

ORIGINAL ARTICLE

Mentally healthy living after pandemic social distancing: a study of older Canadians reveals helpful anxiety reduction strategies

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INTRODUCTION

Prior to the COVID-19 pandemic, four in 10 older Canadians had been experiencing generalised anxiety for 1 year or longer¹ and one in three reported unmet mental health needs, as well as a lack of good quality and affordable community-based counseling.^{1,2} With COVID-19, mental health harms like distress, depression, and anxiety are secondary but very

Abstract

Background: Throughout the COVID-19 pandemic, older Canadians were the most at risk of severe physical harm, including death, and their return to post-COVID life was expected to be especially anxiety-provoking. A study was conducted to obtain nationally representative evidence of older Canadians' self-perceived anxiety levels and their strategies to manage or mitigate it as public health restrictions were lifting.

Materials and Methods: This study had a cross-sectional descriptive design. An e-survey was used to collect data from 1327 Canadians aged 60+ stratified by age, sex, and education to resemble the larger general population. Participants completed the Geriatric Anxiety Scale (GAS-10) and indicated which of the 16 Centre for Addictions and Mental Health's (2022) Coping with Stress and Anxiety strategies they were using to manage or mitigate their anxiety when social distancing was lifting. Descriptive statistics, Pearson correlation, and multiple regression analysis were used to explore the data.

Results: While, on average, older Canadians were mildly anxious, nearly one-quarter of responders rated their anxiety as severe. Age, sex, perceived health, were statistically significant correlates of anxiety. Six coping strategies were associated with significantly lower anxiety scores. Moreover, accepting some fear and anxiety as normal, challenging worries and anxious thoughts, and practising relaxation/meditation appeared to increase anxiety.

Conclusion: Older Canadians used multiple strategies to manage or mitigate their anxiety, and seemingly, with more successful than detrimental tries. Practitioners have much to learn and understand about older people's mental health promotion efforts after social distancing, now and for future pandemics.

real consequences.^{3,4} During the first year of the pandemic, throughout unprecedented multiple waves of infections and related heightened anxiety,⁵ older Canadians believed that it was the government's job not only to safeguard them but also to reduce their anxiety,^{6,7} yet large-scale physically traumatic events are largely managed by professionally trained personnel.⁸ Social distancing was the main mechanism

to contain COVID-19 infections.⁹ However, shrunken social spaces largely protect people's physical versus mental health.¹⁰

Accordingly, mental health care with mandated social distancing took form as an expert-driven 'flood of wellness and self-care information' (p.2).¹¹ Although half or more of older Canadians regularly use the internet,^{12,13} 1 year into the COVID-19 pandemic, very few (4%) had accessed any digital self-care supports.¹⁴ It was later found that the expert-driven mental wellness information flood was not helpful to older people, and it may have even been bewildering as to where and how they could access help tailored to their own experiences and needs.¹⁵ Furthermore, from virtual resources lacking appeal or relevance, halfway through the pandemic, one-third of older Canadians planned not to seek in-person supports out of fear of COVID-19 exposure.¹⁴

Mental health issues also have significant social stigma, and particularly for older people.^{11,16,17} Before the COVID-19 pandemic, 40% of older Canadians who had mild or moderate anxiety did not seek help.¹⁶ One year into the COVID-19 pandemic, half denied needing help and another 20% feared for their privacy.¹⁵ Instead, older people confided mainly in family (51%) and close friends (38%).¹⁴ The 'one-size-fits-all' e-approach fell short of meeting older Canadians' needs.^{11,18}

Experts anticipated that older Canadians' return to a pre-COVID-19 social life would be especially anxiety-provoking.^{5,11,19,20,21} However, over the first 2 years of COVID-19, others found general anxiety levels to be lowest among Canadians aged 85 years and older.²² In multi-country literature reviews, including Canada, generalised anxiety has been shown to lessen with age.^{23,24} Others characterised older Americans as significantly less anxious than younger and midlife Americans.²⁵ In another large study in United Kingdom, researchers saw a 22% reduction in the risk of developing anxiety with every 5-year increment in age after age 50.²⁶

