this pandemic, nearly 2 in 10 were experiencing difficulties mitigating any perceived anxiety [16]. While these findings suggest, as others [17–20] have, that older people tend to be more anxiety-resistant than anxiety-prone, when social distancing lifted, older Canadians were as prone to self-identify with severe anxiety and with no anxiety at all [21].

The 'who' and the 'how' of severe anxiety warrants greater attention to help mental health practitioners and program planners working with older people. Nationally representative evidence about who is most at-risk and what lessens and enhances this risk is essential evidence for practitioners and program planners [22]. We don't yet know whether and how severe anxiety will transpire in older people well into the aftermath of COVID-19 [23]. There is also tremendous stigma attached to mental health help seeking [24].

In this context, the aim of this study was to analyze data collected in a nationally representative study about how older Canadians were self-managing pandemic-related anxiety [25] and social isolation [21] across all 10 provinces. Older people are experts on their position in life, including their health and what helps and hinders it [26], and our best educators. We undertook a secondary analysis of these data to explore: (a) personal characteristics of older Canadians who self-identified with severe anxiety; and (b) everyday coping strategies that they were more *and/or* less inclined to gravitate to.

2. Methods

2.1. Study Design, Population and Sample

This study is a secondary analysis of an online nation-wide survey previously conducted by our team [21] to study self-managing pandemic-related anxiety and social isolation. This study took place when social distancing had lifted across Canada. Data were collected using the Qualtrics e-survey platform [27]. Qualtrics collected data across 10 Canadian provinces using census-based sampling [28]. We were seeking a studied sample mirroring the characteristics of Canadians at-large age 60 and older, in terms of their age, sex, and education. The e-survey included questions about anxiety, everyday coping strategies, and personal characteristics, including health. The e-survey opened on July 1st and closed on August 15th, when older Canadians stopped responding altogether. At the point in time, $N = 1,327$ older Canadians had completed the study questionnaire.

2.2. Measure and Instruments

2.2.1. Outcome Variable

Anxiety

The outcome variable was anxiety, which was measured using the Geriatric Anxiety Scale (GAS-10), which had a robust internal consistency reliability ($\alpha = .92$). This lay-friendly tool includes items such as 'I had a hard time sitting still' and 'I felt like something terrible was going to happen to me'. All items are rated on a scale from 0 (not at all) to 3 (all of the time). Total scores can range from 0 to 30. The clinical cut-off criterion for severe anxiety is a GAS-10 score of 12 or higher [29,30].

2.2.2. Covariables

Personal Characteristics

Participants were asked about their age (60-69, 70-79, 80 years of age and older), sex-at-birth (male, female), gender identity (transgender, CIS gender woman, CIS gender man), educational status (no post-secondary education, post-secondary education), and marital status (with a life partner, without a life partner). Participants were also asked about their overall health (poor/fair, good, very good/excellent) and whether they had any chronic illnesses (no chronic illness, one chronic illness, and two or more chronic illnesses).

Coping Strategies

We asked participants about everyday coping strategies to manage their anxiety using the Centre for Addiction and Mental Health personal checklist [31] ($\alpha = .76$). Older Canadians responded 'Yes' or 'No' to using any of one of 16 strategies like staying active, challenging anxious thoughts and

worries, and tuning into but knowing when to take a break from news about COVID-19. This checklist remains available for public consumption [32].

2.3. Statistical Analyses

The focus of this study is on two groups from our nationally representative studied sample ($N = 1,327$), older Canadians who self-identified as having 'no anxiety at all' and therefore had a GAS-10 score of 0 ($n = 273$; 20.6%). The other group consisted of 'severely anxious' participants self-identifying with a GAS-10 score of ≥ 12 ($n = 280$; 21.1%). We identified the dependent variable in this study as the presence of severe anxiety ($\text{GAS-10} \geq 12$) and recoded it as binary data. Older Canadians who self-identified as having 'no anxiety at all' were the reference group with whom 'severely anxious' participants were compared. Descriptive statistics were used to summarize the demographic characteristics of these two groups, using counts (n) and percentages (%). The significant differences in the characteristics between older Canadians self-identifying with 'no anxiety at all' and as being 'severely anxious' were examined by a chi squared test.

