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'At least you got to see people when you went out for a walk': older adults' lived, embodied experiences during COVID-19 times in the United Kingdom

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ABSTRACT

The COVID-19 pandemic presented myriad global challenges, placing unprecedented pressure on health services. Currently, there is limited qualitative research exploring the 'felt' impact of the pandemic on older adults' health experiences and wider social life. Here, we report on the embodied experiences of older adults (65 and above), before, during and after the COVID-19 pandemic lockdowns in the UK, to chart the physical, social, and mental-health challenges. A figurational sociological lens was adopted to examine data from semi-structured interviews with 18 older adults, face-to-face or via telephone/video call. Notes from follow-up conversations were also recorded. Combined data were analysed thematically. Salient themes cohered around: physical activity engagement; health experiences; the role of family, friends, and community; and the role of modern technology. Our results highlight how older adults reported the felt benefits of increased PA during lockdowns, but also the negative impacts of treatment delays on experiences of hospital services. Participants also recounted how new social community connections were forged during lockdowns. Saliently, we identified a need to support older adults with modern technology so as to capture its potential to modernise, expand, and personalise healthcare within UK health services.

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Introduction

In the United Kingdom (UK), as in many societies in the Global North, as people transition into retirement and older age, they often encounter issues with declining health and fitness (Jackman et al. 2023; Kolotylo-Kulkarni, Seale, and LeRouge 2021; Williams, Allen-Collinson, Evans, et al. 2018. Improving health and wellbeing as people age is a global priority (WHO 2022), and one that can be addressed by, amongst other things, engaging in physical activity (PA) (National Institute on Aging (NIA) 2022). Not only can PA improve physical functioning, but it also has been shown to ameliorate mental ill-health (Cunningham et al. 2020) and generate feelings of pleasure and enhanced

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wellbeing, including in older adults (Allen-Collinson et al. 2011; Phoenix and Orr 2014; Williams, Allen-Collinson, Hockey, et al. 2018).

In contrast, a body of research highlights how loneliness and social isolation are increasingly impacting older adults, particularly those aged 80 and over (e.g. Dykstra 2009; Kemperman et al. 2019; Williams, Allen-Collinson, Hockey, et al. 2018). The adverse consequences, often profound, for mental health and wellbeing are well-documented, and include the likelihood of depression, and lower quality of life in general (e.g. Domènech-Abella et al. 2017). Furthermore, older adults often spend many hours in sedentary mode (Dunlop et al. 2015), and Rezende et al. (2014) found that long periods of time spent sitting increased all-cause mortality in older adults. While some research suggests that sedentary but cognitively engaged activity, such as reading, playing board games or a musical instrument, can lower the risk of dementia (Cheng 2016), it is well accepted that sedentariness poses significant risks to overall health (Weedon et al. 2020).

In sum, together with the increased comorbidity risks faced by older adults (Davis, Chung, and Juarez 2011), sedentary behaviour, social isolation, and loneliness placed older populations at in a vulnerable position during the COVID-19 pandemic. In this article, we report findings from semi-structured interviews with 18 older adults, investigating the effects of the COVID-19 pandemic on their experiences relating to physical, social, and mental health, and PA. Due to its applicability to research on the sociology of ageing, older age, embodiment and physical challenges (e.g. Evans and Crust 2015; Henderson et al. 2018; Williams, Allen-Collinson, Evans, et al. 2018), we draw on a figurational sociological approach. We first contextualise the study against the backdrop of the pandemic and its consequences for older adults.