These contradictory-to-expert-expectations patterns of findings call for empirical attention toward what older people do to safeguard their mental health, particularly after public health measures lifted. Therefore, this study aimed to: (1) learn how anxious older Canadians were when social distancing lifted; and (2) identify everyday strategies that older Canadians used to manage or mitigate their anxiety when

transitioning into opened social spaces. Given the unprecedented nature of the COVID-19 pandemic, we frame the findings of this study as lessons learned by and for older Canadians. Good COVID-19 research seeks such perspectives, with a view to helping people manage everyday stress and anxiety and perhaps even prepare for future pandemics or other large-scale disasters.²⁷

MATERIALS AND METHODS

Study design

A cross-sectional e-survey was conducted in July 2022 by Qualtrics. Qualtrics sent a study advertisement to its Consumer Panel Members residing across all 10 Canadian provinces. Those responding to the advertisement were taken to the study information and an informed consent section on a landing page (Appendix S1.). Those who indicated 'Yes' to take part in this study were assigned a unique password and e-survey access. Our anticipated small effect sizes^{28–30} required a minimum sample of 1300 persons. To reduce potential selection bias and make our results generalisable to the overall population of Canadians aged 60 and older, participants were selected using a stratified random sampling approach. First the target population was stratified by age, and then by sex, education and gender identity, and a random sampling was then carried out within each stratum. The distributions of these four stratification variables in our selected sample ($n = 1300$) had to match the Canadian general population based on Statistics Canada's 2016 age, sex, and education census distributions³¹ and 2018 disclosed proportion of LGBTQ2+ older Canadians as a whole.³² Census proportions for 2021, which also included gender identity, were not yet available.

Data collection tools

The following three forms were used to collect study data: Personal Information Form, Geriatric Anxiety Scale-10 (GAS-10), and Coping with Stress and Anxiety. Altogether, we expected a 15–20-min completion time.

Sociodemographic form

Control variables in this study were sex at birth, gender, education, marital status, and province of residence, with Ontario as the reference group.^{14,19,33}

Along with age, these four researched characteristics were defined using the Census of Population dictionary.³⁴ During the pandemic, Canadian women (reference group) experienced especially heightened general anxiety at all ages.^{15,19,24} Gender-diverse Canadians have reported moderate to severe anxiety.^{15,35} Other reference groups were persons with the least education^{33,36} and married people.^{13,23,25} Responders were asked: 'How is your health these days?' (poor, fair, good, very good, excellent). Perceived health is a key indicator of older people's mental health.^{36–38}

GAS-10

With respect to our first study objectives, anxiety was measured using the 10-item GAS-10.³⁹ In this lay-friendly questionnaire, the scores on all 10 items (0 = not at all to 3 = all of the time) yield a total score of 0–30.⁴⁰ Scores of 0–6 indicate minimal anxiety, 7–9 indicate mild anxiety, 10 or 11 indicate moderate anxiety, and scores of 12 to 30 indicate severe anxiety. The GAS-10 reliability coefficient was $\alpha = 0.921$.

Coping with stress and anxiety

Our second objective was to examine associations between strategies that older Canadians were using to manage or mitigate their anxiety. Established survey questionnaires designed to capture mentally healthy living strategies like Folkman *et al.*'s Revised Ways of Coping,⁴¹ and the BRIEF-COPE⁴² and Coping Inventory for Stressful Situations⁴³ have 28 to 66 items. Minimising responder burden to encourage participation was essential to help us take stock of older Canadians' mentally healthy everyday actions, with a particular emphasis on 'wellness strategies during the recovery or transition period' (p.3).⁴⁴ Hence our use of Coping with Stress and Anxiety, a credible national mental wellness resource containing 16 strategies to help everyday Canadians manage and mitigate anxiety when social distancing was lifting.⁴⁵ Older Canadians were transitioning into opened social spaces. Responders indicated 'YES' or 'NO' as to whether they had used each to mitigate anxiety ($\alpha = 0.747$). This checklist served another broader purpose, namely enhancing responders' awareness of trusted-source messaging aimed at getting everyday people out of mental health harm's way,¹⁸ and perhaps providing some degree of affirmation for them.

