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Beyond Vulnerability: Autonomy, Social Participation, and the Experiences of Older Adults During the COVID-19 Lockdown

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Abstract

Background

During the COVID-19 pandemic, people aged 75 years and over in Spain experienced substantial excess mortality and were disproportionately affected by restrictive measures intended to protect them from infection. These measures limited mobility and access to essential services and had important consequences for social relationships, autonomy, and well-being. This study aimed to explore the experiences of people aged 75 years and over and their family caregivers during the COVID-19 lockdown in Spain, focusing on the political, social, and personal impacts of pandemic measures and strategies to address emerging challenges.

Methods

A qualitative study informed by a critical social perspective was conducted between March and October 2023. Participants included 37 people aged 75 years and over and 70 family caregivers from diverse urban and rural settings across 11 Spanish provinces. Data were collected through semi-structured interviews and discussion groups exploring experiences of the lockdown, perceptions of pandemic policies, and individual and family coping strategies. Data were analysed using a multilayered discourse analysis.

Results

Although protective measures were intended to safeguard older adults, participants described how age-based restrictions could reinforce stereotypes of frailty and dependency, contributing to stigmatization and social isolation. Restrictions also disrupted family and social routines and affected emotional well-being and social connection. At the same time, participants described diverse strategies to cope with these challenges, including physical activity, the use of technology, and engagement in meaningful daily routines. These strategies supported autonomy, social connection, and resilience, although their feasibility varied across individuals and circumstances.

Conclusions

Pandemic responses targeting older adults may have unintended consequences when protection is prioritized over autonomy and social participation. Recognizing older adults as active agents and incorporating their perspectives into emergency planning may contribute to more inclusive responses that protect health while preserving autonomy, dignity, and social connectedness.

1. Background

The COVID-19 pandemic posed a challenge to public health systems worldwide. Most countries opted to lock down their populations in response to rising mortality rates and the lack of a specific treatment for the virus. Stay-at-home orders were issued in most countries in mid-March 2020, with people confined to their homes and businesses closed, with the exception of establishments selling essential goods or fuel[(1)]. In the case of Spain, the lockdown during the first state of alarm lasted 100 days, from March 15 to June 21, 2020, with a subsequent quarantine period in the fall, which led to restrictions on movement between towns and limits on groups in public places to six people who did not live together. The situation was critical at the beginning of the pandemic in Spain, with excess mortality from all causes of 56% nationwide from March 17 to April 7, 2020, concentrated in people aged 74 years and older (65%), followed by the 65–74 year old age group (53%)[(2)].

The start of vaccination in early 2021 and the subsequent decline in mortality attributed to SARS-Cov2 led to the lifting of restrictions in the following months[(3)], although the use of masks and the preference for working from home remained in place for some time.

Mobility restriction measures had a particularly severe impact on older people worldwide[(4)], whose mobility and access to essential services, such as home help, adult day services[(5)], or face-to-face contact with their primary care providers for the monitoring and follow-up of their chronic health problems[(6, 7)], were restricted.

While face-to-face contact was reduced, the use of technology in procedures and virtual contact grew exponentially. This had a major impact on older people, who clearly had fewer technological skills. For them, television was the most widely used means of staying informed, and the telephone was the means that allowed them to stay connected with family and friends. This situation was a clear example of how social inequalities can affect the use of technology as a tool to help in situations of involuntary isolation[(8, 9)].

Some of the interventions evaluated during this period to improve quality of life and reduce social isolation among older people included talking frequently with family and friends, receiving social support from peer groups or volunteers, and the use of cognitive therapy activities [(10–12)].

However, the literature does not delve into the responses that institutions, families, and individuals themselves gave during this lockdown situation and how these responses affected a particularly vulnerable population, such as older people living at home who were aged 75 years and older. In the case of Spain, this population amounts to almost 7 million people.

2. Methods

2.1. Aim and Design

In this context, this study aimed to understand and interpret the political, economic, social, and personal dimensions linked to the COVID-19 lockdown in people aged 75 and over and their family caregivers during the first months of the pandemic, and to consider possible ways to overcome these challenges. Studying institutional, social, family, and personal responses, as well as their consequences, can help us to be better prepared if a similar situation arises in the future

Qualitative study with a critical social approach, through semi-structured interviews and discussion groups, were conducted in 10 Spanish provinces, and analysed using a thematic analysis[13]. The reporting of this study adheres to Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines[14].