COVID-19 as context

On 11 March 2020, the World Health Organisation (WHO) declared SARS-CoV-2, also known as COVID-19, a 'global pandemic' (Cucinotta and Vanelli 2022). COVID-19 spread rapidly from an unknown source in China, disrupting health systems across the world, and was declared a global pandemic (Tarkar 2020). Coronaviruses affect the lower respiratory tract generating symptoms ranging from those analogous to the common cold to severe respiratory problems and death (Menni et al. 2022) particularly in older and/or more vulnerable people (Starke et al. 2021). The COVID-19 pandemic resulted in multiple 'stay-at-home' orders being issued by authorities around the world. The UK government issued orders for three such 'lockdowns' over the course of 2020–2021. When these measures were instituted, there was concern over their impact on the mental wellbeing of the population (e.g. Suryasa, Rodríguez-Gámez, and Koldoris 2021). Reasons cited included: loss of contact with friends, family, and caregivers, causing psychosocial anxiety (Ribot, Chang, and González 2020), worries about contracting the disease, and also about health-care services being overwhelmed and disrupted (Vahia, Jeste, and Reynolds 2020; Zaninotto et al. 2022).

Initial studies of adult populations' mental health during COVID-19 reported that adults aged 50+ experienced less stress than their younger counterparts (Vahia, Jeste, and Reynolds 2020). For example, Daly and colleagues (2022) found that, whilst mental health problems had increased across all age-groups by the end of April 2020 (when UK lockdown orders had been in place for over a month), compared to previous years, young adults' mental health had declined the most, with fear of loss of employment and financial stress cited as key factors. Subsequently, however, extended periods of isolation generated by multiple UK lockdowns altered these patterns of mental health in adults (Zaninotto et al. 2022). Qualitive research by S. N. Williams et al. (2020), for example, found people feeling powerless, and potentially struggling mentally if 'stay-at-home' orders were continually lifted and then reimposed. Zaninotto et al. (2022) analysed data from the English Longitudinal Study of Ageing (ELSA) COVID-19 sub study and found that older adults' mental health had deteriorated during the first lockdown and continued to worsen through the second (in November/December) with higher levels of loneliness, anxiety, and poor quality of life reported.

Whilst the foregoing studies have provided useful insights into the experiences of older adults during lockdowns, there remains a need to investigate the lived, embodied experiences of older adults in the UK. Here we sought to provide a unique contribution to the literature by examining the lives of older adults prior to and during the COVID-19 lockdowns, using a particular theoretical lens, and focusing on how restrictions on face-to-face social interaction impacted the lives of the older population specifically. Figurational sociology provides a powerful theoretical perspective for the investigation of social relationships and 'bonds of association', and employing this specific theoretical framework generates novel understandings of older adults' embodied experiences and social interdependencies during COVID-19 times.

Figurational sociology

This study draws on Norbert Elias' figurational sociological approach, and his theorisation of the relationships or bonds of association people have with others. Elias (1939/1978a) developed the concept of figurations to portray the notion of the ever shifting and fluid linkages between people as the forms and extent of their interdependencies change over time. He was critical of sociological conceptualisations of societies and social systems that he deemed too static and rigid to convey the emergent, unplanned nature of social life. Elias' approach also challenges notions of strong individualism within modern-day society, proposing that societal structures are created through a web of interdependencies or 'figurations' (Elias 1939/1978a) formed by and amongst individuals. This tensile web of power balances places expectations on people and elicits behavioural forms, contextualised within the social groups and networks of which people are part (Van Krieken 2017).

For Elias, we are born into figurations, we develop within and help create them, and finally we die within these interdependency ties (Dunning 1999; Jarvie and Maguire 1994). As such, Elias (1978b, p. 127) argued that people are not isolated, self-contained 'closed' individuals (*Homo clausus*) but are 'open' (*Homines aperti*) and bonded together in dynamic constellations. For Elias (1978b) social structures do not exist independently from the people who constitute them. Germane to our focus here, in '*The Loneliness of the Dying*', Elias (1985) argues that ageing and dying (and ultimately death) are often emotionally isolating experiences in 'Western' societies where older adults are perceived as no longer active, independent members of society contributing to economic development, but as dependent upon other members. Elias (1985) also contends that older adults form interdependent social groups with similar (previously unknown) others in institutional settings, such as care homes and hospitals.

