

## Article

# Social Networks, Use of Communication Technology, and Loneliness of Frail Older People Ageing in Place in Italy: The Impact of the COVID-19 Pandemic

Maria Gabriella Melchiorre <sup>1</sup>, Stefania Cerea <sup>2</sup>, Marco Socci <sup>1,\*</sup> and Giovanni Lamura <sup>1</sup>

<sup>1</sup> Centre for Socio-Economic Research on Ageing, IRCCS INRCA—National Institute of Health and Science on Ageing, 60124 Ancona, Italy; g.melchiorre@inrca.it (M.G.M.); g.lamura@inrca.it (G.L.)

<sup>2</sup> Social Policy Laboratory, Department of Architecture and Urban Studies, Polytechnic University of Milan, Edoardo Bonardi, 3, 20133 Milan, Italy; stefania.cerea@polimi.it

\* Correspondence: m.socci@inrca.it; Tel.: +39-071-8004799

**Abstract:** The study explored how the lockdown, following the first wave of the COVID-19 pandemic in Italy (February–May 2020), impacted frail older people needing Long-Term Care (LTC) and living alone at home in Brescia and Ancona. These two urban cities were differently affected by the pandemic, with a major degree of infections and deaths in the former. In July–September 2020, a follow-up study of the IN-AGE research project (2019) was carried out in both cities, involving 41 older respondents by telephone, to detect the impact of the health emergency on their social networks, use of communication technology, social isolation, and loneliness. Findings showed that the use of communication tools was overall expanded, and seniors increased telephone (TEL) contacts, especially in Ancona. In both cities, fears for the infection emerged too, and mainly in Ancona than Brescia, several cases of worsened perceived loneliness were detected. Despite the exploratory/descriptive nature of the study, with a not-representative sample of the population and notwithstanding some differences among cities, the findings stressed the risk of isolation and loneliness for seniors living alone. This risk was buffered by the use of communication technology during the lockdown, but more interventions allowing sustainable healthy ageing (HA) in place and enhancing healthy behaviours, especially in emergency situations, are needed.

**Keywords:** ageing in place; frail older people; social networks; communication technology; social isolation; loneliness; long-term care; healthy ageing; COVID-19; Italy



**Citation:** Melchiorre, M.G.; Cerea, S.; Socci, M.; Lamura, G. Social Networks, Use of Communication Technology, and Loneliness of Frail Older People Ageing in Place in Italy: The Impact of the COVID-19 Pandemic. *Sustainability* **2023**, *15*, 15073. <https://doi.org/10.3390/su152015073>

Academic Editor: Shereen Hussein

Received: 6 July 2023

Revised: 21 September 2023

Accepted: 18 October 2023

Published: 19 October 2023



**Copyright:** © 2023 by the authors. Licensee MDPI, Basel, Switzerland. This article is an open access article distributed under the terms and conditions of the Creative Commons Attribution (CC BY) license (<https://creativecommons.org/licenses/by/4.0/>).

## 1. Introduction

In Italy, 50% of people living alone are over 65 [1], and 44% of seniors living alone have severe functional limitations [2]. Overall, those aged 65 years and over are 24% of the total population as of 1st January 2023 [3]. Mainly female family caregivers, e.g., spouses and daughters (up to 75%), take care of them when needed [4], frequently with the help of personal care assistants (PCAs), often called migrant care workers (MCWs) when coming from abroad, mainly from Eastern Europe [5]. In several cases, this caring solution can allow the opportunity of ageing in place, that is, remaining as much as possible independently at home while ageing [6], thus maintaining contacts with their own social networks, e.g., family members, friends, and neighbours. Ageing in place represents, however, a crucial challenge for frail older people with functional and cognitive limitations and needing Long-Term Care (LTC) [7], especially when living alone at home without cohabitant relatives. Frailty indeed affects several domains (physical, psychological, and social) [8], with hard consequences for older people in terms of illnesses, disabilities, and limited functional abilities in daily living activities, often leading to institutionalisation [9]. In order to face such challenges and allow also healthy ageing (HA), that is “the process of developing and maintaining the functional ability that enables well-being in older age” [10] (p. 28),

LTC needs, both health and social, should be addressed throughout the life course for allowing seniors to live well and maintain relationships [11]. In particular, functional ability refers to the interaction between the intrinsic capacity, both physical and mental, of people and environmental characteristics (home, communities, and society) [12]. In this respect, in addition to available informal and formal supports, technology also becomes fundamental [13], especially when a health emergency, such as the one following the recent COVID-19 outbreak, requires a long period of lockdown and stay-at-home confinement. Since 11 March 2020, when this infection was officially declared a pandemic by the World Health Organisation (WHO) [14], community services have been reduced or postponed (also closed down in certain cases), and “social distancing” measures have been progressively adopted worldwide. This is to limit mobility and transmission of the infection and to protect, in particular, older people, who recorded the highest mortality risk following the spread of the virus [15]. However, the forced objective social isolation, due to reduced contacts, made the support from relatives and friends for frail older people very difficult. This negatively impacts their overall social interactions and also increases their loneliness as a subjective perception/feeling of being alone/neglected without help [16,17], with hard consequences for their physical and mental health [18]. Such a context is also known as the social connectivity paradox [19,20], with social distancing measures both protecting and isolating older people. It is, however, important to consider that, according to Hawkey et al. [21], loneliness seems unequally distributed across adulthood, with higher levels among both seniors aged over 70 years and young adults aged under 30 years, with a peak for individuals aged 50–60 years. Thus, “it is not age itself that influences loneliness, but rather age differences in experiences and resources account for age differences in loneliness” (p. 13). Some factors, e.g., living alone, poor health, and few social contacts, can represent universal predictors of loneliness at all ages but are more likely to occur in later life. Previous authors [22] found loneliness highest in young adults, reducing until old age, and again increasing in older adults. Moreover, older people suffer from the digital divide and related low digital skills, further increasing in turn their objective social isolation and subjective loneliness [23]. It is also worth highlighting that in 2050, in several countries, over 20% of people will be 60 years of age or older, with an increasing trend to age in place alone and decreasing social networks. Thus, measures regarding social distancing adopted during the COVID-19 emergency have drawn attention to how social isolation and loneliness are crucial issues for seniors and could get worse in the coming years [24].

In order to explore how the pandemic emergency impacted the living situations of frail seniors living alone, this study considered two Italian cities: Brescia (Lombardy region, Northern Italy) and Ancona (Marche region, Central Italy). This since Italy, especially the North, was the Western epicentre of the first wave of the infection (February–May 2020) [25], with 4115.04 cases per million people aged 50 years and over in spring-summer 2020 [26], and 455,170 people aged 80 and over died in the period 2020–2021 [27]. In this national context, in the Lombardy region, a great number of infections occurred in the first weeks of the pandemic, followed by Veneto, Piedmont, Emilia-Romagna, and Marche regions [28,29]. In this period, Brescia was among the Italian provinces most affected by contagion and mortality rates due to the pandemic [30], with 1521 deaths (average age of 77 years) [31], whereas Ancona was less affected [28], with 101 deaths (average age of 79 years) [32]. It is also to highlight that this study represents a 2020 follow-up of the main IN-AGE (inclusive ageing in place) survey [33], carried out in 2019 and involving some Italian cities such as Brescia and Ancona, as explained better in the Section 2.

Starting from the considerations mentioned above, the study focused on the first wave (February–May 2020) of the COVID-19 pandemic, with the following research questions: (1) Did the COVID-19 pandemic and fear for the infection on frail older people ageing alone in place with regard to contacts with their social networks, use of communication technology, and loneliness? (2) Which changes in daily living did emerge? (3) Was the impact of the COVID-19 pandemic and related changes in daily living different between the cities of Ancona and Brescia? In light of these questions, it is hypothesised that the lockdown

following the pandemic in Italy (the first one enacted by a European government after the COVID-19 outbreak) could have had a great overall negative impact on older people living alone and on their social relationships. This is especially true in the latter than the former city, as greater loneliness and fear for the COVID-19 pandemic are probably compensated (in both cities) by a greater use of communication technology (e.g., smartphones) to remain in contact with relatives and friends. In this respect, both individual (e.g., technological skills) and contextual (e.g., family/friendship/neighbourhood) factors may have played a role in the period. It is also to underscore that the Lombardy and Marche regions are representative, respectively, of high and medium levels of socio-economic development in the country, with greater delivery of support services for older people with LTC needs in the North [34]. The exploration of these aspects can provide insights on the difficulties faced by frail seniors living alone during the lockdown, thus potentially indicating a possible different context in two Italian areas as to available supports in this respect.

## 2. Materials and Methods

### 2.1. The Main Survey in 2019: Study Design, Data Collection, Ethical Issues, and Data Analysis

The main qualitative IN-AGE survey was carried out in May–December 2019 and involved 120 older people living alone in three Italian regions (Lombardy in the north, Marche in the centre, and Calabria in the south). In each region, a medium-sized urban city with 100,000–200,000 inhabitants [3] (respectively: Brescia, Ancona, and Reggio Calabria) and an inner/rural site as an area significantly distant from the centres offering essential services [35] were included. Twenty-four qualitative interviews were realised in each urban context (total 72) and 16 in each rural one (total 48). Within these areas, the most fragile locations were identified, e.g., a higher rate of older people living alone and a lower provision of public services [36]. Purposive (not probabilistic) sampling was built [37], with respondents having the characteristics allowing the exploration of the themes included in the study. Qualitative research samples were thus not selected to be statistically representative, and only a theoretical generalisation was allowed as a contribution to a debate on the explored topic. The inclusion criteria for seniors needing LTC were the following: both gender and aged  $\geq 65$  years; living alone at home or with the support of a PCA; limited functional abilities; absence of cognitive impairment; and absence of very close supporting relatives. It is to specify that overall only the term PCA (and not also MCW) is used, since in 2019, private assistants both Italian (three in the Marche region) and from other countries were found [33]. Thus, this more general term was considered suitable to present findings from the follow-up for consistency with the main IN-AGE study, even though only foreign personal assistants emerged in 2020.