This study is part of a multicentre project composed of three subprojects that aim to assess the impact of the COVID-19 pandemic on the health status of people aged ≥ 75 years in Spain[15].

2.2. Study population and sample

The study population included people aged 75 years and older and their family caregivers. For the interviews, we selected participants based on age (≥ 75) and gender. Additional characteristics considered in the sampling and analysis included habitat (urban or rural), living arrangements (alone or with others), level of dependency (Barthel Index), and history of COVID-19 infection. For the discussion groups with caregivers, we used purposive sampling to ensure variation in age, gender, cohabitation status, place of residence, relationship to the care recipient, and years of caregiving experience.

Researchers in each participating province were responsible for recruiting participants, providing study information face-to-face or by telephone, and obtaining informed consent.

2.3. Data collection.

To generate discourse, we used:

- Semi-structured interviews with people aged ≥ 75, which provided insight into their personal experiences and biographies, and allowed us to explore phenomena from each participant's perspective.
- Discussion groups with family caregivers, which enabled us to capture shared narratives and socially constructed meanings related to the study topic.

A predefined script guided the interviews and discussion groups. (Annex 1 and 2). One male and 4 female researchers with extensive experience in qualitative health research and not previous contact with the participants conducted de interviews and discussion groups. Discussion groups were held in primary care centres or nearby community venues, while interviews took place at locations chosen by the participants.

2.4. Analysis

We audio-recorded all interviews and group discussions and transcribed them verbatim. We performed thematic analysis, combining inductive and deductive approaches, by identifying units of meaning and coding them into thematic categories[13]. To deepen the interpretation, we conducted, at the textual level, a semiotic analysis and, at the contextual level, an analysis of discursive positions[16], considering the roles of older adults and caregivers. In line with the study's critical orientation, we also analysed discourse as a reflection of ideological positions related to inequality and power dynamics.

2.5. Ethics

The study received approval from the Central Research Committee of Primary Healthcare Management and the Ethics Committee for Drugs Research (CEIm). All the participating regions obtained ethical clearance from their corresponding committees.

We anonymized all data collected in interviews and discussion groups. Transcripts were stored securely in the institution's cloud storage system, protected by strong authentication protocols.

2.6. Rigor

To enhance credibility, we present the results with verbatim participant quotes alongside researchers' interpretations. Team members maintained a reflective journal throughout the research process to document decisions and observations. We applied methodological triangulation to strengthen the confirmability of the data. Multiple researchers independently coded and categorized the data and reached consensus through discussion. We ensured transferability by providing a detailed description of the study context, participant characteristics, and data collection settings.

3. Results

The narratives of 107 participants were collected in 37 interviews and 9 discussion groups in different regions of Spain from March to October 2023. The main characteristics of the participants are summarized in Table 1.

Table 1
Characteristics of participants

Sociodemographic characteristics	Older people (N 37)	Family caregiver (N 70)
Sex		
Male	14	17
Female	23	53
Age		
75–84	24	
> 85	13	
Environment / Habitat		
Rural	15	19
Urban	22	51
Live alone		
Yes	15	
No	22	
Live with a family member		
Yes		33
No		37
Person cared for		
Mother/father		37
Both		15
Sibling		3
Grandparent		2
Husband/wife		8
Other		5
Total participants	37	70

Analysis of the narratives identified three sets of lessons learned from the COVID-19 pandemic: 1) lessons learned from health policies, 2) lessons learned from established relationships, and 3) lessons learned from individual characteristics and responses of older people (Table 2). The results of this study thus provide lessons for political, social, and individual learning.

Table 2
Themes and subthemes

Lessons learned from health policies	Social isolation and perceived loneliness
	Ageism: being seen as vulnerable and lack of respect for their decisions
	The moral dilemma between public and private norms
Lessons learned from close social relationships	Virtual relationships: the cost of losing face-to-face relationships
	Overprotective families
Lessons learned from individual characteristics	Adaptation and self-control as elements of resilience
	An active and healthy life: routines that save lives

3.1. Lessons learned from policies

The experience of this period reflects a deep tension between the authorities' desire to ensure people's safety and the limitations on their autonomy and right to social participation. This issue was particularly complicated in the case of older people.