Analysis of data

Categorical demographic characteristics and strategies for managing or mitigating anxiety were summarised as frequency counts and percentages. A mean and standard deviation was provided for our continuous dependent variable, the GAS-10. Spearman's correlation coefficients helped us to identify participant characteristics statistically significantly associated with anxiety for inclusion in a multiple linear regression analysis.⁴⁶ Multiple linear regression was used to identify significant risk factors associated with anxiety, controlling for all others in the analysis.^{46,47} The criteria for statistical significance was $P < 0.05$.

Ethical issues

With respect to our anxiety measure, while the parent 25-item GAS has more established reliability and validity,⁴⁸ we chose the GAS-10⁴⁰ to reduce responder burden. If the GAS-10 did trigger flashbacks about threats of physical harm,⁴⁹ responders were also free to abandon the survey or to not answer any of the anxiety questions. If responders chose to remain in the survey or partly responded to the GAS-10, they were taken to a list of strategies to manage or mitigate their anxiety. Responders were given national mental health support URLs and phone numbers in the study's information letter. Up to three reminders were sent to non-responders, and \$4 in Canadian Consumer Rewards were given to responders, regardless of their level of survey completion.⁵⁰ Six weeks into the survey launch, across all four stratification variables, responses ceased in full. The research team had no access to panel member names, IP addresses, or emails. Therefore, the number of persons who initially received the digital advertisement were not shared with any study investigator. Our scrubbed dataset further excluded, for example, repeat responders and those offering identical responses to any question, all of whom were identified using their IP address. Hence our statistical analysis is of a cleaned and fully anonymised dataset ($n = 1,327$). Our survey was completely voluntary. Among all 1327 survey responders, 220 had missing responses across all survey questions.

RESULTS

Sample characteristics are shown in Table 1. Our intention was to have a representative sample of

Table 1 Sociodemographic characteristics (*N* = 1327)

Variables	Actual <i>n</i>	Actual % [†]	Target <i>n</i>	Target % [‡]
Age				
60–64	384	28.9	358	27
65–69	335	25.2	305	23
70–74	264	19.9	252	19
75–79	131	9.9	172	13
80–84	145	10.9	119	9
85+	61	4.6	119	9
Sex at birth				
Female	671	50.6	703	53
Male	620	46.7	623	47
Gender				
CIS gender woman	502	37.8		
CIS gender man	516	38.9		
Transgender/non-binary	178	13.4	93	7
Education status				
University certificate, diploma, degree below/at bachelor level	275	20.7	252	19
College, CEGEP or other non-university certificate or diploma	238	17.9	199	15
Apprenticeship, trades certificate or diploma	168	12.7	145	11
Secondary (high) school or equivalent	392	29.5	331	25
No degree, certificate, or diploma	251	18.9	398	30
Marital status				
Widowed/not living common law	191	14.4		
Divorced/separated/not living common law	217	16.4		
Living common law	89	6.7		
Married	671	50.6		
Never married/not living common law	154	11.6		
Home province				
British Columbia	226	17.0		
Prairie Provinces	312	23.5		
Ontario	510	28.4		
Quebec	148	11.2		
Maritime Provinces	129	9.7		
Perceived health				
Poor/fair	407	30.7		
Good	604	45.5		
Very good/Excellent	298	22.5		
Geriatric anxiety scale				
I am not at all anxious	273	20.6		
I feel minimal anxiety	513	38.7		
I feel mildly anxious	136	10.2		
I feel moderately anxious	70	5.3		
I feel severely anxious	280	21.1		

[†]Frequency proportions do not sum to 100% due to missing values. [‡]Frequency proportions falling below Statistics Canada 2016 Census and 2018 LGBTQ2+ proportion.

older Canadians. We fulfilled most Canadian Census targets.³¹ Exceptions were persons without formal education (11.1% shortfall), those aged 85+ (4.4% shortfall), those aged 75–79 (4.1% shortfall), and women (2.4% shortfall). Non-binary and transgender persons made up 13.4% of our sample; we hoped to recruit 7%.³² Slightly less than one-third of responders were in poor to fair health, 42.4% were without a life partner, and 51.3% reported having

some form of post-secondary education. On average, participant anxiety fell between minimal and mild (mean GAS-10 score = 6.47 ± 6.82).