For figurational sociologists, the constant flux of power balances, relationships and social interaction existing in figurations can be both enabling and constraining (Elias and Scotson 1994). Further, the processual network of power balances is considered beyond the control of any group or individual (Elias and Schröter 1991; Jarvie and Maguire 1994). Through a figurational lens, group tensions can be seen as a central element of all medical and hospital activities during the COVID-19 pandemic, for example. Each healthcare worker is interdependent with all others in the figuration, and every individual's action has a consequence. Some consequences are shorter in duration whilst others act over the long term, but overall, figurations are constantly in flux (Jarvie and Maguire 1994).

The literature illustrates how Elias' figurational theory is highly applicable to research on ageing and embodiment, including physical activity (Elias 1985; Evans and Crust 2015; Evans and Sleap 2012; Williams, Allen-Collinson, Evans, et al. 2018. Thus, subsequent to our data analysis (described below), the research team decided to use this theory as a powerful lens to explore how older adults' embodied experiences were significantly shaped by and evolved in figurations (both pre-existing and also formed during the COVID-19 pandemic). The study itself is next described.

Methods

Recruitment and data collection

Ethical approval was granted by the first author's University ethics committee. The qualitative study was grounded in interpretivism, which also aligns with figurational ontology and epistemology. Data collection was undertaken (post-lockdowns and all restrictions) by all authors, using semi-structured interviews, and written notes from any subsequent follow-up conversations (details below). Participants were recruited initially using purposive and then snowballing methods, and all provided full informed consent prior to being interviewed, after being provided with a detailed participant information sheet. The purposive sampling criteria were for participants to be aged 65 or above, retired from full-time paid employment, and a resident of the UK. As described by Parker, Scott, and Geddes (2019), snowball sampling involves contacting a small number of initial participants or 'Seeds', who subsequently recommend other contacts with the potential to contribute according to the objectives of the study (see also Campbell et al. 2020). To capture some diversity within this small-scale study, we sought participants from various regions across the UK, spanning urban and rural areas. Our participant group comprised 18 older adults aged between 65 and 86 years: 10 women and 8 men, 7 of whom lived in urban locations and 11 in rural areas. Positivist notions of generalisability were not criteria we sought to address (see below).

To help overcome some of the challenges in recruiting participants so soon after UK lockdowns were lifted, we also used a friendship/family methodological approach (Owton and Allen-Collinson 2014; Tillmann-Healy 2003), whereby interviews were conducted with some participants who had pre-existing relationships and a degree of emotional involvement with the researchers. This perspective stands in stark contrast with traditionalist positivist views requiring distance and emotional separation between researcher and participant. There are of course ethical challenges and dilemmas, and Ellis (2007) highlights how participants must be willing to be interviewed by someone they know and trust. To help address these challenges, all interviews were conducted by experienced qualitative and mixed-method researchers, and two research team-members, Rachel and Jacquelyn, had considerable experience of the 'friendship approach'.

Semi-structured interviews were chosen to allow inteviewees to respond in as much depth as they wished and to direct the discussions to topics of importance to them. The interview guide was developed following a detailed review of the literature on older adults' experiences during COVID-19 times. Three key sections were chosen, covering: life before the COVID-19 pandemic, life during the pandemic, and looking to the future. Within these sections, general topics such as social connectivity, PA opportunities, and social, mental and physical health were covered. Opening questions were general, encouraging interviewees to share their thoughts and experiences, for example: 'Can you describe how you felt when you first heard about COVID-19?'. By developing an interview guide, the research team sought to organise selected general topics into a logical sequence and develop questions that were focused, but also open, so as to encourage free-flowing conversation.

The use of online, video conferencing tools was agreed, due to being analogous to face-to-face interactions in a familiar setting for the interviewee, as has been deemed appropriate in qualitative research for some time (Janghorban, Roudsari, and Taghipour 2014). In total, 18 interviews were conducted face-to-face, via telephone, or over Microsoft Teams™. Over 20 hours of interview data and follow-up informal conversations were recorded, and we combined these data in the analyses. Follow-up conversations were sometimes needed to clarify or elaborate on specific points raised by participants. Data collection ceased at the point when we had assembled a considerable data set, identified a number of preliminary (general) themes, and also when the time restrictions facing the researchers obliged us to move to the next stage of the study, given that the research was unfunded.