3.1.1. Social isolation and perceived loneliness

Ensuring the protection of older people's lives meant creating a kind of "bubble" that led to physical and emotional isolation. References to unwanted loneliness are frequent in the respondents' discourse.

Alone, here alone, it seems to me that there was no one else. Everyone was in their own homes and we did not see each other or anything [...]. (E8, woman, 87 years old)

Always locked up alone, my wife and I here all by ourselves, just like everyone else, so yes, it affected me quite a bit [...] the sadness of being locked up all day. (E9, man, 87 years old)

In some cases, the cessation of all community interaction, such as shopping, attending adult day services or social centres, and even going to their health centre, was offset by support actions.

There is a cooperative in the countryside that I used to call, and they would bring me groceries, whatever they wanted, leave it at my door, and I would bring it inside. (E20, woman, 78 years old)

3.1.2. Ageism: being seen as vulnerable and lack of respect for their decisions

Furthermore, in the case of older people, the pandemic contributed to the emergence of ageism and marginalization. The cessation of all community interaction marginalized them from society and fuelled their exclusion. The repeated institutional treatment of older people as "vulnerable" and "at risk of dying," who could not or should not participate fully in social life, constructed a social narrative that reduced them to their frailty. The perception of their value in society was conditioned by their vulnerability.

I remember that, at the beginning of the pandemic, what we were really afraid of was that we could infect them, my father, right? That we could bring the virus home because we knew they were the most vulnerable, right? I think we had the idea that if someone over 80 caught COVID, they were doomed, right? Then, well, we saw that maybe it's not so severe or so strict (DG2)

A view that reduced them to their frailty was also widespread, as if older people were a homogeneous group of "diminished" individuals. The participants' discourse reflects how health policy often failed to recognize the diversity of needs and abilities within the older population, assuming that everyone was the same in terms of vulnerability. This approach exacerbated ageism. Age set the standard; decisions were made based on age.

And they didn't take older people to hospitals because they couldn't treat them, because there wasn't enough room, and a decision had to be made: either you saved the 50-year-olds or the 90-year-olds. So the 50-year-olds, and it's barbaric, but that's the way it is. And the decision is stupid, logically, but you have to... (DG1)

The dominant discourse about their inability to deal with the virus also minimized their capacity for other things, such as decision-making. The lack of respect for their decisions appears numerous times in the study. One of the most repeated responses was the lack of respect for their decision to stay at home alone, in a paternalistic desire to protect them.

I didn't want to leave, because I lived in Madrid and I had my friends there, my parish, my... My place... where I could move around! And then I was comfortable in my home, there in Madrid. When I came here, they put me in a brand new apartment, one of those lofts... beautiful. However, what am I doing there? Alone. I have no friends, the parish is far away, the neighbours are all young people renting these apartments, and you don't talk to any of them (E3, woman, 86 years old)

Therefore, during the COVID-19 pandemic, the isolation decreed and glorified by society and positive discrimination ended up creating a stigma marked by frailty and the loss of individuality and autonomy.

3.1.3. The moral dilemma between public and private norms

Furthermore, these stereotypes and prejudices not only shaped the image of what we knew, but also the reaction to the pandemic. The portrayals of vulnerability and recommendations for "special lock-down," shaped by the information conveyed during this period, made older adults and families particularly cautious about COVID-19 and compliance with laws and regulations. The study contains numerous references to this aspect.

...I imagine that health authorities will advise the decisions made by the government on this matter, and if they tell us, we will obey and do what we have to do (E19, man, 81 years old)

However, in many cases, this compliance with laws and regulations became a source of conflict or dilemma for family members between political norms and personal moral values, as while the rules imposed by governments prevented them from visiting and caring for their older relatives, private norms encouraged them to do so.

[Leaving things at the elevator door] and leaving so that when she opened the door to her home, we wouldn't be there. It was hard, really hard. A lot of changes. And then it happened, we saw each other, we got a little closer to her door from the elevator, but she stayed at the door for a while, until she started saying: "Kids, please come in." "We can't, Mom." "Come in, just into the entry, just into the entry." I mean, it was... Well, when we saw how sad and painful it was for her, we started to go into her house a little. We were very afraid, and she resented not going out, giving up her activities, and the loneliness. (DG 2)

In this context, many older people, family members, and close friends "broke the rules" guided by common sense and personal values, deciding on their own authority.