A binary logistic regression was undertaken to identify, at first blush, statistically significant demographic characteristics and coping strategies associated with being 'severely anxious'. Older Canadians with 'no anxiety at all' were the reference group to whom we compared 'severely anxious' contemporaries. A final adjusted multivariate logistic regression model consisted of age, sex-at-birth, gender identity, number of chronic illnesses, perceived health, education, and marital status. Goodness of fit was determined using the Pearson's chi-square and the Hosmer-Lemeshow chi-square statistics. All statistical analyses were performed with SPSS Version 29.0 (IBM Corporation, Armonk, NY, USA).

Our sample size was also adequate for a multivariate logistic regression analysis, G*Power software revealed a minimum sample size of $n = 155$ per group for detecting significant associations ($\alpha = 0.05$; power = .80)[33]. Because we know very little about how older people were self-managing their anxiety after COVID-19, we were equally interested in personal characteristics and coping strategies that were not statistically significant. Any such tenuous personal characteristics and coping strategies were characteristics and strategies potentially lessening and heightening the prospects of older Canadians at large to be 'severely anxious'. This way, mental health practitioners and program planners stand to gain further insight into the complexities of anxiety-related recovery work at a key turning point in the COVID-19 pandemic.

2.4. Ethical Implications

Ethical approval (Pro0092157) was granted by the University of Alberta's Human Ethics Review Board. This meant that all participants provided informed consent before participating in the survey (**Appendix A**). Qualtrics collected our data to ensure that confidentiality and anonymity of the participants was strictly maintained throughout the study, all of whom were assigned a one-time responder-specific identifier. The research team also had no access whatsoever to participants' names, IP addresses, or emails, ensuring their anonymity during recruitment. Accordingly, on August 16, 2022, we received a scrubbed dataset containing completely anonymized data collected from $N = 1,327$ older Canadians. All such anonymous data was housed on an encrypted computer in a secured office.

Mental health matters should never be taken lightly. We wanted to make prudent recommendations to mental health practitioners and program planners. We therefore adopted a more stringent p-value criterion ($p < .01$) to establish statistical significance and generated bootstrapped 95% confidence intervals for a more plausible range of odds that certain personal characteristics and coping strategies are more and/or less associated with experiencing severe levels of anxiety.

3. Results

As shown in **Table 1**, among our studied sample, 43.6% self-identified with female sex-at-birth and 40.7% with male sex-at-birth; 15.6% self-identified as transgender and non-binary persons. More

severely anxious participants fell in the poor/fair self-rated health group (51.1% versus 15.3% among those with no anxiety at all), to be born as female ($n = 196$; 63.4%) and to identify as such ($n = 149$; 52.7%), and to be the youngest ($n = 211$; 67%) participants.

Table 1. Personal characteristics and general health status of participants ($n = 606$).

Characteristics	No anxiety at all ($n = 273$) n (%)		Severely anxious ($n = 280$) n (%)		X^2	p -Value
Age (years)						
60-69	143	(49.5)	211	(67.0)	21.29	<.001
70-79	101	(34.9)	81	(25.7)		
80 and above	45	(15.6)	23	(7.3)		
Sex						
Female	121	(42.6)	196	(63.4)	25.79	<.001
Male	163	(57.4)	113	(36.6)		
Gender Identity						
Transgender & non-binary	41	(15.4)	45	(15.9)	23.20	<.001
CIS gender woman	91	(34.1)	149	(52.7)		
CIS gender man	135	(50.6)	89	(31.4)		
Number of chronic illnesses						
None	109	(38.7)	132	(42.6)	1.26	.532
One	80	(28.4)	77	(24.8)		
Two or more	93	(33.0)	101	(32.6)		
Perceived Health						
Poor/fair	44	(15.3)	156	(51.1)	86.50	<.001
Good	143	(49.7)	96	(31.5)		
Very good/excellent	101	(35.1)	53	(17.4)		
Post-secondary Education						
No	192	(66.2)	185	(58.7)	3.594	.058
Yes	98	(33.8)	130	(41.3)		
Marital Status						
With partner	175	(60.3)	174	(55.1)	1.72	.189
Without partner	115	(39.7)	142	(44.9)		

Note: A chi-square test (X^2) was used to compare categorical variables between participants with GAS-10 = 0 score and those with GAS-10 \geq 12.