Older people were contacted and recruited with the help of volunteer organisations and operators of public home care services. These channels were fundamental to finding seniors meeting the inclusion criteria and also for providing them with preliminary information on the survey. Face-to-face interviews were carried out at the home of the participants by six trained experts (sociologists and psychologists) in qualitative data collection. They administered a semi-structured interview/topic guide, with mainly open-ended questions and a few structured ones. The sections of the interview explored the following aspects: socio-demographic; family and housing; health status; daily living activities; use of services and care networks; social isolation; and perceived loneliness. These topics were overall analysed using adapted questions from previous similar studies. It is to clarify that the questionnaire of the main IN-AGE study was “inspired” in particular by Lamura et al. [38] (in the context of a project on family caregivers in Europe) for socio-demographic aspects, seniors’ needs (health, emotional, and domestic), available help for meeting these needs, services used, and economic situation. Moreover, ADLs (Activities of Daily Living) and IADLs (Instrumental Activities of Daily Living) scales [39], integrated with two sensory limitations (difficulty in seeing and hearing) and two mobility limitations (going up/down the stairs and bending to pick up an object) [40], were used to detect the overall limitations in performing the activities of daily life (in autonomy, with help, not able). Further dimen-

sions (e.g., family structure, housing, social isolation, perceived loneliness, quality of life, and leisure time) were explored with open questions developed ad hoc for the IN-AGE questionnaire, which was edited only in Italian. Conversely, the “inspiring” questionnaire cited above was translated/back-translated (from English into the native language in each country participating in the study and vice versa) and cultural adaptation/cross-cultural validation were performed, following established protocols, with the support of a review committee [38].

The IN-AGE study was approved by the Ethics Committee of the Polytechnic of Milan for the whole Consortium (POLIMI, Research Service, Educational Innovation Support Services Area, authorization n. 5/2019, 14 March 2019). Participants were carefully informed on the privacy, confidentiality, and anonymity of their personal information collected, according to the ethical issues of the European Union’s (EU) General Data Protection Regulation (GDPR) n. 679, of 27 April 2016 [41]. Each participant also signed a written informed consent form before starting the interview.

Narratives were audio-recorded and transcribed in full/verbatim by interviewers. A mixed-methods analysis was performed. First, a qualitative analysis was provided by means of the Framework Analysis Technique [42], and a thematic content analysis was carried out [43]. A manual qualitative analysis was carried out without using software, as also supported by some literature [44]. Secondly, some qualitative dimensions were also quantified [45] (e.g., mild, moderate, high, and very high levels of physical limitations). Some verbatim statements from the narratives were also included to support and integrate the overall analysis [46]. Additional details (setting, sampling, measures, and data analysis) are available in a previous publication [33], from which the present section “Materials and methods” has been partly drawn.

## 2.2. The Follow-Up in 2020

### 2.2.1. Sampling, Data Collection, and Ethical Issues

The follow-up study was realised in July–September 2020, in the cities of Brescia (Lombardy region) and Ancona (Marche region), by collecting experiences of seniors living alone during the first wave (February–May 2020) of the COVID-19 pandemic and consequent health emergency and lockdown, with regard to some dimensions already explored with the main survey in 2019. The follow-up was not realised in Reggio Calabria (Calabria region) and in rural areas (both conversely involved in the survey of 2019), since several difficulties in recruiting available local interviewers during the lockdown emerged. Recruitment channels already involved in the survey in 2019 in Brescia and Ancona re-contacted seniors to remind them of their previous interview and to have further follow-up. These channels also verified preliminary if some older people had died in the meantime, were hospitalised, or were in other particularly fragile conditions that would have excluded a new involvement in the study.

Interviews were administered by telephone due to social distancing imposed by the pandemic, by the same interviewers who carried out the main survey in the two cities. Answers were thus only written down on the paper questionnaire and not audio-recorded. The data collection tool was a simple/short semi-structured questionnaire (Supplementary Materials File S1), including closed-ended questions with space for possible free/clarifying reporting by seniors (e.g., to justify/motivate better any answer/reported change). Questions first generally addressed the impact of the COVID-19 pandemic on the health of seniors, as well as possible contagion. Then, self-reported/perceived impact following the lockdown in 2020 (compared to 2019) on different domains of their lives (i.e., social networks, loneliness, use of remote communication tools) was collected in order to catch overall perceived changes, as performed also by other authors [47]. Finally, fears related to the COVID-19 pandemic were assessed.

Before starting the follow-up study, a query was sent to the POLIMI Ethical Committee that approved the main IN-AGE study in 2019 in order to know if a novel formal authorization was needed. The Committee (response on 11 May 2020) confirmed that it



was possible to carry out the new interviews in 2020 without a further application since the study framework was the same as in 2019 (i.e., same participants, same inclusion criteria, same contact and information procedure, same sections of the questionnaire), with only one general question on the potential contraction of the virus and the remaining questions exploring changes with respect to 2019. Moreover, participants provided verbal consent following the social distancing imposed by the pandemic. In this respect, we referred to what the EU Commission established in derogation from GDPR n. 679/2016, stating that written informed consent from participants was not mandatory for surveys carried out during the first phase of the COVID-19 pandemic and exploring the impact of the health emergency on the population. These studies were indeed considered of high significance for public health and thus conductable by means of simplified procedures [48].

### 2.2.2. Data Analysis

Closed responses were elaborated by means of simple frequency distribution and bi-variate analysis using Microsoft Excel 2019 (Microsoft Corporation, Washington, DC, USA). Overall, the impact of the COVID-19 pandemic and consequent social distancing measures were analysed with regard to: overall relationships and social isolation from family, friends, and neighbours (face-to-face/FF contacts and telephone/TEL contacts to ask for practical/psychological support); use/utility of remote communication tools (mobile phone, smartphone, and personal computer (PC)/tablet) to connect with the persons mentioned above and others (e.g., physicians, social workers); perceived sense of loneliness; and fears generated by the pandemic (e.g., of contracting the virus, of not receiving adequate assistance, and of dying). It is worthy to clarify that in this study, and overall, for older Italians, the mobile phone is a basic device for making calls and sending short text messages (SMS), whereas the smartphone has the functions of a computer and an Internet connection (to browse websites, send and/or receive e-mail messages, listen to music, take photos/videos, and watch films), also by means of several apps that can be downloaded and used for this purpose. Moreover, social isolation is defined as objective social relationships measurable by means of a lack/reduction of contacts, and loneliness is a subjective emotional feeling of being alone/neglected [49], as anticipated in the Introduction.

It is to highlight that some aspects were explored when comparing T1 (2019) and T2 (2020), but with a different modality. Regarding the perceived loneliness, the changes at T2, concerning the respective answers provided at T1, were reported in terms of both worsening and (possibly) improving. As for the communication technology, the overall referred use at T1 and T2 was compared, since the question of possible change in this respect was less understandable as worsening/improving. Other dimensions were analysed only at T2, due to the lack of a precise/corresponding type of question/answer at T1. In particular, at T2, the overall relationship/isolation with/from the family, neighbours/friends, was assessed in terms of less/more contacts (FF and TEL) during the pandemic for different needs (as explained above). This dimension was partly explored at T1 with a different focus, i.e., relationships with family and friends/neighbours for intimate confidence (persons to whom to confide any concerns with regard to their physical proximity, frequency, and modality of contacts) [17]. Thus, during the follow-up, a wider/broad concept of social relationships was considered by asking seniors to refer to an overall pre-pandemic context not recorded in the main survey of 2019, and only the modality of contacts was collected in order not to stress the interviewees too much with the request for a lot of details in this respect. Also, the perceived usefulness of remote communication tools during the health emergency was recorded only at T2 (not/little useful, not useful). Finally, the COVID-19-related fears represent, of course, a new topic at T2.

Only for T1, the perceived loneliness was asked by means of ad hoc open questions (i.e., “Do you feel alone/abandoned?”; “Have you been lonely most of the time in the past four weeks?”; “How much does it seem that others are attentive to what happens to you?”). It was then classified as follows: absent/mild if the person does not/rarely feel alone; moderate if the person feels sometimes lonely, but this feeling is linked to

contingent events (e.g., a rainy day), to certain times of the day or of the week (e.g., night or weekend), at certain times of the year (e.g., major holiday periods); high if the person often feels lonely as described above and this feeling is intense; very high if the person often feels alone and this feeling is so intense as to generate perceptible psycho-physical effects (e.g., depressive states, insomnia, inability to find meaning in life, and, in some rare cases, suicidal thoughts) [17,50]. This dimension for T2 was only explored as overall perceived worsening/improvement compared to T1, since the COVID-19 emergency did not allow articulated in-depth interviews, which were necessary to elaborate responses and classify loneliness as described above.

Moreover, as mentioned, the questionnaire included spaces for possible spontaneous additions by seniors (e.g., further specifications or clarifications regarding the explored topics). Since we have only unrecorded telephone interviews, we collected in turn only a few and short open responses; thus, a thematic analysis of the contents, with the identification of macro- and sub-categories [43], was not provided. However, in order not to neglect some precious information, further details referred/added by seniors have been included in the results section (in the text and not in the tables), e.g., who decided (seniors or relatives) to suspend/decrease personal contacts to reduce the risks of contagion; increased use of video calling for communication with the family; and why the communication technology was useful during the lockdown. Also, some short quotations have been written down on the paper questionnaire during the interviews and reported in the manuscript when relevant, with the aim of integrating the overall findings and further supporting/completing what is set out in the tables. Each quotation was codified by inserting the first two initials of the urban city and the progressive number of the interview (e.g., Brescia 1 = BS-1; Ancona 1 = AN-1). It is worth clarifying that the overall comparison/analysis of the results between Ancona and Brescia is not always homogeneous because the answers have been more or less enriched with details or spontaneous narratives (and related quotations) in different ways and according to the topics explored, also on the basis of the willingness to answer of the interviewees in the two cities.

All tables at T1 and T2 present only respondents who participated in both surveys, with the exception of the table comparing the full sample in 2019 and the (slightly) smaller sample in 2020. Moreover, tables present only absolute values according to the small sample size ( $n = 41$ ).