My mother said: "We broke the rules because if we didn't... well, I'd die." (DG 2)

I went every day to pray the rosary, [...] and I went to help the priest, even though "his people" told him not to go out. He tricked them by saying he wasn't going out, but he went everywhere. I went out every day and went to church every day. (E7, man, 80 years old)

This conflict was constant during this period, where the public and the private, and authority and self-management became dilemmas that we all faced during the pandemic, especially older people, who were the target of stricter and more vigilant regulations both by the system and by those around them.

3.2. Lessons learned from close social relationships

Face-to-face social encounters were therefore considered prohibited and risky, which made this period difficult.

3.2.1. Virtual relationships: the cost of losing face-to-face relationships

Faced with the difficulties imposed on face-to-face interaction, staying connected meant incorporating the habit of interacting virtually. We then witnessed new "virtualized" social normalcy that involved interaction mediated by electronic devices. In many cases, this new form of relationship was a challenge. The need to transform face-to-face contact into online contact in order to meet relational needs posed an additional difficulty for older people due to the digital divide. In this case, children and grandchildren became the main source of support, providing the most practical support on a day-to-day basis.

When I wanted to make an appointment with the doctor, I would call my daughter and say, "Get me a number," and she would get me one, and then we would talk on the phone and I would tell him what was wrong, and he would see me (E28, woman, 83 years old)

Despite this, many older people report having lost "precious" time and many displays of affection shared with their loved ones. Radical decisions, such as the frequent decision to stop seeing grandchildren, came at a very high price for older people.

Well, it prevented me from hugging them and having more physical contact, the same with the kids, and this prevented you from expressing yourself more. [...] Well, it makes you sad or... I don't know how to express it, but you're sadder, because you're used to always having them there. (E10, man, 84 years old)

Furthermore, in many cases, virtuality and the loss of many spaces for face-to-face interaction caused the interruption of routines that have never been recovered.

[…] people stopped going to bars (the main social space) […] All the bars in Alfarrás had tables for eating butifarra, all of them, and now I don't think so, I don't see people even on the terraces anymore (DG7)

3.2.2. Overprotective families

Those who wanted and were able to continue with their lives in their homes and usual environments during lockdown do not report this profound perception of emotional and social loss, linked to isolation. Nevertheless, in many cases, family members insisted on moving in with the older person or even decided that it was best to take them out of their home and move them in with them.

It was the grandchildren themselves who decided that one of them would stay with her full time, that is, live with her for as long as COVID lasted, which was unknown at the time. Well, we were lucky that one of the granddaughters who was studying medicine at the time [...] voluntarily decided to move in with my mother (DG1)

The lack of confidence of adult children in their parents' ability to be independent sometimes became an obstacle to their ability to continue engaging in their daily activities and maintain their independence. In addition, leaving their homes meant an added moral effort for many older people to adapt to unfamiliar environments, which, rather than providing them with well-being, caused feelings of loss.

[…] My mother-in-law was with a caregiver. She had widowed a year ago. She already had a caregiver 24 hours a day, and when the lockdown happened, well, we decided to bring her home. We said, "Look, we don't know how long this is going to last, the two of you are not going to be there alone, she'll be safer in our house" [...], so we said, "Let's bring her home." She left her home in tears. (DG6)

In any case, this decision, made by many families, was simply a way of making it easier to look after their older relatives. When people live together, it is easier to take responsibility for caring for older people than when they live alone. In this way, the family provided affection and met basic needs and material care at a lower personal cost.

[…] what we did was go twice a week, take them food, do their shopping, [...] Well, one night one of them called me at 4 in the morning to say that something had happened to one of them, that she had fallen. [...] I brought them to my house, and they are staying with me. (DG5).

3.3. Lessons learned from individual characteristics

Beyond political issues or media coverage, as well as the broader social dynamics that emerged during the pandemic, the study data confirm the important role that individual differences played in older adults' ability to cope constructively with the COVID-19 pandemic and overcome those challenges in a healthy way. This individual ability was shown to be a determining factor in how older people experienced the social isolation to which they were subjected.

3.3.1. Adaptation and self-control as elements of resilience

Among the most decisive personal abilities was the ability to adapt to the new reality, which translated into following the recommendations of the health authorities and trying to do everything within their control in the best possible way.