A crude binary logistic regression analysis revealed that age, sex-at-birth, gender-identity, and perceived health were statistically significantly associated with severe anxiety. Education level, marital status, and being chronically ill were not. The unadjusted odds ratios with confidence intervals are shown in **Table 2**. In the adjusted logistic regression analysis, the variables with

statistically significant p-values in the crude logistic analysis were adjusted by each other, and for additional covariates, including gender identity, number of chronic illnesses, education, and marital status. For practical purposes, we were interested in both.

With respect to personal characteristics analyses (**Table 3**), being between 70-79 years of age (AOR = 0.437, 95% CI 0.248-0.772, $p = .004$), and 80 years of age and older (AOR = 0.230, 95% CI 0.098-0.543, $p < .001$) was associated with a lower chance of experiencing severe anxiety. Being in good (AOR = 0.196, 95% CI 0.110-0.351, $p < .001$) and very good to excellent (AOR = 0.138, 95% CI 0.068-0.279, $p < .001$) health was associated with a lower chance of experiencing severe anxiety.

Other findings suggest that participants born male (AOR = 0.59, 95% CI 0.171-2.036, $p = .404$) and self-identifying as male (CIS-gender woman: AOR = 0.689, 95% CI 0.267-1.777, $p = .441$; CIS-gender man: AOR = 0.657, 95% CI 0.249-1.734, $p = .397$) had a lesser chance of experiencing severe anxiety, but not statistically significantly so. So too were chronically ill participants (one chronic illness: AOR = .785, 95% CI .531-1.189, $p = .264$; two or more chronic illnesses: AOR = .897, 95% CI .614-1.310, $p = .573$). Other tenuous personal characteristics were having a post-secondary education (AOR = 1.377, 95% CI 0.811-2.324, $p = .239$) and a life partner (AOR = 1.026, 95% CI 0.620-1.697, $p = .920$).

In keeping with our second aim, we identified coping behaviors that severely anxious participants were more *and/or* less inclined to gravitate to. Strategies that they were more inclined to try were accepting that some fear and anxiety were normal (AOR = 4.76, 95% CI: 2.031-11.200, $p < .001$), challenging worries and anxious thoughts (AOR = 5.21, 95% CI: 2.663-10.228, $p < .001$), and practicing relaxation and meditation (AOR = 2.36, 95% CI: 1.365-4.112, $p = .002$). Older Canadians at large who accept and/or challenge felt anxiety could be 10 to 11 times more likely to experience severe to very severe anxiety. Severely anxious participants were far less inclined to decrease other sources of stress (AOR = 0.39, 95% CI 0.211-0.729, $p = .003$), to stay active (AOR = 0.21, 95% CI 0.110-0.408, $p < .001$), and to get proper rest and sleep (AOR = 0.52, 95% CI 0.275-0.995, $p = .048$).

Our findings revealed a number of tenuous strategies (**Table 3**). Severely anxious participants were generally somewhat less likely to seek credible information, engage in structured problem-solving, remember that they were resilient, be kind to themselves, and eat healthily. They were also generally somewhat more likely to have balanced media consumption, unplug from electronic devices, seek out loved ones, avoid substance use, and watch their caffeine intake. All associated confidence intervals suggest that trying any such strategies could enhance and lessen one's prospects of being severely anxious. For example, seeking credible information might afford older Canadians at large a 50.5% lesser likelihood and up to a 54% greater likelihood of experiencing severe anxiety. If older Canadians in the general population remembered that they were resilient (OR = 0.54, 95% CI 0.267-1.092, $p = .086$) and dealt with problems in a structured way (OR = 0.62, 95% CI 0.310-1.249, $p = .182$), they were generally less inclined to be severely anxiety. Use of the latter two strategies could also tip their anxiety scale into the severity zone.

Table 2. Logistic regression analysis showing personal characteristics associated with severe anxiety among the participants ($n = 606$).