### 3. Results

#### 3.1. Socio-Demographic Characteristics of the Sample

In Brescia, 20 older people (out of 24 in 2019) were interviewed, since three individuals died before the start of the follow-up in July 2020 and one refused to be interviewed. In Ancona, 21 participants were interviewed, since one person was deceased and two refused. As referred to by recruitment channels/families, the four seniors who died before the follow-up were not infected by the COVID-19 virus. Overall, in 2020, only four older people in Brescia and three in Ancona were “lost”, and the main socio-demographic characteristics of the samples at T1 [33] and T2 remained very similar. Thus, subjects were all aged 80 and over (representing over half of the sample in Ancona), female, widowers (especially in Ancona), with a low educational level, and living alone without PCA (the total in Brescia). Moreover, only a senior in Brescia was referred to as having contracted the COVID-19 virus at T2 (Table 1).

**Table 1.** Sample characteristics: T1 (2019) and T2 (2020) (absolute values/n).

Characteristics	Brescia (Lombardy)		Ancona (Marche)	
	T1	T2	T1	T2
Age groups (years)				
65–74	5	5	3	3
75–79	4	4	4	3

Table 1. Cont.

Characteristics	Brescia (Lombardy)		Ancona (Marche)	
	T1	T2	T1	T2
80–84	6	5	5	5
85 and over	9	6	12	10
Gender				
Male	5	4	5	4
Female	19	16	19	17
Education				
No title/primary school (5 years)	11	11	12	11
Middle school (3 years)	5	5	7	5
High school (3–5 years)	8	4	5	5
Marital status				
Single/divorced/separated	12	11	5	5
Widowed	12	9	19	16
Living situation				
Alone	24	20	21	17
With Personal Care Assistant (PCA)	-	-	3	4
Contracted the COVID-19 virus	n.a. <sup>1</sup>	1	n.a. <sup>1</sup>	-
Total respondents	24	20	24	21

<sup>1</sup> n.a.—not applicable.

### 3.2. Contacts with Social Networks

As anticipated, at T1, the relationship with family members and friends/neighbours was analysed only for intimate confidence (respectively, nine and 12 cases for Brescia, 16 and 14 for Ancona), thus it was not considered for comparison with the wider definition of social relationships used at T2. During the first wave of the pandemic, the overall social contacts of older people (e.g., to ask for practical help or psychological support) changed both in persons (FF) and at distance (by TEL), with different situations of isolation and more frequently in Ancona than in Brescia (Table 2).

**Table 2.** Changes in relationships/contacts <sup>1</sup> (FF and by TEL) with family, friends/neighbours with regard to the overall pre-pandemic context (absolute values/n).

Relations/Contacts	Brescia T2						Ancona T2					
	No	Less	Less	More	More	Total	No	Less	Less	More	More	Total
	change	FF	TEL	FF	TEL	respond. <sup>2</sup>	change	FF	TEL	FF	TEL	respond. <sup>2</sup>
Family	9	8	1 <sup>3</sup>	2	1	20	6	3	-	6	13	21 <sup>4</sup>
Friends/neighbours	14	6	-	-	-	20	10	3	-	2	8	21 <sup>5</sup>

<sup>1</sup> At T1, such contacts (FF and by TEL) were recorded only with regard to intimate confidences and were not considered for comparison with T2; <sup>2</sup> horizontal total respondents because each row in the table corresponds to a question of the interview. In some cases, more types of changes were referred to by each respondent. Seniors reporting changes are thus calculated by the difference between total respondents and seniors reporting no change; <sup>3</sup> older woman who reduced both TEL and FF contacts with family members; <sup>4</sup> in three cases, FF contacts decreased but TEL contacts increased; and in four cases, both types increased; <sup>5</sup> in one case, FF contacts decreased but TEL contacts increased, while in one case both types increased.

Overall, in Ancona, 15 seniors declared 22 changes in their relationships with family, and 11 reported 13 changes in those with friends/neighbours, while in Brescia, the seniors referring to changes were 11 and 6, respectively. It is important to consider that in some cases, more types of changes were referred to by each respondent. Moreover, friends/neighbours are put together since respondents themselves reported how, in later life, these supports often coincide.

In Brescia, TEL contacts with family members (children and grandchildren) and friends/neighbours remained mostly stable, while FF contacts decreased (reduced but also interrupted). It was often the family who decided in this respect, but also the senior in

some cases, to limit the chances of contagion. Moreover, during the few occasions of FF contacts, seniors requested precautionary measures.

*“When my grandchildren and sons come, I do not want them to kiss me! And they must absolutely wear a mask!” (BS-1).*

In one case, an increase in FF contacts with the family was specified as greater frequency but not as a better quality of the relationship. However, the parent-child relationship, in that particular case, was bad/poor also in the pre-COVID-19 period and was confirmed as such also during the pandemic.

*“During the lockdown my daughter took care of me, she cooked for me and so on. But she never spoke to me! She often treated me rudely” (BS-20).*

When the decrease in FF contacts involved friends/neighbours in Brescia, it was reported as a shared choice, but an increase in TEL contacts was not referred to.

In Ancona, above all, TEL contacts increased, both with family and friends/neighbours. In particular, the increased TEL contacts, especially with the family (13 cases out of 21), replaced in some way previous/usual FF contacts with three to four telephone calls a day. Also, the TEL contacts with friends/neighbours were considered very important.

*“I had several contacts with my children and grandchildren mainly by telephone, since I fear the virus a lot!” (AN-15).*

*“By telephone I remained in contacts with my friends, since the municipal day care centre I was usual to attend was closed during the lockdown. We kept each other company” (AN-2).*

FF contacts were both reduced (again for precautionary reasons, but less than in Brescia) and, in some cases, also increased in Ancona. In particular, children and grandchildren provided and delivered food and medicines to their old relatives. Moreover, despite the prohibitions due to lockdown, seniors referred some occasional FF visits by friends/neighbours (mainly for socialising), however, using all the necessary precautions.

*“We exchanged sometimes illegal visits, but however we were carefully with masks and so on” (AN-21).*

When in both cities no changes were reported, good relations existed and continued in the same way also during the health emergency and especially by TEL, or conversely, contacts were already non-existent or scarce/cold before the pandemic and remained difficult.

*“With some friends contacts were already cold and remained so also during the lockdown, without solidarity” (AN-14).*

### 3.3. Communication Technology Tools

The overall use of TEL contacts with family and friends/neighbours partly emerged from the previous paragraph. In this one, the more in-depth use (e.g., to connect with physicians and social workers) and perceived usefulness of various communication tools (e.g., mobile phones, smartphones, PCs/tablets) during the lockdown were explored, and differences between the two cities were detected (Table 3).

Compared to T1, it is noted that there is an increased use of smartphones and PCs/tablets in both cities at T2. The use of the mobile phone remained the same in Brescia, while it dropped significantly in Ancona (from 17 to nine users). However, seniors living in Brescia who considered these three tools little or not at all useful clearly prevailed compared to those who found them useful (17 vs. five). In Ancona, conversely, a great majority of respondents referred to these tools as useful (19 vs. 3). Above all, in this city, the possibility of keeping in touch with family members, especially children outside the region/abroad, was underlined. Furthermore, overall, in some cases in both cities, changes in the method used to communicate were reported, with the addition of exchanging messages or video calls. In particular, the possibility of using voice messages via WhatsApp or navigating the internet with a smartphone is highlighted, with the latter also serving as an opportunity to spend some hours during the forced stay-at-home due to the pandemic.



**Table 3.** Use and usefulness <sup>1</sup> of remote communication tools to be in contact with others (absolute values/n).

Tools <sup>2</sup>	Brescia				Ancona			
	Used T1	Used/Little-Not Useful T2	Used/Useful T2	Total Respond. <sup>3</sup> T2	Used T1	Used/Little-Not Useful T2	Used/Useful T2	Total Respond. <sup>3</sup> T2
Mobile	10	9	1	20	17	1	8	21
Smartphone	6	5	3	20	5	2	7	21
PC/tablet	2	3	1	20	2	-	4	21

<sup>1</sup> At T1, the usefulness of these tools was not investigated; <sup>2</sup> in some cases, more tools are used (both at T1 and T2); <sup>3</sup> horizontal total respondents are indicated because each row in the table corresponds to a question from the interview.

*"I used the smartphone to be able to see grandchildren and great-grandchildren" (BS-5).*

*"Relations with family members, and in particular with my nephew, were daily also through video calls" (AN-12).*

*"When I have nothing to do I look at the recipes in internet. For me it is life!" (AN-6).*

However, those who reported on the whole the uselessness of these devices during the lockdown underlined above all their difficulty/inability to use them, especially the smartphone. Thus, some seniors prefer the landline phone.

*"I use the smartphone very little, I still have to understand something about it. It is too complicated for older people" (AN-3).*

*"In general I know how it works, but sometimes I do not remember some functions" (AN-5).*

*"I do not like the smartphone, I prefer the fixed one [the landline]. With it I can call even to the other side of the world" (AN-9).*

### 3.4. Perceived Loneliness

The social distancing imposed by the lockdown also had an overall impact on the perceived loneliness of seniors. However, notable differences between Brescia and Ancona emerged (Table 4).

**Table 4.** Perceived loneliness (absolute values/n).

Level of Loneliness <sup>1</sup>	Brescia				Ancona			
	Loneliness T1	No Change T2	Worsened T2	Improved T2	Loneliness T1	No Change T2	Worsened T2	Improved T2
Absent/Mild	6	6	-	-	4	1	3	-
Moderate	5	4	1	-	10	2	7	1
High	6	6	-	-	4	2	2	-
Very high	3	2	-	1	3	2	1	-
Total respondents	20	18	1	1	21	7	13	1

<sup>1</sup> Absent/Mild: never/rarely respondent feels loneliness; moderate: sometimes; high: often; very high: often with psycho-physical effects, e.g., depression/insomnia.