Table 2 frequencies reflect strategies used to manage or mitigate anxiety. More than three-quarters of responders accepted that some fear and anxiety was normal, dealt with problems in a structured way, took breathers from COVID-19 news stories, were kind to themselves, and got proper rest and sleep. Less than

Table 2 Coping with stress and anxiety checklist[†]

	Participants (N = 1327)			
	Yes		No	
	n	% [†]	n	% [†]
I accepted that some fear and anxiety is normal	1163	87.6	142	10.7
I sought credible information about COVID-19	581	43.8	718	54.1
I found a balance staying tuned in and knowing when to take a breather	1016	76.6	289	21.8
I brought an internal mindset to unplugging	281	21.2	1021	76.9
I dealt with problems in a structured way	1020	76.9	281	21.2
I remembered that I am resilient/careful with 'What ifs'	989	74.5	315	23.7
I challenged anxious worries and thoughts	841	63.4	460	34.7
I decreased other sources of stress in my life	756	57.0	544	41.0
I practised relaxation and meditation	503	37.9	796	60.0
I sought support from loved ones	565	42.6	735	55.4
I was kind to myself	1107	83.4	198	14.9
I ate healthy	950	71.6	352	26.5
I avoided substance use	854	64.4	448	33.8
I had moderate caffeine intake	976	73.5	328	24.7
I got proper rest and sleep	1012	76.3	290	21.9
I stayed active	914	68.9	389	29.3

[†] Frequency proportions do not sum to 100% due to missing values.

Table 3 Results of correlation analysis between study variables

Variables	Age	Sex at birth	Gender	Marital status	Education	Province	Health
Sex at birth	r	0.158					
	P	<0.001					
	N	1107					
Gender	r	0.131	0.681				
	P	<0.001	<0.001				
	n	1107	1107				
Marital status	r	0.165	−0.187	−0.105			
	P	<0.001	<0.001	<0.001			
	n	1107	1107	1107			
Education	r	0.112	0.047	−0.044	0.056		
	P	<0.001	0.120	0.140	0.062		
	n	1107	1107	1107	1107		
Province	r	−0.061	0.070	−0.113	−0.011	−0.029	
	P	0.043	0.020	<0.001	0.705	0.329	
	n	1107	1107	1107	1107	1107	
Health	r	0.021	−0.046	−0.041	0.098	0.149	−0.017
	P	.475	0.128	0.171	0.001	<0.001	0.564
	n	1107	1107	1107	1107	1107	1107
GAS [†]	r	−0.186	−0.144	−0.113	−0.043	0.016	−0.080
	P	<0.001	<0.001	<0.001	0.151	0.590	0.008
	n	1107	1107	1107	1107	1107	1107

[†] Geriatric Anxiety Scale.

half sought credible information about COVID-19 or sought support from loved ones. The least popular strategies were practising relaxation and meditation (37.9%) and unplugging from electronic devices (21.2%).

In Table 3, the correlation between sociodemographic characteristics of participants and their GAS-10 scores is presented. No statistically significant relationship was determined between participant marital status and education, and their anxiety scores. Two

Table 4 Multiple regression analysis[†]