Variable	Crude		Adjusted #	
	OR (95% CI)	p-Value	AOR (95% CI)	p-Value
Age (years)				
60-69	Ref		Ref	
70-79	.544 (.379-.780)	<.001***	.437 (.248-.772)	.004**
80 and above	.346 (.201-.598)	<.001***	.230 (.098-.543)	<.001***
Sex				
Female	Ref		Ref	
Male	.428 (.308-.595)	<.001***	.590 (.171-2.036)	.404 ^a

Gender Identity				
Transgender & non-binary	Ref		Ref	
CIS gender woman	1.492 (.908-2.452)	.115 ^a	.689 (.267-1.777)	.441 ^a
CIS gender man	.601 (.364-.991)	.046 [*]	.657 (.249-1.734)	.397 ^a
Number of chronic illnesses				
None	Ref		Ref	
One	.785 (.531-1.189)	.264	.904 (.494-1.654)	.743
Two or more	.897 (.614-1.310)	.573	.632 (.353-1.133)	.123
Perceived Health				
Poor/fair	Ref		Ref	
Good	.189 (.124-.289)	<.001 ^{***}	.196 (.110-.351)	<.001 ^{***}
Very good/excellent	.148 (.092-.237)	<.001 ^{***}	.138 (.068-.279)	<.001 ^{***}
Post-secondary Education				
No	Ref		Ref	
Yes	1.377 (.989-1.3917)	0.058	1.372 (.811-2.324)	.239
Marital Status				
With partner	Ref		Ref	
Without partner	1.242 (.899-1.716)	0.189	1.026 (.620-1.697)	.920

Abbreviations: OR = odds ratio, AOR= adjusted odds ratio, CI = confidence interval, Ref = Reference. Notes: # The adjusted logistic regression model consisted of age, sex-at-birth, gender identity, number of chronic illnesses, perceived health, education, and marital status. The goodness-of-fit tests for the multivariate logistic regression was the Hosmer-Lemeshow ($p = .282$) chi-squared test; p-values: *** $p < .001$, ** $p < .01$, * $p < .05$.

Table 3. Logistic regression analysis showing coping strategies associated with severe anxiety among the participants ($n = 606$).

Variable	AOR (95% CI)	p-value
I accepted that some fear and anxiety was normal	4.76 (2.031-11.200)	<.001 ^{***}
I sought credible information, i.e. WHO, Health Canada, Provincial Ministry of Health, Local Public Health Unit	0.88 (.505-1.540)	.657
I found a balance by staying tuned in (open to new stories about COVID-19) but knowing when to take a breather	1.26 (.649-2.445)	.494
I brought an intentional mindset to unplugging from electronic devices, including phones, tablets, and computers	1.04 (.584-1.882)	.874
I dealt with problems in a structured	0.62 (.310-1.249)	.182

I remembered that I am resilient and was careful with the WHAT-IFs (asking 'what if questions)	0.54 (.267-1.092)	.086
I challenged worries and anxious thoughts	5.21 (2.663-10.228)	<.001***
I decreased other sources of stress in my life	0.39 (.211-.729)	.003**
I practiced relaxation and meditation	2.36 (1.365-4.112)	.002**
I sought support from loved ones	1.69 (.979-2.945)	.060
I was kind to myself	0.70 (.310-1.580)	.391
I ate healthy	0.72 (.367-1.445)	.364
I avoided substance use, including smoking, vaping and alcohol	1.57 (.899-2.775)	.112
I had a moderate caffeine intake	1.34 (.738-2.442)	.335
I got proper rest and sleep	0.52 (.275-.995)	.048*
I stayed active	0.21 (.110-.408)	<.001***

Abbreviations: OR = odds ratio, AOR= adjusted odds ratio, CI = confidence interval, Ref = Reference. Notes: # The adjusted logistic regression model consisted of age, sex-at-birth, gender identity, number of chronic illnesses, perceived health, education, and marital status. The goodness-of-fit tests for the multivariate logistic regression analysis was the Hosmer-Lemeshow ($p = .282$) chi-squared test; p-values: *** $p < .001$, ** $p < .01$, * $p < .05$.