Data analysis

Interview recordings were transcribed verbatim by a professional transcription service. Data were analysed by Robert, drawing on Braun, Clarke, and Weate (2016) 'Thematic Model Approach', an organic and reflective process (see also Bowes and Kitching 2021). Robert thus familiarised himself with the data, reading and re-reading the transcripts thoroughly to enhance embeddedness in the data, before identifying key codes. He systematically analysed the full dataset, identifying and interpreting those segments of texts that were considered most relevant to participants' experiences of the COVID-19 pandemic, and subsequently coding and labelling these. Following this initial coding process, Robert reviewed the codes and gradually combined them into broad candidate themes. These themes were then discussed with Rachel as a 'critical friend' (Smith and McGannon 2018), who helped in the refining and naming process.

We sought to enhance the robustness of data collection and analysis via four means. First, data collection was undertaken by experienced qualitative researchers and interviewers. Second, the primary analyst, Robert, had no contact with any of the interviewees himself and was thus able to bring a more 'distanced' approach to the initial data analysis, which included interview transcripts from friends or family members of the interviewing team. Third, the data were analysed multiple times allowing Robert to immerse himself fully in the data-set and coding process. Finally, bringing in Rachel as a 'critical friend' (Smith and McGannon 2018) to discuss codes and themes, and constructively question and challenge Robert's initial interpretations, meant that codes and themes could be refined and eventually agreed upon (for all practical purposes) in relation to theoretical perspectives, and by more than one researcher, thus enhancing theoretical robustness. For example, Rachel is experienced in the application of figurational theory, and was thus able to bring her figurational perspective to bear on some of Robert's initial thoughts on coding and constructing themes. Whilst generalisability and replicability of the findings were not deemed appropriate aims for the research, we nevertheless considered the quality of the data was enhanced by the above processes. Furthermore, in finding such strong resonance with figurational insights when reviewing our data, we consider that qualitative notions of theoretical generalisability (e.g. Carminati 2018; Smith 2018) were addressed. For instance, participants recounted their fears generated by somewhat alarming media coverage of the COVID-19 situation. Bringing figurational perspectives to bear on these accounts helped us to consider how figurations of individuals and social groups (families, communities, and so on) can be created, affected and transformed by media engagement.

Findings

The following key themes were identified from data analysis as being particularly important to participants: physical activity; health experiences; family, friends, and community; and the use of modern technology. Numbers are used for participants' data extracts, to provide anonymity, and as required by the relevant University ethics committee, which also specified that biographical information regarding participants (such as age, gender, time since retirement) must not be included in any write-up, due to potential identification issues, including by other participants.

Physical activity (PA) engagement

A highly salient issue raised by participants was their pre-/during/post-pandemic PA routines. Many recalled their engagement in low intensity PA pre-lockdowns, such as walking, golf, gardening, and housework, and then recounted the benefits of substantially increasing their PA levels during lockdowns, including the social aspects:

> We were walking nearly every day for as long as we could, and we were doing our exercises, so we were probably more active as in that sense physically than before. (P12)

> To me, it was a two-fold benefit, the physical benefit of walking and I felt it was also good for my mental wellbeing. (P5)

> At least you got to see people when you went out for a walk. I mean you couldn't go near them, but you could interact, shout 'hello' and give them a wave. See how they are doing and that. (P8)

> Getting out of the house and going for walks were some of the happier times during lockdown, you needed that, you know. Even on days when the arthritis was playing up, just getting out in the fresh air, and moving helped a lot. (P10)

The need to 'get out and about' was raised by many, and their observations about the importance of seeing other people also resonate with figurational conceptualisations of humans as 'by nature' social animals inclined to be part of a collective and constituted for life in society (Elias and Dunning 1986; Jarvie and Maguire 1994; Maguire 2005).