Gosh, I never felt that way... I took it very philosophically, you have to get through it, you have to get through it, they're in charge, they're in charge, I never complained, I never got nervous, I never got hysterical with my family, quite the opposite.… (E17, woman, 80 years old)

Self-control was another coping strategy that allowed them to maintain the lockdown measures without letting fear get the better of them. In many cases, they reported basing this skill on the strength and resilience acquired in past experiences.

"…what had to be done was to take measures, of course, each one their own... I'm not someone who gets scared easily, but yes, of course, take measures, all you can... I took it seriously, I didn't get scared, but I took it seriously... No, I didn't have a hard time; I went through it with a lot of respect." (E18, man, 82 years old)

Actively seeking social support was another effective coping strategy that was very common among older people. Maintaining social and family relationships by phone, reconnecting with old friends, and participating in online gatherings were a crucial source of emotional support in a context of social isolation.

At church, I'm in a liturgy group [...] So every day they send us what we call "bocaditos" (little bites), which are phrases, by phone, via WhatsApp (E37, woman, 82 years old)

3.3.2. An active and healthy life: routines that save lives

Striving to maintain healthy lifestyles, such as physical activity in the available environment, was also part of this useful coping strategy for developing a positive outlook on the situation.

Then the routines, everyone doing sports, we put a bike on the terrace, I'm lucky I have a garden, so we set up an obstacle course and we're all there like hamsters, an hour or an hour and a half, and that helped the day go by (DG7)

He has his step counter and [...] he walks from one end of the house to the other and he knows that every day he walks 5 kilometres (DG 7)

Engaging in meaningful activities (reading, writing, listening to music, writing a journal) that were important to oneself was another successful coping strategy that allowed them to enjoy fulfilling activities in such an adverse situation. Keeping busy, making use of cultural, instrumental, manual, and leisure resources, among others, allowed some of them to re-evaluate their isolation in a positive way, turning it into an opportunity for personal growth.

I really like writing. It doesn't mean I'm good at it, but I enjoy it and it keeps me entertained, so that also helped me because when you start reading or doing an activity, music or whatever, what you're doing at that moment absorbs you [...] And so that helped me a lot, it also isolated me from the disease (E18, man, 82 years old)

The search for meaning through religious practice was a source of hope, comfort, and even acceptance of death.

[…] it helps me that I am a believer, and I say, "My God, whatever you have in store for me, here I am..." (E17, woman, 80 years old)

Distancing oneself from immediate reality through specific actions that provided well-being was also shown to be another protective strategy during isolation. For example, enjoying small pleasures as a way of diverting attention to other aspects of life, or laughing. The use of humour has also been an effective way of escaping from or reframing the stressful situation caused by the pandemic.

I'll tell you something, one day I went to the patio and started singing songs. We had a good laugh, the neighbours came out... And that was also a lot of fun, because we took turns going up to the terrace and saying, "Come on, let's sing, one each day." Anyway, the terrace was an escape, and that's how I spent my time. (E27, woman, 81 years old)

But at that time, I did need to have my usual glass of wine because, maybe, it reminded me, maybe not, it reminded me of other moments I had experienced... and that also helped me (E18, man, 82 years old)

In short, the data reflect how some older adults adapted better than others to the stressful living conditions imposed by the pandemic and managed to maintain acceptable levels of well-being by using various psychological skills such as those described above.

4. Discussion

Our findings highlight how the COVID-19 pandemic, and particularly the lockdown measures in Spain, revealed structural ageism embedded in public policy. Older adults were treated as a homogenous group defined primarily by vulnerability, leading to measures that, while designed to protect, contributed to social isolation, dependency, and erosion of autonomy—findings that are consistent with previous literature[8, 17–24] .

Media narratives and institutional discourse reinforced these perceptions, emphasizing frailty and dependence while neglecting the diversity and capabilities of older individuals. This age-based approach had negative consequences not only for physical and mental health but also for participation rights, autonomy, and self-perception [17, 21–23]. Moving forward, policy design must shift toward a salutogenic model that recognizes older adults' heterogeneity and supports their capacity for decision-making and self-care [19, 20, 24].