4. Discussion

The COVID-19 pandemic is an historic global event enhancing the risk for acquiring a life-threatening illness and dying, particularly for older persons within the first two years [34]. Pandemic-related anxiety is on the rise globally [14], as is living this way in isolation from others [35]. Research that offers healthcare practitioners and program planners a nationally representative snapshot of older persons seemingly more prone to severe anxiety and self-selected strategies helping and perhaps even hindering them is important and timely. We analyzed data collected in our parent study across 10 Canadian provinces to compare and contrast: (a) personal characteristics of older Canadians self-identifying with severe to very severe anxiety; and the (b) everyday coping strategies that they are more *and/or* less inclined to gravitate to.

Personal Characteristics

Personal characteristics can offer anticipatory guidance for practitioners and program developers as to the who's who of meddlesome anxiety post-COVID-19. A higher percentage of severely anxious participants were 60-69 years of age, which is consistent with previous literature elsewhere [36–38]. We found, as others have in the first year of the pandemic [9,39], that being in one's 80s and 90s is an asset. Consistent age-specific patterns of findings at different time points in the pandemic lend further credence to age-anticipatory clinical assessment. This is especially important given that Canadians in their 80s can expect to have a mere 1.3 additional life years left to live [40]. Longitudinal studies are necessary to best understand age-related trajectories of mentally healthy recovery work after COVID-19, however. Whether any of these age-specific patterns fall out differently later on remains to be seen.

Perceived health was also another between-anxiety-group differentiator. Literature reviews prior to our study tell of being in very good to excellent perceived health as a mental health asset in later life [41]. Feeling less health-related vulnerability has been associated with remarkably greater tolerance for uncertainty during COVID-19 [42]. Perhaps older people in better health feel more protected against getting or recovering from COVID-19, or are more forgiving in anticipation thereof. Experiencing better mental well-being over time appears to be associated with self-compassion [43]. Health-related mindsets may become even more important long after COVID-19, given that our years

lived in good health are expected to come to a close as early as age 71 [40]. Qualitative research will permit exploring with depth relationships between health mindsets and expectancies.

Living with chronic illness(es) was not a remarkable differentiator. In earlier studies, chronically ill older Canadians have reported significantly higher symptoms of depression [10] but not anxiety [44]. Findings about chronic illnesses have tended to be more compelling for depression than for anxiety in others' studies abroad [45,46] as well. In this study, being chronically ill was somewhat advantageous. We therefore wondered whether older people, presumably having to adjust their home, work, and social livelihoods to best manage a chronic illness, are better able to take actual or potential COVID-19 health-related outfalls in stride. Older people living with multiple chronic illnesses may be even more adept negotiators. Perhaps having to eke out a chronically ill livelihood for oneself brings heightened self-compassion [43] or an ability to genuinely see that there are no guarantees in life and to not fixate on own-health hardships [43,47]. Older Canadians better able to persevere alongside unexpected and longstanding interruptiveness of multiple chronic illnesses appear to express lesser COVID-19 worry [18].

Groups living at risk for infectious illnesses are well aware of how to best navigate their surrounding environments to stay as healthy and as well as possible [48]. Early in the pandemic, Gutman et al. [49] found that chronically ill older people were more in favor of masking than their midlife counterparts. Throughout COVID-19, along with highly anxious and older Canadians, who might also self-identify as a likely candidate for getting COVID-19 were characterized as public health measure followers [50]. Other older people in their 70s and 80s have been more inclined to get tested for COVID-19 [51]. When social distancing lifted, older people across Canada, most of whom were chronically ill, reminded contemporaries to stay vigilant about their physical surroundings and to a lesser extent, public health measures [21]. At this time, people in their 60s and older across Canada were also less prone than middle-aged and young adults to test positive for COVID-19 [52]. As of this July, some 391,000 Canadians in their 60s (versus about 755,000 people in their 20s) had been infected with the COVID-19 virus.