In Brescia (mainly mild/moderate loneliness at T1), the aforementioned fewer FF contacts with family members, friends/neighbours, as well as the general heavy climate of social distancing during the lockdown, do not seem to have particularly affected the sense of loneliness of interviewed people. As many as 18 of them declared their perception of loneliness unchanged, and an older woman even referred to how it decreased/improved since she spent the lockdown period at her daughter's home, and therefore she felt less alone. Only one person perceived a worsening (a senior with a moderate level of loneliness at T1), closely linked to the restricted possibility of going out and meeting people.

*"Despite the confinement due to the lockdown, I did not feel loneliness" (BS-12).*

*“Not being able to go out was terrible, terrible! Even before [the lockdown] I had to go out. I suffer so much staying at home” (BS-15).*

In Ancona (mainly moderate loneliness at T1), conversely, despite the greater contacts (both FF and by TEL) than in Brescia with family members, friends/neighbours, the sense of loneliness worsened in 13 out of 21 cases and remained unchanged in seven cases. It improved in only one case (as in Brescia), and for a senior who referred, he felt even better during the lockdown.

*“I have heard a beautiful silence, it was like living in a cloud” (AN-3).*

Regarding Ancona, among those who reported a deterioration (i.e., seven cases with moderate loneliness at T1), some seniors seem very exhausted, even though they have been living alone for a long time, and the lack of opportunity to chat with others in person was greatly felt. Among those who did not refer to having experienced a particular or greater level of loneliness during the lockdown (i.e., four cases with a serious level of loneliness at T1), the routine of living alone seems to be the main reason for not suffering so much.

*“There was a heavy atmosphere in the days of the emergency. By when a person is not talking to anyone, his memory is lost!” (AN-1).*

*“I am always alone, I live alone, I am used to loneliness. I do not suffer this condition particularly” (AN-14).*

### 3.5. Fear for the COVID-19 Infection

Concerning the fears perceived by older people in relation to the pandemic infection (e.g., to contract the virus, not to receive adequate assistance, to die), seniors not referring to them prevail when considering single typologies. However, the majority referred to at least one fear, with similar values both in Brescia and Ancona, i.e., 12 out of 20 and 14 out of 21, respectively (Table 5).

**Table 5.** Pandemic fears (absolute values/n).

Fears	Brescia T2			Ancona T2		
	No	Yes	Total Respond. <sup>1</sup>	No	Yes	Total Respond. <sup>1</sup>
<i>At least one fear</i>	8	12	20	7	14	21
Respondent contracting the virus	12	8	20	14	7	21
Respondent contracting the virus and dying	15	5	20	15	6	21
Not to receive adequate assistance if sick	20	-	20	15	6	21
Family members contracting the virus	12	8	20	11	10	21
Family members left without work	18	2	20	15	6	21
Other	9	2 <sup>2</sup>	11 <sup>3</sup>	20	1 <sup>4</sup>	21

<sup>1</sup> Horizontal total for respondents because each row in the table corresponds to a question from the interview;

<sup>2</sup> fear of physical pain due to COVID-19; <sup>3</sup> nine cases are missing; <sup>4</sup> fear of going out and contracting the virus.

In particular, similar results in both cities emerged with regard to the most widespread fears, i.e., personal infection or of a family member (respectively, eight cases for both in Brescia and 7 and 10 cases in Ancona). The fear of death is not reported by most. More substantial differences emerge in relation to the fear of not receiving adequate assistance if sick, since no senior has expressed this fear in Brescia, against six cases in Ancona. Further differences were also recorded about the fear that family members could remain out of work during the lockdown and even after (two older people in Brescia against six in Ancona).

Among those living in Brescia who were not afraid of contracting the virus, some consider that there was no danger in this respect by adopting all the necessary precautions (mask, social distancing, frequent washing of hands).

*“I am not afraid! I always wear a mask, and I keep a safe distance when I meet other persons, we remain in a circle” (BS-19).*

Other seniors in Brescia, with previous/current several health problems (e.g., heart attacks, embolisms, tumours), perceived the virus as a health problem not worse than others.

*“No! I have no fear. I have always had health problems, I am visually impaired since birth, I have a cancer. The COVID does not scare me!” (BS-18).*

Concerning Ancona, some seniors are not worried by the virus since they feel very old, therefore without particular concern for their own future. However, those worried about a possible contagion, potentially dangerous for their own precarious health conditions, are very attentive to the rules of social distancing and remain at home.

*“I am very old, I have not so much things to do in the coming years” (AN-9).*

*“I try to avoid close contacts as much as possible” (AN-18).*

As for Ancona, it is also to highlight that some older people, usually living alone at home, seem almost unaware of what is happening concerning the infection and related confinement.

*“I have no particular fears, I continue to do everything as I have always done, without losing my heart” (AN-19).*

On the opposite, a woman feels that everything has changed with the pandemic.

*“I think that existence has substantially changed following the pandemic, and all people in the world is stressed and worried” (AN-4).*

#### 4. Discussion

The aim of this study was to analyse the impact of the first wave of the COVID-19 pandemic (February–May 2020), related to lockdown and fear for the infection, on frail older people needing LTC and living alone at home in the cities of Brescia (Northern Italy) and Ancona (Central Italy) with regard to their social networks, use of communication technology, and loneliness. Findings showed that seniors changed overall relationships, with decreased FF contacts, especially in Brescia, greater TEL contacts, especially in Ancona, and increased use of smartphones and PCs/tablets in both cities. Also, fears of contracting the virus in both cities emerged, whereas in Ancona, several cases of worsened perceived loneliness were detected, as discussed more in detail below. It is the premise that, to discuss research findings, overall international/national, and regional data are considered due to the scarce/specific available and comparable local information regarding the topics explored in Brescia and Ancona. Moreover, in Italy, the contrast to the COVID-19 pandemic was performed above all at a regional level.

##### 4.1. Social Networks and Social Isolation

During the first wave of the pandemic, different situations of social isolation in Brescia and Ancona emerged. In the former city, a widespread interruption or reduction of FF contacts was reported, which was not compensated by more TEL contacts. In the latter city, both types of contacts increased (FF slightly), especially by TEL and with relatives, even though FF contacts were also reduced in some cases.

In Brescia, the suspension/reduction of FF contacts could be linked to the presence of family networks mainly located in different municipalities and outside the city where seniors live, as found according to the 2019 survey [17]. The impossibility of moving between municipalities during the first wave of the pandemic, following government containment measures, probably made it even more difficult to maintain contact in person with one's family members. Furthermore, in Brescia, the high diffusion of infections and deaths has created an almost widespread climate of fear that discourages overall FF contacts when perceived as not strictly necessary. The lack of substitution of decreased FF contacts with TEL ones could also be explained by usual/frequent TEL contacts even before the emergency (again following the geographical distance of family and older people).

In Ancona, the high increase in TEL contacts and also FF contacts, even though in lesser measure, especially with family members, could be linked to two main reasons. On the one hand, in this city, the role of caring for relatives was already relevant in 2019 before the pandemic [33], and it also increased widely during the first wave of the infection [51]. On the other hand, FF contacts were facilitated by a remarkable proximity that characterises

the family networks of seniors in Ancona. As emerged from the 2019 survey, these networks were indeed mainly located within the same city as their older relatives [17].

Apart from territorial differences, overall ageing often leads to a rarefaction of support/social networks due to the possible loss of a spouse, brothers/sisters, and friends, and also because functional limitations make it difficult to maintain and build social ties. This can lead to social isolation, with health-social LTC needs being neglected, and this in turn does not allow an overall HA, as also highlighted by Pot [11]. According to ISTAT [52], in Italy, the perception level of the social support network (defined as physical and psychological help) is indeed strong, only 26% among the over-65s. In later life, the time spent with other people is also reduced, and conversely, the amount of time spent alone increases, e.g., about 10 h a day for seniors ageing in place alone [53].

#### 4.2. Use and Usefulness of Communication Technology

The overall use of TEL contacts, already discussed above as a potential means for maintaining social contacts and mitigating social isolation, has been further explored with particular regard to the perceived usefulness of various communication tools (e.g., mobile phone, smartphone, PC/tablet) during the lockdown.

The use of these tools by older people increased in both cities due to the possibility of keeping in contact with video calls or navigating the internet, apart from the standard/basic mobile that does not allow such functionalities. However, in Brescia, seniors considered these devices little or not at all useful, probably since they did not change the related frequency/mode of use during the pandemic. In Ancona, seniors considered them useful, particularly for contacting children living outside the city/region or for replacing reduced FF contacts. However, the issue regarding difficulty/inability to use, especially the smartphone, also emerged.

Overall, technology has transformed daily life, offering new communication and relational opportunities, especially during the pandemic, thus creating “networks in the network” [53] (p. 212), that is, networks of care via the internet. Modern communication tools have great potential for reducing the isolation of seniors by means of remote daily interactions, thus sustaining their LTC needs and enhancing their overall well-being and HA [17]. Cipolletta and Gris [19] found in particular that technology was crucial for maintaining social contacts in the pandemic period, but not all seniors considered it useful during the lockdown, in particular those with functional limitations and low digital literacy.

As for the digital skills of seniors, ISTAT data [54] indicates that in 2019, Italians aged 65 and older overused various devices (e.g., 70% mobile phones/smartphones and 45% PCs), but their e-competences remained above all low/basic (about 60%). These national data regarding seniors are not available also for regions/provinces from the ISTAT source cited above [54]. However, that indicates how, generally speaking for Italian people aged 14 years and over, the use of laptops, tablets, and mobile/smartphones is higher in Lombardy than Marche (respectively, 35%, 32%, and 92%, vs. 25%, 24%, and 90%). Also, the digital skills of these individuals are overall higher in the former than the latter region (respectively, 33% vs. 27% with high e-competence). A further source [55], which is however limited to rural/internal areas (excluded from our follow-up) in four Italian regions (i.e., Lombardy, Veneto, and Tuscany regions in the North; Calabria region in the South), highlights in particular how the use of technology by Italian seniors for health reasons (i.e., access to digital health services) was higher in the north than the south of the country. In this respect, we can suppose that the Marche region (the centre, excluded from the study), can be placed in the “middle” (better than the south but worse than the north), as also highlighted by other studies [34]. The latter discovered such a scalar gradient North-Centre-South as for high-medium-low overall levels of socio-economic development of the country (as stated also in the Introduction).