With regard to PA engagement, the extant literature on PA levels during COVID-19 lockdowns and restrictions (to date) appears contradictory. Salman et al. (2021), for example, found lower PA levels in older adults during lockdowns, whereas Richardson et al. (2021) identified that both women and men maintained their PA levels, and in a follow-up study (Richardson et al. 2022) found that their participants managed to maintain or increase PA levels compared to pre-COVID -19 times. Cohering with other research on seasonal and weather influences on PA (e.g. Allen-Collinson 2018; Allen-Collinson and Leledaki 2015; Hunt and Papathomas 2020), participants identified the importance of the timing of the lockdowns in relation to seasonal and meteorological variations:

> During that summer, it was fine because, as I say, I have a south facing flat and I could spend time outside . . . the winter of 2020/21, I found that harder because it's darker. (P5)

> We're fair-weather walkers, so we don't go out in the rain. (P18)

> I felt the October one, it had more effect on me I think, really, mentally. And physically, probably, too. Because you were coming into the winter months. (P4)

Seasonal effects on mood and general wellbeing, including Seasonal Affective Disorder (SAD) mean that critical consideration needs to be given to any descriptions of depression or negative mental health during the pandemic, and the potential for participants to be experiencing SAD, which could have been exacerbated by long periods spent indoors due to lockdowns and restrictions. Thompson and Cowan (2001) identified two key symptoms of SAD as an increase in sleep or inactivity, and carbohydrate cravings. Although not medically diagnosed with SAD, many participants identified both these tendencies as lockdowns continued; for example, P7 noted:

> Gradually as the lockdowns went on, I noticed I was eating a bit more. I was starting to put on weight. I was starting to not be so fit. (P7)

Additionally, 'incidental' PA such as going out shopping, was also reduced due to COVID-19 restrictions, and many participants reported reducing or even abandoning shopping-related PA and using online modes instead, for example:

> We didn't need anything because we got our shopping online. (P13)

Only one participant (a regular runner, 70s) reported sustaining frequent engagement in high-intensity PA (running), noting little to no negative effect of lockdowns on their mental or physical health, perhaps due to maintaining their full PA regime throughout lockdowns.

We next consider participants' experiences of their general physical and mental health during lockdowns.

Health experiences during COVID-19 lockdowns

Another prominent theme in the data focused on participants' physical and mental health. The link between the COVID-19 pandemic and poor mental health has been documented, with recent studies demonstrating an increase in numbers suffering with depression (e.g. Richardson et al. 2021, 2022) during lockdown restrictions in the UK. People experienced feelings of discontent and low optimism (Richardson et al. 2021) and high anxiety and powerlessness (S. N. Williams et al. 2020). In our study, participants reported similar negative feelings, including fear and horror, and highlighted the influence of the media on their mental health, particularly news programmes:

> Every time you turn the news on, there was these horrible pictures of people in hospital ventilators. (P12)

> You had all these briefings every day, and the numbers [relating to COVID-19 deaths] were going up, and up, and up, and everything was getting worse. (P17)

> You're watching the news and it's like rolling news and eventually you could, I think, get depressed. (P5)

For some participants, the media coverage generated such anxiety that they felt at times compelled to turn off their television:

> Sometimes I had to turn it off, the images they showed you of inside the hospitals was like something from a horror movie. My anxiety levels were through the roof. (P17)

Media messages during the pandemic emphasised the ease and rapidity of transmission, and the severe ill health and subsequent death that could result from contracting COVID-19, particularly in older people and those with underlying health conditions. Decades prior to the COVID-19 pandemic, research by Witte and Allen (2000) argued that media messages regarding 'susceptibility to' and 'severity of' a threat can increase perceptions that a health issue is very severe and highly likely to occur. The fear generated by media coverage of COVID-19 has been associated with increased levels of depression, anxiety, stress, and sleep problems (Alimoradi et al. 2022). From a figurational perspective, as Hepp and Hasebrink (2018) note, in contemporary society, figurations are created and transformed by the use of media. Figurations of individuals, collectivities (such as social groups, peers, families, communities) and organisations (such as government, health services, schools) change and develop in media ensembles (Hepp and Hasebrink 2018).