In the first two years of the pandemic, in Canadian [10,53] and international studies [37,54,55], older men were a consistently significantly anxiety-advantaged demographic. Some blame this on the increased burden that women experience with caregiving responsibilities [18,56] or heightened potential exposure to domestic violence in the wake of pandemic-related stresses and strains [39,55]. A recent meta-analysis also revealed that at any age men tend to express less fears and anxieties about the pandemic, with this perhaps owing to social norms about standing on one's own two feet and keeping one's emotions in check [57]. In our study, men were generally but not always less likely to experience severe anxiety. Chima et al. [58] found that CIS-gender men to be significantly less severity-inclined than CIS-gender women and even more so compared to non-binary or transgendered persons. Research also tells us that older people self-identifying as LGBT were significantly more prone to anxiety and to a host of COVID-19 stressors, including access to mental health care and financial strain [59], and to more depression and loneliness [60] throughout their 60s, 70s, and 80s than are same-age heterosexual persons. Given the tenuous nature of our findings in relation to sex and gender identity, objective assessments with mixed expectancy and open-ended questions are prudent.

We were surprised that people with severe anxiety were not significantly more likely to be without a life partner or to have sought support from a loved one. In the first year of the pandemic, living in isolation from others was detrimental to older Canadians' perceived mental health [61,62]. Older Canadians also reported being far less prone to report familial conflicts than midlife adults [49]. In the first two years of the pandemic, news about older people's heightened risk for COVID-19-related harms became part of the fabric of everyday life [63]. We are now coming to learn, as others forewarned [64] of the anxiety-provoking effects of negative news [65], any television news [66], and rehashed news among online acquaintances [67] about COVID-19. We therefore wondered whether participants' support seeking might be seen as exacerbating loved ones' worries about them. Perhaps not having a partner also living at a heightened risk for COVID-19 offsets this worry. We ought not

to assume that older people who are not alone are far better off in terms of their mental health and well-being.

In keeping with others' findings about older Canadians [39,44], the same can be said with respect to education, wherein more is not better. Perhaps it is not book wisdom but rather, as Ardelt and Jeste found, life wisdom that helps older people be open to experiences and to expect to grow in some way when experiencing crises in their life [47]. Expressing discomfort around not knowing what the future will bring [42] and ruminating over what is yet to come [68] can be a mentally detrimental and a lonely headspace to be in. Open- and present-mindedness seems to be a salutary approach [69].

Coping Strategies

A global pandemic is hardly an everyday experience, particularly when transitioning from one's own four walls into open spaces with COVID-19 still lingering. There is a good deal of literature condoning confronting reality and embracing acceptance of one's circumstances to diminish fear and anxiety [34,70–73]. Our findings tell a different story when older Canadians were confronted with transitioning back into open spaces, albeit in a grocery store, a bank, or a drugstore. Under the auspices of establishing a "new normal" [32,70] wherein fear and anxiety are commonplace [74], severely anxious participants were less likely to be exercising and getting adequate sleep. Regular exercise seems to provide breathing space and a change of place to dissipate anxiety, at a reasonable distance from others [75]. Inadequate sleep and anxiety can fuel one another [76]. These are back-to-basic, familiar creature comforts. Practitioners and program planners should not take for granted the mental benefits of getting out for a walk [77] or a sleep routine [78]. Simple can be better when one's health-related stakes are high.

We are far less inclined to recommend information management. Seeking credible information from sources like WHO and Health Canada seemed to be somewhat beneficial and somewhat detrimental. Finding a balance between staying informed and taking breaks from news could lessen and could also double one's prospects of experiencing severe anxiety, albeit with less rarity ($p = .494$ versus $p = .657$). It would not be unusual in the larger population ($p = .857$) to be doubly-disadvantaged when decidedly unplugging from electronic devices. These patterns support others' contentions that the advent of COVID-19 has fuelled people's appetites for being in the know, and on a variety of news platforms, even if it frightens them [79,80]. That the pros and cons of information seeking remain a topic of public interest and debate [81–83] make our findings about managing streams of COVID-19 information an ideal icebreaker for patient-practitioner conversations. Wide confidence intervals in all three instances are telling, calling for cautious optimism for COVID-aware aficionados.