Furthermore, often seniors have a negative and dangerous view of the internet, which is considered almost a risk to personal security rather than an opportunity that facilitates and enriches people’s lives [56]. Older people living alone and having low digital literacy

seem thus little connected. Conversely, Boreskie et al. [57] highlight the benefits of socialisation and interaction activated during the pandemic through communication technology, especially for older people who know how to use modern communication tools. Other authors [58] indicate that older people aged 80 or over who participated in a short training course in the Lombardy region on the use of social networks (compared to non-participants) reported a significantly higher use of them during the lockdown, with maintenance of contacts and social relationships and less feeling of being excluded.

#### 4.3. Stay-at-Home and Perceived Loneliness

The analysis of the perceived changes affecting the sense of loneliness of older people during the first phase of the pandemic brings out perhaps the most pronounced difference between Brescia and Ancona.

In Brescia, the reduction in FF contacts, which was not compensated for by greater TEL contacts, does not seem to have much impacted the sense of loneliness, which remained unchanged over time for almost all seniors, in particular those with mild/moderate loneliness in 2019. It could be supposed they found in themselves their own resources to stem the sense of loneliness during the health emergency, following a level of loneliness that implies feeling lonely at least sometimes, as indicated also by other authors [17]. In Ancona, despite the increase in contacts in 2020 and the greater support by family members in 2019 [51], the sense of loneliness worsened in over half of the cases. This regarded mainly seniors with mild/moderate loneliness in 2019, who probably suffered more from the reduction/suspensions of usual chats with others during the lockdown. This is in line with a great part of the previous literature, showing how loneliness usually arises when people have to reduce/suspend their usual social connectedness and FF interactions [59].

With regard to the different feelings/perceptions of seniors with mild/moderate loneliness in 2019, in the two cities, the different expectations towards the social relationships that older people have, expressed in terms of the “loneliness threshold”, could be considered too. In Northern European countries, with more individualistic societies, these expectations, especially towards family members, are much lower than in Southern/Central European countries, with more collectivist societies and a lower risk that expectations will be disappointed [17,60]. Similarly, it could be argued that in the Marche region (centre) expectations of care and perceived loneliness are higher than in Lombardy region (north). This is also a possible consequence of traditional family support prevailing in the centre-south of Italy, whereas in the north, more public services are available and the lower disposal of family caregivers is more accepted. This is also associated with higher employment levels for women (usual informal caregivers) in the labour market, with little time for taking care of older relatives [33]. However, differences between Brescia and Ancona concerning loneliness can have further reasons, and the abovementioned explanations are only some hypotheses.

Older people in both cities with high/very high loneliness in 2019 and who reported no changes in 2020 probably did not perceive a worsening since they felt in a “lockdown situation” even before the health emergency. This reveals a probable pre-pandemic state of deep loneliness, often with depression and insomnia, as indicated by Arlotti and Cerea [17]. Other authors [61] speculate that some seniors living alone did not perceive safety measures as too restrictive during the pandemic, since they were more used to loneliness than people living with other people/relatives.

It should be generally considered that older people are generally more exposed to the risk of social isolation and loneliness due to life events such as the loss of family and friends, in addition to chronic diseases and reduced mobility. Some authors [62] found in particular that seniors living alone and with multimorbidity (over 4 chronic conditions) were more affected by increased loneliness during the COVID-19 pandemic. However, previous authors analysed the vulnerability of older people in emergency situations. They argued that, on the one hand, especially older people with worse health conditions, run a greater risk for their psychological health [63], but on the other hand, a greater experience of



“lived life”, and the need to face previous stressful events can act as a protective factor [64]. Therefore, although old age can be correlated to some risk factors, it can also be a resource in case of emergencies, with seniors living alone being more resilient than younger people to loneliness during the COVID-19 pandemic [65,66], also due to fewer expectations for social contacts during the period [67]. A further study on the effects of COVID-19 on the mental health of the Italian population [68] reported higher scores of depressive symptoms in young adults than in older people.

Other authors [61] exploring pre- and peri-pandemic loneliness in community-dwelling seniors underscore that it remained low and increased slightly in the period, as if this was a “new normal” condition during the COVID-19 pandemic. They suppose in particular that remote social contacts (e.g., video calls) could have been of help in this respect, supporting a gradual adaptation to the new situation as for fear and anxiety. Peng and Roth [69] also reported that, despite stay-at-home policies, adults aged 50 years and over were protected from loneliness by means of digital contacts, with physical/social isolation not leading to digital isolation. The possibility to maintain contacts with their own social networks, allowed by technology, seems to reduce loneliness and enhance the ability of older people living alone to sustain healthy behaviour, thus contributing to overall HA. Some literature indicates connections among social isolation, loneliness, and health-related behaviours among older people [70]. In particular, social relationships as engagement with persons/ties, including active ageing activities (e.g., volunteering, grandparenting), social control, and support, could encourage healthy behaviours [71], resulting in HA. On the other hand, loneliness can negatively impact healthy behaviours, leading to depression, morbidity, and mortality [70].

#### 4.4. Fear for the Pandemic

A general fear for the pandemic (at least of one type) was recorded in both cities, mainly with regard to the possibility of contracting the infection, even though in both cities the majority of older people did not report any alarm/worry. The number of participants who did not express any fear is not irrelevant when considering that the virus affected mainly frail older people in terms of symptoms and mortality. However, it is possible that the period in which the interviews were carried out, i.e., July–September 2020, when the first wave of the pandemic was ending and economic activities were slowly reopening, contributed to “returning” possible fears. As confirmed also by ISTAT [72], Italy was among the countries most affected by the first wave, and especially in the North, the peak was indeed recorded in the months of March and April 2020, when vaccination coverage was still lacking.

Also, the worry of dying is not greatly reported in both cities, despite several deaths among seniors due to the pandemic. This seems particularly surprising for Brescia, a city where the pandemic impacted greatly more than Ancona, both in terms of infections and deaths. Some authors [73] report that mainly seniors in North Italy (e.g., Lombardy) expressed positive emotions and demonstrated resilient attitudes, such as cultivating hobbies, maintaining long-distance relationships, moving around at home, and learning to use technologies. They seem to have committed themselves to maintaining their plans, despite and beyond the pandemic.

However, with regard to health, the main difference between the two cities regards the fear of not receiving adequate assistance in the event of contracting the COVID-19 virus, more expressed in Ancona and by no older people in Brescia. A result that is surprising at first glance, in consideration of the structural weaknesses of the Lombard primary care as for territorial coverage, which strongly emerged during the first phase of the emergency [74]. This can be explained, however, by the high traditional performance of the healthcare system in this region, which, in its collective representation, is considered one of the best in Italy because of its proven excellence in the hospital field, specialist medicine, and overall high level of health services [75].

The fear that family members could remain out of work during the lockdown and even after emerged more in Ancona. This is probably because Brescia offers greater opportunities for work in the labour market than Ancona, following socio-economic differences between the two cities and related regions, representing indeed high and medium levels of socio-economic development in the country [34]. Moreover, ISTAT data [72] confirms that large companies (over 250 employees) in the North-West were leading the process of spreading remote/smart working in the private sector, thus facilitating job retention during the lockdown. Also, in Ancona, seniors who used to stay mainly at home before the pandemic (e.g., those with disabilities) and who therefore have not essentially experienced profound changes in their daily lives due to the confinement do not express particular concerns about the emergency and related worries. This aspect is also highlighted by some authors [69], who found that physical isolation was also suffered as social isolation by individuals more concerned with the severity and impact of COVID-19. People with less concern probably adopted fewer precautionary measures and, in turn, remained less isolated and alone.

#### *4.5. Limitations of the Study*

The follow-up study presents some limitations to be considered. Firstly, this study represents a narrow follow-up, with a small sample size (total  $n = 41$ ), of a previous qualitative survey. Thus, it does not have the aim of statistical representativeness of the target population, and only general insights, rather than socially/politically relevant, can be proposed. Secondly, tables present only (low) absolute values to be interpreted with caution. Thirdly, following the emergency situation and social distancing imposed by the COVID-19 pandemic, the interviews were carried out by telephone (not audio-recorded), thus collecting only basic/short responses and a few open narratives, which were handwritten on paper by interviewers. Interviewing frail seniors immediately after the first wave of the pandemic did not allow us to delve in depth into the different topics or take extensive note of the answers. It was necessary to balance the needs of research with the need not to strain and stress frail respondents. Moreover, due to several difficulties in recruiting local available interviewers during the lockdown, the follow-up was not realised in Reggio Calabria and rural areas (all conversely involved in the survey of 2019). Fourthly, this is only a descriptive study, and more sophisticated statistical analyses have not been provided. Moreover, at T2, self-reported changes with regard to T1 were recorded instead of direct/more precise measurement as at T1, and this could partly affect the significance of more in-depth statistical processing. Fifthly, the scarce availability of local data/sources in the English language led to the inclusion of several references in Italian. Sixthly, the sample structure, mainly composed of females than males, both at T1 (90 vs. 30) and T2 (19 vs. 15 in both cities), did not allow a further investigation, including the gender dimension. Seventhly, the exploration of the type of available dwelling during the lockdown was not considered, even though this could provide further insights, e.g., seniors with the possibility to access and walk in an open courtyard probably may have suffered less from isolation and loneliness. Finally, a further limitation regards the definition of frailty, which is restricted to being aged  $\geq 65$  years and ageing alone in place with physical/functional limitations and a need for support for performing the activities of daily living.

#### *4.6. Implications and Practical Applications*

According to our Italian findings, the pandemic highlighted the importance of technology during the lockdown for seniors living alone, allowing them to stay connected with family, friends, and the community. Also, the crucial issue of digital literacy, to be managed by means of dedicated educational initiatives improving the digital skills of older people, needs careful consideration. Moreover, the pandemic has stressed the need for psychological support to contrast loneliness and social isolation, with a heavy impact on LTC and HA. A sustainable HA requires accessibility to LTC services for improved overall social protection and quality of care [11]. The health emergency has further indirectly underscored different territorial possibilities to manage it, with regions taking welfare

actions at different times and methods. This suggests the necessity of a higher and stronger collaboration among regional contexts to achieve the psycho-physical and social well-being of the communities [76]. Overall, since the pandemic and related lockdown and social distancing policies negatively impacted the usual way for individuals to “live” in public spaces, especially in urban areas, it seems also crucial to rebuild an emotional mood in such environments, keeping in mind new insights affecting people’s existence and closeness [77].