Variable	B [‡]	SE	b [‡]	t	P-value	95% BCI for B	
						Lower	Upper
Constant	13.163	1.183		13.081	0.001	10.821	15.433
65–69 years of age	–0.959	0.526	–0.063	–2.062	0.066	–1.929	0.140
70–74 years of age	–1.521	0.509	–0.091	–3.024	0.005	–2.528	–0.501
75–79 years of age	–2.425	0.566	–0.106	–3.771	0.001	–3.502	–1.339
80–84 years of age	–2.775	0.619	–0.128	–4.457	0.001	–3.907	–1.493
85+ years of age	–3.379	0.713	–0.100	–3.714	0.001	–4.772	–2.031
Male	–1.129	0.357	–0.084	–3.159	0.001	–1.835	–0.372
Good health	–2.945	0.447	–0.218	–7.133	0.001	–3.808	–2.032
Very good/Excellent health	–3.664	0.482	–0.229	–7.288	0.001	–4.588	–2.652
British Columbia	0.525	0.457	0.030	1.056	0.248	–0.331	1.434
Prairie Provinces	0.546	0.462	0.034	1.214	0.242	–0.336	1.505
Quebec	–0.094	0.620	–0.044	–0.161	0.885	–1.228	1.181
Maritime Provinces	0.311	0.641	0.013	0.498	0.615	–0.903	1.670
I accepted that some fear and anxiety is normal	1.975	0.613	0.089	3.322	0.001	0.780	3.123
I sought credible information about COVID-19	0.750	0.398	0.055	2.000	0.057	–0.046	1.501
I found a balance staying tuned in and knowing when to take a breather	0.273	0.477	0.016	0.577	0.559	–0.683	1.161
I brought an internal mindset to unplugging	0.580	0.484	0.035	1.323	0.240	–0.392	1.510
I dealt with problems in a structured way	–2.109	0.528	–0.128	–4.415	0.002	–3.107	–1.124
I remembered that I am resilient/careful with ‘What ifs’	–1.167	0.505	–0.074	–2.390	0.027	–2.184	–0.154
I challenged anxious worries and thoughts	2.391	0.420	0.169	5.778	0.001	1.569	3.265
I decreased other sources of stress in my life	–1.194	0.393	–0.087	–2.975	0.004	–1.978	–0.470
I practised relaxation and meditation	1.862	0.377	0.135	4.90	0.001	1.115	2.600
I sought support from loved ones	0.384	0.384	0.028	1.012	0.337	–0.353	1.147
I was kind to myself	–0.376	0.576	–0.020	–0.703	0.506	–1.462	0.808
I ate healthy	–1.522	0.474	–0.099	–3.368	0.002	–2.445	–0.563
I avoided substance use	0.493	0.387	0.035	1.275	0.197	–0.281	1.186
I had moderate caffeine intake	0.358	0.422	0.023	0.856	0.394	–0.489	1.218
I got proper rest and sleep	–1.446	0.479	–0.089	–3.267	0.004	–2.351	–0.492
I stayed active	–2.307	0.480	–0.156	–5.280	0.001	–3.325	–1.391
Adjusted $R^2 = 0.267$							
Dependent variable: Geriatric Anxiety Scale-10							

other control variables (sex at birth and gender) were highly correlated. Our subsequent multiple regression analysis therefore excludes marital status and education, and controls for sex at birth.

In Table 4, the results of the analysis demonstrated the regression model was statistically significant ($F(28,1143) = 16.211$, $P < 0.001$). We used bootstrapping to generate 95% confidence intervals (BCI) and significance tests for each regression coefficient.⁴⁶ According to the results of this analysis, there were statistically significant relationships between older Canadians’ anxiety scores and their age (partitioning r^2 (r^2_{part}) range = 0.002–0.012). According to these results, across increasing age categories, anxiety scores decreased and significantly so from age 70 onward. The largest effect sizes were for challenging worries and anxious thoughts ($r^2_{part} = 0.02$) and staying active

($r^2_{part} = 0.02$).⁴⁷ For our control variables, men appeared to be less anxious than women ($r^2_{part} = 0.006$), as did people in good and very good/excellent health ($r^2_{part} = 0.032$ –0.033). The independent variables accounted for 26.7% of the variance in GAS-10 scores.

There were no serial correlations between errors in older Canadians’ predicted anxiety scores (Durbin-Watson = 1.977; 95% BCI = 1.162–1.394). Variance Inflation Factors (range = 1.142 to 1.575) were not indicative of multicollinearity between any independent variables, and all tolerance values were >0.20 (range = 0.635 to 0.892).⁴⁸

DISCUSSION

The purpose of our study was to learn how anxious older Canadians were when social distancing lifted,

and to identify everyday strategies they used to manage or mitigate their anxiety.

With respect to anxiety, as others have found,^{23–26} anxiety levels steadily declined with age, albeit, in our case, not statistically significantly so until age 70, and most remarkably at age 85 and onward. Nonetheless, a key lesson learned is that older Canadians' anxiety levels when social distancing lifted across Canada varied a great deal. Most people experienced only minimal levels, while near equal proportions reported no anxiety at all or severe anxiety. The magnitude of the severe anxiety group (21.1%) is worrisome. In the first year of the pandemic, the prevalence of moderate to severe anxiety was significantly lower among Canadians 45–64 (13%) and 65+ years of age (7%) than among people between 25 and 44 years of age (15%).¹⁹ Proportions were nearly 16% from age 60 onward among people in Quebec³⁷ and nearly 8% from age 50 onward across provinces.⁵¹ While beyond the scope of this study, future studies might determine whether this high prevalence could be owing to lingering fears of physical harms, even after COVID-19 ends,¹⁴ and among a subset, greater fear of dying⁵² and/or more disrupted social lives, tenuous family ties, or difficulties accessing food.⁵³