Practicing relaxation and meditation was more common among severely anxious participants, and this defies others' findings [84,85]. Meditation involves acknowledging positive or negative thoughts and without prejudice while attending to muscle tension, the rising and falling of one's chest, or the sound of subtly spoken words [86]. We wondered whether the very thought of transitioning into open spaces with COVID-19 lingering rendered some participants' overly in-sync-with symptoms like muscle tension or feeling that something terrible was about to happen. Meditators' odds of experiencing severe anxiety in the larger population could be 4-fold higher than what the odds ratio for this strategy suggests. We therefore recommend connecting older people with physiotherapists or occupational therapists to explore older people's intentions and anticipated mental drawbacks and benefits. Adding soundscapes might be beneficial. Some older Canadians having been through intensive care experiences have found these mentally beneficial [87].

In contrast, severely anxious participants appeared to be less likely to decrease other sources of stress in their lives and to perhaps reduce mental clutter. Research supports enhancing older people's awareness of thorny sources of anxiety [71,73,88]. Psychosocial stressors like unsafe living arrangements, being isolated from friends, and having unmet health-related needs can take a toll on our anxiety levels [8,89,90]. So too can persistent loneliness [91]. Arguably, COVID-19 magnified these stressors, particularly during lockdowns [92,93]. While older Canadians seemed to be far less likely to experience financial losses and family breakdowns, they were not immune to losing someone

close to COVID-19 or to difficulties accessing health care [10]. Losing a significant other is an irreversible loss.

Research from the first year of COVID-19 tells us that mental resilience, particularly during lockdowns, is an invaluable piece of armor. Some resilient older people have seen having an unwelcome viral companion as a means to psychological growth [94] and to a thicker skin to ward off anxiety that pandemic-related stressors like facing precarious health and looking after others when you too need support [95]. Throughout COVID-19, others lacked symptoms of anxiety that fed off of each other and felt less alone [96] and had a family who they could, at the very least, talk to or let any friction between them be [97]. Remembered resilience in this study was underwhelming. Participants with severe anxiety were somewhat but not significantly less likely to remember this. Resilience reflects how well people bounce back from adversity [98]. Practitioners and program planners should keep in mind that age-as-vulnerable public health messaging early in the COVID-19 pandemic might set the stage for dismissing or downplaying own-resilience [99]. The 'new normal' age-as-an-asset messaging borne out of COVID-related research could change this. What resilience looks like in older people's eyes, and how and why it matters, warrants further exploration in practitioner assessments and in mental health program planning. Resilience-related qualitative inquiry can best help us better understand the many faces of resilience within the context of a pandemic at future points in time. As perhaps with meditating, remembering that you are resilient could pose time-sensitive benefits.

5. Limitations and Conclusions

This study uniquely investigates differences in personal characteristics and coping strategies among older Canadians experiencing severe to very severe anxiety versus none at all. We shed light on what early recovery work might look like post-COVID-19 for a nationally representative sample of Canadians ranging from 60 to 100+ years of age. Nonetheless, it should be interpreted with the following limitations in mind. Hence our foraging for less empirically and more substantively laudable characteristics and strategies. Such findings proffer instructive tales (tails) in an historic time of crisis.

Cross-sectional findings, regardless of how corresponding they are, do not make us soothsayers with respect to anxiety severity [23]. For example, contrary to consistently observed higher levels of anxiety among women during COVID-19, our post-COVID-19 findings suggest that older men's odds of being severely anxious are similar to older women's prospects. Some might also argue that anxiety has more than two faces. It is not a two-sided coin. Our penchant for looking to the far right of the GAS-10 variable distribution limits what we can learn. Our nationally representative cross-sections of findings tell tales (tails) about the complexity of mental health recovery work within the context of a pandemic. Our intentions were practical, and our post-hoc guidance for practitioners and program planners is limited.

We tell of coping strategies of prior significance posing lesser and greater odds of experiencing severe anxiety, and more commonly than one might think for older Canadians at large. What limits us can also make us more insightful. For example, we had no formal measure of resilience. The Brief Resilience Scale [4] generated many informative findings during COVID-19 (for example, see Beringer et al.; Brinkhof et al.) [59,96]. We used a lay tool that posed a single question to reduce responder-burden. Wister et al. [18] tell of differences in mental health betterment with respect to older Canadians' mental, social, and functional resilience. Disaster management experts tell of resilience measures seldom robustly predicting who will best recover over time [99]. Perhaps expecting the unexpected is the 'new normal' post-COVID-19 [23]. In the meantime, we ask researchers to ardently speak to observed strategy-specific confidence intervals and *p*-values.