## 5. Conclusions and Future Research

Ageing in place represents a crucial issue for frail older people living alone, especially during the pandemic. Our study is based on a follow-up including a small, non-representative sample, and thus it was only exploratory/descriptive. The findings however support our overall hypothesis regarding the negative effects of the lockdown on frail seniors living alone at home, both in Brescia and Ancona. This with regard to reduced FF contacts with their social networks, especially in Brescia, increased TEL contacts, especially in Ancona, overall increased use of communication technology, and general fear of contracting the virus in both cities. Moreover, as supposed, differences emerged between them, but without particular worst results for Brescia, where, despite the greater severity of the pandemic, only one case of worsened perceived loneliness was detected, and no senior expressed the worry of not receiving adequate assistance in case of contagion or illness.

Our small study needs further investigation to build a more complete understanding of the topics analysed with the follow-up. Future research could use the same questions with a larger sample size and explore more comparisons in depth between cities and between urban and rural areas, thus drawing possible insights on different socio-cultural contexts. Moreover, it would be useful to compare respondents by age group, educational level, and socio-economic status to better understand the potential impact of these dimensions on the resilience of seniors living alone. Also, it could be interesting to analyse how possible differences in personal/injunctive social norms between regions (e.g., wearing masks and social distancing/stay-at-home measures) and sources of information (government and scientists) could have impacted the perception of the pandemic risk, thus leading to potentially different healthy behaviours of seniors to avoid infection [78]. This will provide insights for policymakers and set up interventions to improve HA and protect the right of older people to effective LTC during and after pandemic times.

**Supplementary Materials:** The following supporting information can be downloaded at: <https://www.mdpi.com/article/10.3390/su152015073/s1>, File S1: Survey questionnaire used in the follow-up study.

**Author Contributions:** Conceptualization, M.G.M., S.C. and G.L.; Methodology, M.G.M. and S.C.; Software, M.G.M., M.S. and G.L.; Validation, M.G.M., S.C., M.S. and G.L.; Formal Analysis, M.G.M. and S.C.; Investigation, M.G.M., S.C. and G.L.; Resources, M.G.M., S.C., M.S. and G.L.; Data Curation, M.G.M., S.C. and G.L.; Writing—Original Draft Preparation, M.G.M. and S.C.; Writing—Review and Editing, M.G.M., S.C., M.S. and G.L.; Visualization, M.S. and G.L.; Supervision, G.L. and M.S.; Project Administration, M.G.M. and G.L.; Funding Acquisition, G.L. and M.G.M. All authors have read and agreed to the published version of the manuscript.

**Funding:** The paper was produced within the framework of the *IN-AGE* project, funded by Fondazione Cariplo, Grant N. 2017-0941. This work has also partially been supported by the Ricerca Corrente funding from the Italian Ministry of Health to IRCCS INRCA. The funders had no role in the design of the study; in the collection, analyses, or interpretation of data; in the writing of the manuscript, or in the decision to publish the results.

**Institutional Review Board Statement:** The study was conducted in accordance with the Declaration of Helsinki, and the protocol of the overall IN-Age study was approved (for the whole Consortium) by the Ethics Committee of the Polytechnic of Milan (PO-LIMI), Support Services Area for Research and Didactic Innovation (Project identification code N. 5/2019, approved 14 March 2019).

**Informed Consent Statement:** Informed consent was obtained from all subjects involved in the main study. It was not necessary for the follow-up due to the pandemic and consequent social distancing, as also allowed by the European Commission, in derogation from the General Data Protection Regulation (GDPR 679/2016) with regard to surveys conducted during the first phase of the COVID-19 emergency.

**Data Availability Statement:** All relevant data supporting the findings (i.e., absolute values, quotations) are within the manuscript. Additionally, the quantitatively anonymised dataset is available in Mendeley at <https://doi.org/10.17632/6y7v84g2f7.1> (accessed on 1 September 2023). The full qualitative data supporting the findings of the study (complete verbatim transcriptions of narratives) are not publicly available due to ethical restrictions. There is indeed confidential information that could compromise the privacy/anonymity of research participants (e. g., the names of persons and other potential indirect identifiers of respondents).

**Acknowledgments:** The authors wish to thank the IN-AGE partners for contributing their expertise: Department of Architecture and Urban Studies (DASU), Polytechnic of Milan (POLIMI), Italy; Department of Architecture and Territory (DARTe), Mediterranean University of Reggio Calabria, Italy; Auser, Italian association of volunteers in the social field. The authors wish to thank also all the Local Auser Sections, operators of municipal/public home services, and other local/voluntary associations (Anteas, Caritas) who contributed to the study. Moreover, the authors are also grateful to the interviewers and especially to older people who participated in the study, for their kindness, efforts, and answers.

**Conflicts of Interest:** The authors declare no conflict of interest.

## Abbreviations

ADL	Activity of Daily Living
EU	European Union
FF	Face-to face contacts
GDPR	General Data Protection Regulation
HA	Healthy Ageing
IADL	Instrumental Activity of Daily Living
LTC	Long-Term Care
IN-AGE	Inclusive ageing in place
MCW	Migrant Care Worker
PCA	Personal Care Assistant
POLIMI	Polytechnic of Milan
SMS	Short Message Service/Text
TEL	Telephone contacts
T1	2019 Main IN-AGE survey
T2	2020 Follow-up
WHO	World Health Organization

## References

1. ISTAT. *Aspetti Della Vita Quotidiana. Famiglie, Persone Sole*; ISTAT: Rome, Italy, 2021. Available online: <http://dati.istat.it/Index.aspx?QueryId=17631#> (accessed on 3 September 2022).
2. ISTAT. *Le Condizioni di Salute Della Popolazione Anziana in Italia. Anno 2019*; Statistiche Report; ISTAT: Rome, Italy, 2021. Available online: <https://www.istat.it/it/files/2021/07/Report-anziani-2019.pdf> (accessed on 5 September 2022).
3. ISTAT. *Popolazione Italiana Residente al 1° Gennaio, 2023*; Geodemo Istat.it, Demografia in Cifre; ISTAT: Rome, Italy, 2023. Available online: <http://demo.istat.it/popres/index.php?anno=2021&lingua=ita> (accessed on 10 February 2023).
4. Petrini, M.; Cirulli, F.; D'Amore, A.; Masella, R.; Venerosi, A.; Carè, A. Health issues and informal caregiving in Europe and Italy. *Ann. Ist. Super. Sanità* **2019**, *55*, 41–50. [CrossRef] [PubMed]
5. Barbabella, F.; Poli, A.; Santini, S.; Lamura, G. The Role of Informal Caregivers in Long-Term Care for Older People: Needs and Supports. In *Cultures of Care: Handbook of Cultural Geropsychology*; Boll, T., Ferring, D., Valsiner, J., Eds.; Information Age Publishing: Charlotte, NC, USA, 2018; pp. 193–212.
6. Rogers, W.A.; Ramadhani, W.A.; Harris, M.T. Defining Aging in Place: The Intersectionality of Space, Person, and Time. *Innov. Aging* **2020**, *4*, igaa036. [CrossRef] [PubMed]
7. Grove, H. Ageing as well as you can in place: Applying a geographical lens to the capability approach. *Soc. Sci. Med.* **2020**, *13*, 113525. [CrossRef] [PubMed]