With respect to managing or mitigating anxiety, another important lesson comes from variations in older Canadians' use of strategies and the degree to which such strategies mitigated their anxiety. In this study, in no instances were any of the 16 strategies not tried and the frequency of use varied considerably across the entire studied sample. Accepting that some fear and anxiety was normal and being kind to yourself were most prevalent. Unplugging from electronic devices and meditating and relaxing were the least prevalent strategies (21.2% vs. 37.9% respectively). In the first year of the pandemic, along with being accepting,⁵⁴ other older Canadians paid attention to their nutrition and sleep.^{26,55} Along with adequate sleep, establishing daily routines has been shown to reduce their anxiety.³⁸ Although 40–51% of older Canadians exercised,⁵⁵ frequent exercise was found not to be beneficial for anxiety.⁵⁶ When social restrictions were lifting, two-thirds of our participants stayed active and less anxious, albeit in a small way. Older Italian people have similarly benefited from getting rest and sleep and caring for themselves.⁵⁷ For other older Canadians, seeking credible information

on COVID-19 had mixed effects on their anxiety.^{58,59} In this study, participants who sought such information experienced marginally increased anxiety.

People are known to react to large-scale traumatic events differently.²⁸ Our patterns of findings suggest, as others do,^{60–62} that this may be true of COVID-19. Further, just as no one person ages in the same way, some may have felt more vulnerable than others during the pandemic.^{63,64} The willingness of participants to try a variety of strategies conveys perseverance. Older people a psychologically and behaviourally adapt to COVID-19 in different ways.⁶² Along with the observed differences in frequency of strategy use, the largest effect sizes were the small effects of challenging worries and anxious thoughts and staying active, with the former seemingly increasing, not decreasing anxiety.

Likewise, practising relaxation and meditation, and participants' most frequent inclination to accept that some fear and anxiety as normal was associated with higher anxiety. This runs counter to what others have found. Along with self-compassion, quiet reflection and accepting life's uncertainties are considered markers of wisdom.⁶⁵ Being accepting was seen as health-enhancing by older Canadians,⁵⁴ and, along with structured problem solving, it has dampened older British people's anxiety in a small way.⁶⁶ Older Italians doing meditation have experienced greater positive emotions.⁵⁷ Other older people's mental wellness has come from relaxing leisure activities.⁶⁷ One would think that both such behaviours would be very helpful during a pandemic where much fear and anxiety existed, and as open life resumed. A study in the first year of COVID-19 revealed that 17% of Canadians 65 and older were practising meditation.⁵⁵ In our second-year study, while meditating and relaxing was far more prevalent (37.9%), this was also the second-least popular strategy and one palling in comparison to the benefits of staying active. Along with repetitiously performing domestic chores,⁵⁷ regularly moving about by walking to be nearer to others⁶⁸ has distracted other older people from the life-changing impacts of COVID-19. Perhaps being physically busy is more beneficial than staying still and quietly alone with one's own thoughts. With respect to the least popular strategy of unplugging, in the first year of the pandemic, news for public consumption about older peoples' heightened risk for physical health harms was hardly lacking.⁶⁰ However,

negative pandemic-related news can fuel in some older people an appetite for sharing⁶⁹ and for continuing to access such news.²⁷ Not unplugging might therefore stem from a need to know and to speak to others about the potential impacts of moving into opened spaces on age-peers' health. Qualitative inquiry is needed to shed further light on the intended purpose and expected impact of unplugging and meditating and relaxing.