Although participants in our study reported deleterious effects of news reports, Morii, Miura, and Komori (2023) also found positive effects on health-related behaviour, as media airtime was devoted to providing education on enhanced hygiene practices. Participants described their improved hygiene practices and precautions, for example:

> I took wipes with me, and I wiped down all the trolley with wipes and my hands and everything. And as soon as I got in, I was washing my hands. (P18)

Despite such precautions, people inevitably had to engage with healthcare figurations, including emergency treatment in hospital. Whilst the COVID-19 healthcare 'burden' resulted in delays in diagnosis and treatment for some patients, including cancer patients (Fox et al. 2022), emergency treatment witnessed a more complex picture, with some improvements in performance. Oomman and Todd (2021), for example, studied the impact COVID-19 lockdowns had on patient time spent in two specific Accident & Emergency (A&E) Department in the UK, and found waiting times dropped from an average of 10 hours 44 minutes in February 2020 (pre-lockdown) to 4 hours 46 minutes in April 2020 (during lockdown). Such an improvement occurred, however, in the context of people's changed behaviour, as the combined attendance at A&E for the two hospitals dropped from 10,878 in February 2020 to 6,779 in April 2020. Oomman and Todd (2021) proposed that the drop of numbers presenting at A&E was due to the public's belief that hospitals should be kept available for those suffering from COVID-19. There is some resonance with our own study, in that participants also subscribed to the same belief. For one participant, P7, the outcome was serious. P7

described having chest pains and feeling very lethargic but did not seek medical attention because they did not wish to 'bother' busy doctors. When eventually admitted to hospital, the emergency team found that P7 had suffered a heart attack. Subsequently, this participant's health experiences were somewhat mixed:

> I thought, 'no I'm not going to do that because the doctors are really busy. It's not fair'. I didn't want to bother the doctors while we were all going through lockdown. But I did sort of think when lockdown is sorted, I'll ring up and ask them if I can come in for a check-up . . . You are monitored all the time [in hospital], you know, every sort of ten minutes really. I can't fault it at all. It was absolutely brilliant . . . [but once discharged] I never saw a doctor. I only spoke to a doctor in June . . . Also, I think if there wasn't lockdown, I think my medication wouldn't have got messed up as much as it did, because I think you would have been seeing doctors more and probably been monitored better. I didn't get monitored. (P7)

Relatedly, from a figurational perspective, Elias (2001) notes how the essential relatedness of human beings starts at birth when the helpless infant has no control of the environment and depends entirely on the actions of others to sustain her/his life; a state-of-being often revisited in older age. Such a state of other-dependency is illustrated in the quote from P7. In relation to intentional interaction within figurations, during lockdowns some participants refrained from entering the healthcare figuration and seeking medical care, fearing they might contract COVID-19. Moving to a more macro-level of analysis, Elias and Schröter (1991) argue that people's short-term actions often create long-term unintended consequences. In the case of the COVID-19 pandemic, delays in initially seeking medical attention (as for P7) subsequently resulted in more pressure on A&E departments and post-acute outpatient care services as patients suffered serious health problems.

Role of family, friends and community

As a result of lockdowns and subsequent restrictions on social life in the UK, many participants expressed great concern about lack of contact with key figurations, such as their families, friends, and the wider community:

> My [main] concern was that I was not going to see the family. (P16)

> I missed seeing the family, I missed seeing my brother and I missed seeing my grandkids and both sons. (P7)

> The main thing [problem] I think in that first year was that we couldn't see anybody (P11)

Figurationally speaking, such concerns and anxieties reverberate strongly with Elias (1985) observations about ageing, as he argues that in developed industrial societies, the processes of ageing, dying and death are highly emotionally isolating experiences. He (1985) also portrays the protectionist approach adopted by many governments and other organisational bodies vis-à-vis the 'aged' or dying person. Such protectionism was clearly apparent in the UK during the COVID-19 pandemic. Public Health England, which is tasked with protecting the nation's health, announced that older people with COVID-19 were more likely to die (UK Parliament 2020), and the National Health Service (NHS) and government officials advised anyone aged 70-and-over to stay at home and 'self-isolate'. Practising social distancing and isolating older adults from their figuration of family and friends was designed to protect health, but engendered isolation, loneliness, and social suffering. Whilst such social isolation was not exclusive to older adults during lockdowns and social distancing requirements, given that many older adults live on their own following the death of a partner/spouse, the impact on this group was considerable. Despite feeling 'cut off' from family and friends, more positively, participants reported the benefits of new social interactional norms, however:

> People stopped and said 'hello' you know. Kept their distance, but still said, 'hello', 'Good morning' or whatever. . . People were a lot friendlier. (P18)

> We had someone call us once a week asking if we needed anything and were we ok.(P14)

> I'm sure they were in touch and almost doing a relay with me. . . One would ring me and say how was I doing and then, if that was X, she would ring Y in [local town] and tell her and, a week later, Y would ring. (P5)

Divided (to some extent) before the pandemic began, participants expressed a strong sense of connectivity with members of their local communities during the lockdowns. In figurational terms, members of community figurations were inclined towards and bonded with each other through a shared need to help each other through the crisis. Such connectivity could be greatly assisted and enhanced by the use of modern technology and social media platforms.

Role of modern technology

Goethals et al.'s (2020) qualitative research on COVID-19 experiences found that older adults reported lacking the technical knowledge to access online exercise activities. Our findings diverge notably, with participants describing embracing various forms of modern technology. For example, to counter the stay-at-home orders, which meant not physically being with figurations of family and friends, many participants used FaceTime, Zoom, Teams and other platforms, including for meetings with community clubs and groups:

> I used to just FaceTime them [family], because you couldn't go, and they couldn't be out. So, we just had to do FaceTime. (P6)

> My church streamed the masses every day, so I used to watch them online. (P14)

> Choir went online, and we did a couple of flower club nights online, where everybody was there on FaceTime. (P4)

Those participants who had maintained or increased their PA levels during the lockdown periods often discussed the benefits of modern technology in encouraging PA:

> I was told that I needed to monitor my heartbeat. I got a [smart] watch, and then I bought a better one for my birthday in the summer, which I still wear. (P7)

> On this app I've got - you have to do steps [to achieve a minimum number]. (P11)

> I think it was then too I started online exercise classes, because I thought, 'I'm not getting out and about so much'. So, I did a little exercise class two days a week, that a friend in Scotland was running. (P4)

> I got a Christmas present which was a Fitbit . . . when I had this Fitbit and I started really regular walks. It's been like that ever since . . . I can look back and I have, especially when I got this Fitbit, and I can look back and I've honestly gone for a walk practically every day. (P16)

These findings suggest that in certain contexts older adults are open to embracing the benefits of modern technology, including increasing PA levels so as to improve health and fitness. For those with certain age-related conditions, such technology can also enhance communication and social connectivity. P11, for instance, mentioned that their wife was 'hard of hearing', which created problems when speaking to the doctor by telephone. FaceTime proved to be highly effective in improving doctor-patient communication:

> She couldn't hear [the doctor] on the telephone, you see, and this was very hard. Fortunately, FaceTime wasn't too bad because she could see people talking. (P11)

Our findings align with those of Haase et al. (2021), who suggest that a growing number of older adults adopted and embraced modern technology during COVID-19 lockdowns. In addition, Li et al. (2021) analysed data from the 2019–2020 National Health and Aging Trends study. Of the 23,547,688 participants aged 65 years and older who responded, 60.2% reported increasing their use of technology during lockdowns. These findings open the possibility for public services and other social figurations to acknowledge the increased acceptance of modern technology by older adults; an acceptance that seems to have been accelerated by the pandemic situation. Xie et al. (2020), for

example, suggest that informatic tools using eHealth technologies should be developed to assist older adults in using healthcare.

There would therefore seem to be scope for further research to investigate transforming communications by analysing changing 'communicative figurations' (Hepp and Hasebrink 2018). Drawing on figurational perspectives and focusing attention on structured processes, which have occurred over space and time (see Elias and Jephcott 1992; Jarvie and Maguire 1994), specifically during COVID-19 pandemic times, would allow researchers to explore how the social worlds of older adults might be enhanced using modern technologies in everyday environments.