8. Pilotto, A.; Custodero, C.; Maggi, S.; Polidori, M.C.; Veronese, N.; Ferrucci, L. A multidimensional approach to frailty in older people. *Ageing Res. Rev.* **2020**, *60*, 101047. [CrossRef]
9. Pivetta, N.R.S.; Marincolo, J.C.S.; Neri, A.L.; Aprahamian, I.; Yassuda, M.S.; Borim, F.S.A. Multimorbidity, frailty and functional disability in octogenarians: A structural equation analysis of relationship. *Arch. Gerontol. Geriatr.* **2020**, *86*, 103931. [CrossRef]
10. WHO. *World Report on Ageing and Health*; WHO Library Cataloguing-in-Publication Data: Luxembourg, 2015; Available online: <http://www.who.int/iris/handle/10665/186463> (accessed on 26 October 2022).
11. Pot, A.M. *Healthy Ageing and the Need for Long-Term Care Systems Accessibility, Sustainability, Quality and Ageism*; WHO: Luxembourg, 2016; Available online: [https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2017/11/Pot\\_PP\\_EGM\\_Healthy-Ageing-LTC.pdf](https://www.un.org/development/desa/ageing/wp-content/uploads/sites/24/2017/11/Pot_PP_EGM_Healthy-Ageing-LTC.pdf) (accessed on 26 October 2022).
12. Beard, J.R.; Officer, A.; de Carvalho, I.A.; Sadana, R.; Pot, A.M.; Michel, J.P.; Lloyd-Sherlock, P.; Epping-Jordan, J.E.; Peeters, G.M.E.E.; Mahanani, W.R.; et al. The World report on ageing and health: A policy framework for healthy ageing. *Lancet* **2016**, *387*, 2145–2154. [CrossRef]
13. Pani-Harremann, K.; Bours, G.; Zander, I.; Kempen, G.; Van Duren, J. Definitions, key themes and aspects of ‘ageing in place’: A scoping review. *Ageing Soc.* **2021**, *41*, 2026–2059. [CrossRef]
14. ISS—Istituto Superiore di Sanità. *Tutto Sulla Pandemia di SARS-CoV-2*; ISS: Rome, Italy, 2021. Available online: <https://www.epicentro.iss.it/coronavirus/sars-cov-2> (accessed on 2 September 2022).
15. Tesch-Römer, C.; Lamura, G. Older adults in the first wave of the Corona pandemic. *Eur. J. Ageing* **2021**, *18*, 145–147. [CrossRef]
16. Grenade, L.; Boldy, D. Social isolation and loneliness among older people: Issues and future challenges in community and residential settings. *Aust. Health Rev.* **2008**, *32*, 468–478. [CrossRef]
17. Arlotti, M.; Cerea, S. Invecchiare a Domicilio Nei Contesti Urbani e Nelle Aree Interne. Fragilità, Isolamento Sociale e Senso di Solitudine. *DASTU Work. Pap. Ser.* **2021**, *4*, LPS.18. Available online: [http://www.lps.polimi.it/wp-content/uploads/2021/05/DASTU\\_WP\\_no.418.pdf](http://www.lps.polimi.it/wp-content/uploads/2021/05/DASTU_WP_no.418.pdf) (accessed on 15 March 2022).
18. Tyrrell, C.J.; Williams, K.N. The paradox of social distancing: Implications for older adults in the context of COVID-19. *Psychol. Trauma Theory Res. Pract. Policy* **2020**, *12*, S214–S216. [CrossRef] [PubMed]
19. Cipolletta, S.; Gris, F. Older People’s Lived Perspectives of Social Isolation during the First Wave of the COVID-19 Pandemic in Italy. *Int. J. Environ. Res. Public Health* **2021**, *18*, 11832. [CrossRef] [PubMed]
20. Smith, M.L.; Steinman, L.E.; Casey, E.A. Combatting Social Isolation among Older Adults in a Time of Physical Distancing: The COVID-19 Social Connectivity Paradox. *Front. Public Health* **2020**, *8*, 403. [CrossRef] [PubMed]
21. Hawkey, L.C.; Buecker, S.; Kaiser, T.; Luhmann, M. Loneliness from Young Adulthood to Old Age: Explaining Age Differences in Loneliness. *Int. J. Behav. Dev.* **2022**, *46*, 39–49. [CrossRef] [PubMed]
22. Qualter, P.; Vanhalst, J.; Harris, R.; Van Roekel, E.; Lodder, G.; Bangee, M.; Maes, M.; Verhagen, M. Loneliness across the life span. *Perspect. Psychol. Sci.* **2015**, *10*, 250–264. [CrossRef]
23. Huxhold, O.; Hees, E.; Webster, N.J. Towards bridging the grey digital divide: Changes in internet access and its predictors from 2002 to 2014 in Germany. *Eur. J. Ageing* **2020**, *17*, 271–280. [CrossRef]
24. Latikka, R.; Rubio-Hernández, R.; Lohan, E.S.; Rantala, J.; Nieto Fernández, F.; Laitinen, A.; Oksanen, A. Older Adults’ Loneliness, Social Isolation, and Physical Information and Communication Technology in the Era of Ambient Assisted Living: A Systematic Literature Review. *J. Med. Internet Res.* **2021**, *23*, e28022. [CrossRef]
25. ISTAT. *Rapporto BES 2020. Il Benessere Equo e Sostenibile in Italia*; ISTAT: Rome, Italy, 2021. Available online: [https://www.istat.it/it/files//2021/03/BES\\_2020.pdf](https://www.istat.it/it/files//2021/03/BES_2020.pdf) (accessed on 20 June 2022).
26. Tur-Sinai, A.; Bentur, N.; Fabbietti, P.; Lamura, G. Impact of the Outbreak of the COVID-19 Pandemic on Formal and Informal Care of Community-Dwelling Older Adults: Cross-National Clustering of Empirical Evidence from 23 Countries. *Sustainability* **2021**, *13*, 7277. [CrossRef]
27. ISTAT-ISS. *Impatto dell’Epidemia COVID-19 Sulla Mortalità Totale della Popolazione Residente. Anni 2020–2021 e Gennaio 2022*; ISTAT: Rome, Italy, 2022. Available online: [https://www.istat.it/it/files//2022/03/Report\\_ISS\\_ISTAT\\_2022\\_tab3.pdf](https://www.istat.it/it/files//2022/03/Report_ISS_ISTAT_2022_tab3.pdf) (accessed on 28 October 2022).
28. Gioia, E.; Colocci, A.; Casareale, C.; Marchetti, N.; Marincioni, F. The role of the socio-economic context in the spread of the first wave of COVID-19 in the Marche Region (central Italy). *Int. J. Disaster Risk Reduct.* **2022**, *82*, 103324. [CrossRef] [PubMed]
29. Riviello, B.A.; Luconi, E.; Boracchi, P.; Pariani, E.; Romanò, L.; Salini, S.; Castaldi, S.; Biganzoli, E.; Galli, M. Heterogeneity of Covid-19 outbreak in Italy. *Acta Biomed.* **2020**, *91*, 31–34. [CrossRef]
30. Cereda, D.; Manica, M.; Tirani, M.; Roviola, F.; Demicheli, V.; Ajelli, M.; Poletti, P.; Trentini, F.; Guzzetta, G.; Marziano, V.; et al. The early phase of the COVID-19 epidemic in Lombardy, Italy. *Epidemics* **2021**, *37*, 100528. [CrossRef]
31. Brescia Today. *Coronavirus Brescia: Decessi, Fasce d’età, Patologie Pregresse al 1° Aprile 2020. Le Statistiche Dettagliate dall’Inizio della Pandemia*; Brescia Today: Brescia, Italy, 2020; Available online: <https://www.bresciatoday.it/attualita/coronavirus/eta-media.html> (accessed on 3 October 2022).
32. Marche Region-GORES. *Coronavirus Marche: Dati Servizio Sanità. Aggiornamento 1° Aprile 2020*; Marche Region-GORES: Ancona, Italy, 2020; Available online: [https://www.regione.marche.it/portals/0/Salute/CORONAVIRUS/DatiGORES/REPORT\\_sint\\_DECESSI\\_COVID19\\_aggiorn\\_1\\_APRILE\\_ore18.pdf](https://www.regione.marche.it/portals/0/Salute/CORONAVIRUS/DatiGORES/REPORT_sint_DECESSI_COVID19_aggiorn_1_APRILE_ore18.pdf) (accessed on 3 October 2022).
33. Melchiorre, M.G.; Quattrini, S.; Lamura, G.; Socci, M. A Mixed-Methods Analysis of Care Arrangements of Older People with Limited Physical Abilities Living Alone in Italy. *Int. J. Environ. Res. Public Health* **2021**, *18*, 12996. [CrossRef]