Another lesson stems from our finding that all 16 coping strategies had small or very small associations with anxiety, and among which six lessened and three enhanced participants' anxieties. Accordingly, older Canadians in this study were trying many strategies to manage or mitigate their anxiety, and while they realised this with mostly small mental benefits, they managed to identify more mentally beneficial than non-beneficial strategies. Such resourcefulness, albeit partly a process of trial and error within lockdowns,¹⁰ also represents a process of discovery that can bring what Hobfoll *et al.* term 'opportunities for small wins' (p. 291).⁸ Older people's inner capacity for mental well-being is also partly contingent on health-related behaviours and everyday age-friendly spaces.⁷⁰ Older Canadians trying many strategies while managing their variable effects on anxiety signifies their taking great pains to discover and build anxiety-friendly living spaces for themselves. The seven strategies of little statistical significance, that is, unplugging from electronics, being kind to yourself, and avoiding substance use, are other cases-in-point. Older Canadians' lesser propensities for feeling anxious in the first year of the pandemic might stem from such resourcefulness.^{24,26}

Shared learning and support from and for older people is essential for a mentally healthy recovery.^{44,71,72} Perhaps the appreciable widths of observed 95% confidence intervals associated with strategies of significance also represent lessons learned. Age-peers should expect a broad range of lessening and increasing anxiety-related responses to any one of the 16 strategies when re-entering opened social spaces. Contemporaries with more severe forms of anxiety might come to see their own anxiety as expected, and rightfully so,²⁸ and to be optimistic⁷³ and see in themselves some degree of resilience.^{10,27} Older Canadians continue to navigate opened social spaces and to be most at risk for infection, for hospitalisations, and for losing their lives.⁵² COVID-19 remains a steadfast companion,⁷⁴

as does social distancing, a recommended as opposed to mandated practice.⁷⁵

Our study is not without limitations. It was a cross-sectional e-survey study undertaken in one developed country. While e-surveys from credible sources are cost-effective and efficient means to reach many people,⁷⁶ internet use tends to be lowest among older Canadians in their 80s,⁷⁷ and after age 75, so too might the comfort of those with lower levels of education around using internet-based technology.⁷⁸ Our largest sampling shortfalls were among Canadians who had no degree, certificate or diploma, and who were 75–79 years of age and in their mid-80s and older. Our cross-section of beneficial coping strategies also cannot tell us whether these were new things that responders were trying or past go-to strategies, and across age groups. Other older people have found pre-COVID-19 coping strategies mentally beneficial.^{79,80} Readers should approach our findings with cautious optimism.

As the mental harms of COVID-19 continue to surface, studies are needed to compare how older people in different countries perceive and manage their anxiety.^{81–83} Evaluating anxiety to better understand negative emotional states is also essential,^{63,64} as such adversities can prompt broader coping attempts and resiliency.⁸⁴ Future qualitative work may help to better understand what was best learned from trying multiple mitigating strategies and to identify relevant positive and negative impacts on older people's mental health with more depth.^{64,85}

A strength of our study is an appreciably sized sample that approximates the general population of older Canadians. At a pivotal time during the COVID-19 pandemic, when social distancing was being lifted, we were able to capture wide variations in and a balanced perspective on everyday strategies seemingly lessening, heightening, or having no noticeable effect on anxiety. This study provides much needed evidence about how older Canadians were managing as social distancing directives lifted, for other researchers to compare their findings to, and for future comparisons as the pandemic fades in memory and impact.

CONCLUSIONS

Among a sample of 1327 older Canadians resembling the general population in terms of age, sex, and education, this study offers preliminary evidence of a

process of discovery seemingly leading to lesser versus heightened anxiety. Such lessons learned have been translated into a recipe book format called *Cooking up calm*.⁸⁶ We invite our readers to consider sharing this resource with other researchers and community stakeholders.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

STUDY APPROVAL STATEMENT

All study procedures were conducted according to the Helsinki Declaration and its later amendments or comparable ethical standards and was reviewed and approved by the University of Alberta's Human Research Ethics Board (Pro00118512; initial approval: 9 March 2022; renewal approval: 8 February 2023; 15 February 2024).

CONSENT TO PARTICIPATE

The subjects participating in this study received a thorough explanation of the risks and benefit of inclusion, and consented to having their survey responses analyzed and published as set forth in Appendix S1.

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SUPPORTING INFORMATION

Additional supporting information may be found in the online version of this article at the publisher's website: <http://onlinelibrary.wiley.com/doi/supinfo>.

Appendix S1.