Conclusion

Globally, the profile of the population is ageing and it is important to investigate and explore the daily lives, and lived, embodied experiences of older adults, which can aid both understanding and care of this social group. When the COVID-19 global pandemic was announced in early 2020, many societies quickly sought to protect those deemed to be at high risk of illness, death and/or serious health complications, and this included older adult populations. Governments around the world attempted to achieve such protection via restricting (sometimes severely) face-to-face interactions and implementing 'stay at home orders' or lockdowns. As we now move away from the most immediate threat of COVID-19, it remains of importance to understand its impact on specific social figurations such as older adults, given their increased vulnerability both to COVID-19 and to increased sedentariness generated by lockdowns and other restrictions (Goethals et al. 2020).

Through a figurational lens, here we have explored some of the embodied and social relational experiences of participants during the COVID-19 pandemic and particularly during the lockdown periods and restrictions on socialising, which were imposed in the UK. The status of older adults as 'outsiders' to the mainstream public was emphasised through the rules and recommendations put forward by the UK government and also by health officials, such as the Chief Scientific Adviser, and the Chief Medical Officer for England. At a more micro-level and focusing on the everyday experiences of participants, our findings explored how these older adults were able to adapt and find their place through new and developing communicative figurations that were often social and/or health focused. In accord with Elias' (1939/1978a) theorisation, we found that the short-term actions of individuals were situated within, and influenced by, webs of relationships that both enabled and constrained people in their respective figurations, including in relation to physical-activity engagement, and within health contexts. For example, participants described deliberately *not* seeking medical care from health services because they did not want to be a 'burden' during the pandemic, considering that others needed treatment more urgently. As portrayed above in relation to one participant who was suffering cardiac problems, such 'thoughtfulness' could have highly deleterious consequences.

Due to restrictions on face-to-face social interaction, older adults reported incorporating modern technology into their daily lives on a more frequent basis during the pandemic. The majority of interviews in the current study were carried out via video conference calls, and it seems likely that researchers will continue to use online approaches to data collection. Research undertaken prior to the COVID-19 pandemic found the take-up of modern technology by older adults to be restricted, for example, due to poor internet access, lack of understanding, and the need for greater assistance (Geraedts et al. 2017; Martins Van Jaarsveld 2020). This meant that in the domain of healthcare, older adults appeared to be relatively slow in adopting communicative technologies to aid their day-to-day lives, for example in seeking virtual or online appointments with their General Practitioners. In contrast, in our research, participants reported that modern technology greatly enhanced social connectivity, allowing individuals to meet online with members of their different figurations, counteracting the potentially highly isolating experience of COVID-19 lockdowns and restrictions on social life, and thus combating loneliness. Such technology also promoted

engagement in PA, for example, via online exercise classes, and the use of wearables and apps designed to increase and sustain levels of PA by 'nudging' (Toner, Allen-Collinson, and Jones 2022) individuals to do exercise, achieve a minimum number of steps *per diem*, or stand up at various points throughout the day, for instance.

As with all research, our study has limitations: it was small-scale, exploratory, and UK-based, and we did not seek representativeness or generalisability of findings. Further wider-scale research is therefore needed, particularly to explore how we might draw on this newly found (in many cases) use and acceptance of modern technology and social media by older adults, especially as this group has often been considered relatively slow to adopt such technology and media (Mitzner et al. 2019). Although generalisability and replicability of findings were not aims of the study, in identifying in our data strong resonance with many of Elias's (1985, 2001) figurational insights on loneliness and social isolation, and the importance of social connectivity, we hope to have achieved some degree of theoretical generalisability (Smith 2018).

In conclusion, our findings suggest that, for key health services such as the NHS in the UK, and other healthcare providers, supporting older adults with the use of modern technology has the potential to modernise, expand, and target healthcare more effectively. This could enhance the health and wellbeing of older adults, many of whom require, or would benefit from, greater levels of healthcare support in their everyday lives.

Disclosure statement

No potential conflict of interest was reported by the author(s).

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