This study, while nationally representative, may not fully account for cultural differences in the perception and reporting of anxiety, and the use of coping strategies [70]. Canada is home to some 450 ethnic or cultural origins [100]. Researchers tell us that older Black, Indigenous persons, and people of color have experienced more symptoms of anxiety than Caucasian older people [59]. It was beyond the scope of this study to compare participants by ethnicity. There may be cultural differences

in the perception and reporting of anxiety, and the use of coping strategies, which may affect the number of people facing severe anxiety. This limits our ability to contribute to much-needed discourse about cultural nuances of mental health recovery work, and to further apprise practitioners and program planners accordingly.

6. Implications for Practice and Research

Nationally representative evidence is essential to help pinpoint who is most at-risk for severe anxiety and mitigating strategies, ideally lessening or at the very least keeping people afloat [22]. Practitioners and program planners can better anticipate the 'who' and 'how' of community interventions and initiatives. This is important because mental health seeking is an often stigmatized practice [24].

Characteristics and strategies of little empirical significance illuminate an all too human side to severe anxiety. Our findings contradict others' claims during COVID-19. Older men, those without chronic illnesses, and those with a life partner are seemingly no longer an anxiety-advantaged demographic when transitioning into open spaces. While education is a well-known determinant of health, neither were older people with a post-secondary education. Perhaps as Bonnano et al. [99] now aver and as Hobfoll et al. [101] have long forewarned, the sudden and chaotic nature of the changes that a pandemic can bring makes once-routine tasks an arduous task for everyday people. Older Canadians' dealings with everyday problems in a structured way was somewhat beneficial and somewhat detrimental. Just prior to our study, a national survey revealed evidence of an overwhelming sense of weariness among Canadians of all ages waiting with bated breath for a future carved in cardboard versus stone [102].

Learning who has resided on the unsavory side of anxiety is sobering. Amidst a desire to rebuild our lives and livelihoods, let us not forget that our mental health can change swiftly and unexpectedly [14]. We hope that our findings address the pervasive stigma associated with untoward mental health and speak to the merits of peer-to-peer support. Shared everyday trials and tribulations could take the edge off of mental health conversations. Safe spaces and places for older adults to confide can foster empathic understanding and emotional support [14]. Program planners might explore whether older people living with multiple chronic illnesses would be keen to mentor contemporaries encumbered by more severe forms of anxiety. Education for healthcare providers, caregivers, and family members on how to show empathy and support for older adults experiencing mental health issues is an important consideration. Empathy training can enhance the clarity and sincerity of communication and thus foster mutual understanding and better mental health outcomes [65].

Our findings highlight the urgent need for a paradigm shift in how we look at and how we treat pandemic-related anxiety post-COVID-19. It seems rather benign for us to encourage people recovering from life-threatening events to take time to relax and recharge one's physical and mental energy [84,85]. The same could be said for stopping ruminating or worrying over things you cannot control [68], and perhaps even to strive to accept your circumstances [86]. A penchant for strategies that afford a greater and a lesser propensity for severe anxiety, albeit for remembering resilience or meditating or seeking support, demand an empathic approach and open-mindedness. Cutting down on caffeine or substances, and being kind to yourself, were also tenuous.

Program planners and practitioners should consider integrating more comprehensive and tailored approaches to anxiety management to procure interventions that address the unique challenges faced by older adults. Anxiety management remains a global concern. Severe anxiety disrupts anyone's ability to tend to their homes, banking and shopping, or caregiving, and none of us are immune to it. Policies are needed to render mental health services as essential as physical health services, and with a mindset towards pandemic preparedness now and for the future. Policies that prioritize public awareness to better engage communities and normalize risk communication are essential (for example, see Hu et al.) [103]. So too are campaigns to dispel myths, reduce stigma, and encourage open discussions about mental health [104]. Mental health campaigns should be inclusive and collaborative endeavors that resonate across cultures [105]. Our findings are meant to spark such conversations.

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