34. OECD. *OECD Regions and Cities at a Glance 2020*; OECD Publishing: Paris, France, 2020; Available online: <https://www.oecd.org/publications/oecd-regions-and-cities-at-a-glance-26173212.htm> (accessed on 18 April 2022).
35. NSIA—National Strategy for Inner Areas. *Annual Report on the National Strategy for Inner Areas*; NSIA: Rome, Italy, 2018. Available online: [https://www.agenziacoesione.gov.it/wp-content/uploads/2020/07/Relazione\\_CIPE\\_2018.pdf](https://www.agenziacoesione.gov.it/wp-content/uploads/2020/07/Relazione_CIPE_2018.pdf) (accessed on 7 March 2022).
36. ISTAT. *Le misure della Vulnerabilità: Un'applicazione a Diversi Ambiti Territoriali*; ISTAT: Rome, Italy, 2020. Available online: <https://www.istat.it/it/files//2020/12/Le-misure-della-vulnerabilita.pdf> (accessed on 22 June 2022).
37. Ritchie, J.; Lewis, J. (Eds.) *Qualitative Research Practice. A Guide for Social Science Students and Researchers*; Sage Publications: London, UK, 2003.
38. Lamura, G.; Dohner, H.; Kofhal, C. (Eds.) *Supporting Family Carers of Older People in Europe—Empirical Evidence, Policy Trends and Future Perspectives*; Lit Verlag: Hamburg, Germany, 2008.
39. Katz, S. Assessing Self-Maintenance: Activities of Daily Living, Mobility, and Instrumental Activities of Daily Living. *J. Am. Geriatr. Soc.* **1983**, *31*, 721–727. [CrossRef]
40. ISTAT. *Conoscere il Mondo della Disabilità: Persone, Relazioni e Istituzioni*; ISTAT: Rome, Italy, 2019. Available online: <https://www.istat.it/it/files//2019/12/Disabilita.pdf> (accessed on 8 April 2022).
41. European Union. Regulation 2016/679 of the European Parliament and of the Council. General Data Protection Regulation. *Off. J. Eur. Union* **2016**, *679*, L 119/1. Available online: <https://eur-lex.europa.eu/eli/reg/2016/679/oj> (accessed on 8 April 2022).
42. Srivastava, A.; Thomson, S.B. Framework Analysis: A Qualitative Methodology for Applied Policy Research. *J. Adm. Gov.* **2009**, *4*, 72–79. Available online: <https://roam.macewan.ca:8443/server/api/core/bitstreams/53026c07-60e4-4bfc-b895-9d8e7e358b74/content> (accessed on 3 August 2022).
43. Mayring, P. Qualitative Content Analysis. *Forum Qual. Soc. Res.* **2000**, *1*, 20. Available online: <https://www.qualitative-research.net/index.php/fqs/article/view/1089/2385> (accessed on 3 August 2022).
44. Saldana, J. *The Coding Manual for Qualitative Researchers*; Sage Publications: London, UK, 2009.
45. Chi, M.T.H. Quantifying Qualitative Analyses of Verbal Data: A Practical Guide. *J. Learn. Sci.* **1997**, *6*, 271–315. [CrossRef]
46. Corden, A.; Sainsbury, R. *Using Verbatim Quotations in Reporting Qualitative Social Research: Researchers' Views*; The Social Policy Research Unit, University of York: York, UK, 2006; Available online: <https://www.york.ac.uk/inst/spru/pubs/pdf/verbquotresearch.pdf> (accessed on 4 August 2022).
47. Grondal, M.; Ask, K.; Luke, T.J.; Winblad, S. Self-reported impact of the COVID-19 pandemic, affective responding, and subjective well-being: A Swedish survey. *PLoS ONE* **2021**, *16*, e0258778. [CrossRef]
48. ISS—Istituto Superiore di Sanità. *Protezione dei dati Personali Nell'Emergenza COVID-19. Rapporto ISS COVID-19, n. 42/Maggio*; ISS: Rome, Italy, 2020. Available online: [https://www.iss.it/documents/20126/0/Rapporto+ISS+COVID-19+42\\_2020+%281%29.pdf/7fbd7a22-ba86-e323-1ff8-ebc2d4ae5da9?t=1608041817126](https://www.iss.it/documents/20126/0/Rapporto+ISS+COVID-19+42_2020+%281%29.pdf/7fbd7a22-ba86-e323-1ff8-ebc2d4ae5da9?t=1608041817126) (accessed on 2 September 2022).
49. Beller, J.; Wagner, A. Loneliness, social isolation, their synergistic interaction, and mortality. *Health Psychol.* **2018**, *37*, 808–813. [CrossRef] [PubMed]
50. Smith, K.; Victor, C. Typologies of loneliness, living alone and social isolation, and their associations with physical and mental health. *Ageing Soc.* **2019**, *39*, 1709–1730. [CrossRef]
51. Cerea, S.; Melchiorre, M.G. L'ageing in Place Alla Prova Della Pandemia. Gli Effetti Indiretti del COVID-19 Sugli Anziani di Brescia e Ancona. *DASIU LPS. Pap. Ser.* **2021**, *5*, LPS.19. Available online: [http://www.lps.polimi.it/wp-content/uploads/2021/05/DASIU\\_WP\\_n-052021-LPS.19.pdf](http://www.lps.polimi.it/wp-content/uploads/2021/05/DASIU_WP_n-052021-LPS.19.pdf) (accessed on 5 May 2022).
52. ISTAT. *Condizioni di Salute e Ricorso ai Servizi Sanitari in Italia e nell'Unione Europea, Indagine EHIS 2015, Tavole di Dati*; ISTAT: Rome, Italy, 2017. Available online: [www.istat.it/it/archivio/204655](http://www.istat.it/it/archivio/204655) (accessed on 8 October 2022).
53. ISTAT. *Rapporto Annuale 2018. La Situazione del Paese*; ISTAT: Rome, Italy, 2018. Available online: <https://www.istat.it/storage/rapporto-annuale/2018/Rapportoannuale2018.pdf> (accessed on 25 November 2022).
54. ISTAT. *Cittadini e ICT, anno 2019. Testo Integrato e Tavole*; ISTAT: Rome, Italy, 2019; Available online: <https://www.istat.it/it/files//2019/12/Cittadini-e-ICT-2019.pdf>; <https://www.istat.it/it/archivio/236920>; (accessed on 7 June 2022).
55. Vainieri, M.; Vandelli, A.; Benvenuti, S.C.; Bertarelli, G. Tracking the digital health gap in elderly: A study in Italian remote areas. *Health Policy* **2023**, *133*, 104842. [CrossRef] [PubMed]
56. ISTAT-FUB. *Internet@Italia 2018. Domanda e Offerta di Servizi Online e Scenari di Digitalizzazione*; ISTAT: Rome, Italy, 2018. Available online: <https://www.fub.it/wp-content/uploads/2020/06/Internet@Italia-2018.pdf> (accessed on 24 July 2022).
57. Boreskie, K.F.; Hay, J.L.; Duhamel, T.A. Preventing Frailty Progression during the COVID-19 Pandemic. *J. Frailty Aging* **2020**, *9*, 130–131. [CrossRef] [PubMed]
58. Rolandi, E.; Vaccaro, R.; Abbondanza, S.; Casanova, G.; Pettinato, L.; Colombo, M.; Guaita, A. Loneliness and social engagement in older adults based in Lombardy during the COVID-19 lockdown: The Long-Term Effects of a Course on Social Networking Sites Use. *Int. J. Environ. Res. Public Health* **2020**, *17*, 7912. [CrossRef] [PubMed]
59. Lee, R.M.; Draper, M.; Lee, S. Social connectedness, dysfunctional interpersonal behaviors, and psychological distress: Testing a mediator model. *J. Counsel. Psychol.* **2001**, *48*, 310. [CrossRef]
60. Lykes, V.A.; Kemmelmeier, M. What Predicts Loneliness? Cultural Difference Between Individualistic and Collectivistic Societies in Europe. *J. Cross Cult. Psychol.* **2014**, *45*, 468490. [CrossRef]

61. Heidinger, T.; Richter, L. The Effect of COVID-19 on Loneliness in the Elderly. An Empirical Comparison of Pre-and Peri-Pandemic Loneliness in Community-Dwelling Elderly. *Front. Psychol.* **2020**, *11*, 585308. [CrossRef] [PubMed]
62. Wong, S.Y.S.; Zhang, D.; Sit, R.W.S.; Yip, B.H.K.; Chung, R.Y.; Wong, C.K.M.; Chan, D.C.C.; Sun, W.; Kwok, K.O.; Mercer, S.W. Impact of COVID-19 on loneliness, mental health, and health service utilisation: A prospective cohort study of older adults with multimorbidity in primary care. *Br. J. Gen. Pract.* **2020**, *70*, e817–e824. [CrossRef]
63. Kwan, C.; Walsh, C.A. Seniors' disaster resilience: A scoping review of the literature. *Int. J. Disaster Risk Reduct.* **2017**, *25*, 259–273. [CrossRef]
64. Knight, B.G.; Gatz, M.; Heller, K.; Bengtson, V.L. Age and emotional response to the Northridge earthquake: A longitudinal analysis. *Psychol. Aging* **2000**, *15*, 627–634. [CrossRef] [PubMed]
65. Arpino, B.; Mair, C.A.; Quashie, N.T.; Antczak, R. Loneliness before and during the COVID-19 pandemic. Are unpartnered and childless older adults at higher risk? *Eur. J. Ageing* **2022**, *19*, 1327–1338. [CrossRef]
66. Varga, T.V.; Bu, F.; Dissing, A.S.; Elsenburg, L.K.; Bustamante, J.J.H.; Matta, J.; van Zon, S.K.R.; Brouwer, S.; Bültmann, U.; Fancourt, D.; et al. Loneliness, worries, anxiety, and precautionary behaviours in response to the COVID-19 pandemic: A longitudinal analysis of 200,000 Western and Northern Europeans. *Lancet Reg. Health Eur.* **2021**, *2*, 100020. [CrossRef]
67. Dahlberg, L. Loneliness during the COVID-19 pandemic. *Aging Ment. Health* **2021**, *25*, 1161–1164. [CrossRef]
68. Delmastro, M.; Zamariola, G. Depressive symptoms in response to COVID-19 and lockdown: A cross-sectional study on the Italian population. *Sci. Rep.* **2020**, *10*, 22457. [CrossRef] [PubMed]
69. Peng, S.; Roth, A.R. Social Isolation and Loneliness Before and During the COVID-19 Pandemic: A Longitudinal Study of U.S. Adults Older Than 50. *J. Gerontol. B Psychol. Sci. Soc. Sci.* **2022**, *77*, e185–e190. [CrossRef]
70. Kobayashi, L.C.; Steptoe, A. Social Isolation, Loneliness, and Health Behaviors at Older Ages: Longitudinal Cohort Study. *Ann. Behav. Med.* **2018**, *52*, 582–593. [CrossRef] [PubMed]
71. Berkman, L.F.; Glass, T.; Brissette, I.; Seeman, T.E. From social integration to health: Durkheim in the new millennium. *Soc. Sci. Med.* **2000**, *51*, 843–857. [CrossRef] [PubMed]
72. ISTAT. Rapporto Annuale 2022, La Situazione del Paese; ISTAT: Rome, Italy, 2022. Available online: [https://www.istat.it/storage/rapporto-annuale/2022/Rapporto\\_Annuale\\_2022.pdf](https://www.istat.it/storage/rapporto-annuale/2022/Rapporto_Annuale_2022.pdf) (accessed on 8 January 2023).
73. Zannini, L.; Daniele, K.; Bernardelli, G.; Dicuonzo, M.G. L'esperienza degli anziani autosufficienti durante il primo lockdown. Uno studio qualitativo con soggetti residenti in tre diverse Regioni italiane. *J. Health Care Edu. Pract.* **2022**, *4*, 20–31. [CrossRef]
74. Arlotti, M.; Marzulli, M. La Regione Lombardia nella crisi sanitaria da Covid-19: Ospedali, territorio e RSA. In *Libro Bianco. Il Servizio Sanitario Nazionale e la Pandemia da Covid-19. Problemi e Proposte*; Vicarelli, G., Giarelli, G., Eds.; Franco Angeli: Milan, Italy, 2021; pp. 41–48.
75. D'Angela, D.; Polistena, B.; Spandonaro, F. *Le Performance Regionali*; CREA Sanità: Rome, Italy, 2022. Available online: [https://www.creasanita.it/wp-content/uploads/2023/04/CREASanita\\_PerformanceRegionali\\_10\\_2022\\_Volume.pdf](https://www.creasanita.it/wp-content/uploads/2023/04/CREASanita_PerformanceRegionali_10_2022_Volume.pdf) (accessed on 8 January 2023).
76. Giarelli, G.; Vicarelli, G. Conclusioni. Una Bussola per il Rilancio del SSN. In *Il Servizio Sanitario Nazionale e la Pandemia da COVID-19. Problemi e Proposte*; Vicarelli, G., Giarelli, G., Eds.; Franco Angeli: Milan, Italy, 2021; pp. 117–141.
77. Elshater, A.; Abusaada, H. People's absence from public places: Academic research in the post-covid-19 era. *Urban Geogr.* **2022**, *43*, 1268–1275. [CrossRef]
78. Cucchiaroni, V.; Caravona, L.; Macchi, L.; Perlino, F.L.; Viale, R. Behavioral Changes After the COVID-19 Lockdown in Italy. *Front. Psychol.* **2021**, *12*, 617315. [CrossRef]

**Disclaimer/Publisher's Note:** The statements, opinions and data contained in all publications are solely those of the individual author(s) and contributor(s) and not of MDPI and/or the editor(s). MDPI and/or the editor(s) disclaim responsibility for any injury to people or property resulting from any ideas, methods, instructions or products referred to in the content.