At the microsocial level, our participants' experiences showed complex changes in family and caregiving dynamics. Some older adults, especially those who had previously lived independently, maintained that autonomy throughout the lockdown. Others opted, or were encouraged to cohabit with relatives as a protective measure. While this increased access to care and emotional support, it also implied a loss of independence and, at times, paternalistic family dynamics. In these cases, the family system is "reconfigured" with new boundaries, roles, and ways of relating, even leading to the breakdown of family ties

with the consequence of family exclusion[22]. Yet, the desire for proximity, particularly with grandchildren, often prevailed over fear of infection, reflecting the irreplaceable value of physical contact in maintaining emotional well-being[25–28].

The pandemic also accelerated the "virtualization" of social interactions, highlighting stark inequalities in digital access and literacy. While some older adults used video calls and social media to remain connected, many were unable or unwilling to engage with these tools. This **grey digital divide**[29–34] not only limited social contact but also amplified feelings of loneliness, segregation and invisibility.

Participants' narratives showed that digital communication, although useful, could not substitute the emotional depth of in-person relationships. Public policies should promote digital inclusion through training and access, but must also acknowledge the limitations of technology during involuntary social isolation[29, 33, 35]. The tendency to replace direct interaction with digital tools risks reinforcing exclusion among the most vulnerable[8], especially those living alone or in rural areas.

Crucially, this study highlights the **resilience and adaptability** of many older adults during lockdown. Participants who maintained daily routines, physical activity, or meaningful personal projects reported greater emotional stability and a sense of control. These coping strategies—also observed in other studies in different contexts [36–40]—underscore the importance of enabling environments that support autonomy, self-efficacy, and psychological well-being during crises.

Engagement in fulfilling daily tasks, even small ones, allowed participants to reclaim a sense of purpose and agency in a time of uncertainty. This aligns with broader research linking intentional activity to improved mood, reduced helplessness, and enhanced resilience[35, 41–44].

The lessons from this period should inform preparedness efforts for future health emergencies. Communication strategies must shift from fear-based messaging to inclusive, transparent models that promote trust and informed autonomy. Public discourse should avoid portraying older people as passive recipients of care, and instead recognize them as active citizens capable of managing risk and contributing to solutions[43, 45, 46].

Finally, resilience should be integrated into health promotion policies as a **learnable and supportable capacity**. While contextual and cultural factors influence coping strategies, structured programs can foster emotional and cognitive tools to help older adults respond to adversity. Involving older people in the design and delivery of these programs will ensure relevance, legitimacy, and effectiveness[47].

4.1. Strengths and Limitations

This study provides in-depth qualitative insights into the lived experiences of older adults and their family caregivers in Spain during and after the COVID-19 lockdown. While the findings are context-specific, the challenges and responses observed echo those reported in other international settings, suggesting broader relevance.

As with any interpretive methodology, multiple meanings and perspectives exist within participants' discourse. However, the analytical process was systematic and reflexive, ensuring rigor and transparency. One limitation is the time elapsed between the first lockdown period in Spain (March–June 2020) and data collection in 2023. This delay may have introduced recall bias or fragmented memories, but it also allowed participants to reflect on which aspects of the experience had lasting impact on their lives.

Another limitation concerns sample diversity. Despite efforts to ensure variation, recruiting participants from low to middle socioeconomic backgrounds proved difficult, resulting in their underrepresentation. This may limit the study's ability to capture experiences strongly shaped by social and economic inequality.

4.2. Future Research

Future lines of research include the design and evaluation of public health programs designed with citizen participation, programs against ageism, and health promotion programs that incorporate resilience and mental health care.

5. Conclusion

This study identified three interrelated areas of learning during the pandemic: the consequences of age-based public policies, the transformation of social and family relationships, and the role of individual coping strategies.

A reductive and ageist perspective that overlooked the diversity and capacities of older adults guided lockdown policies. A more equitable approach must adopt a salutogenic model that balances health protection with personal autonomy and social inclusion. Older people must be recognized not as inherently vulnerable, but as capable agents, whose values and preferences should shape public responses.

The shift to virtual interaction exposed and deepened the digital divide, leaving many older adults excluded from meaningful social contact. While promoting digital literacy is important, it is equally necessary to preserve and restore physical spaces for face-to-face connection. Policymakers and families must move beyond protectionist attitudes and create environments that support social participation and self-determination.

Finally, the study shows that resilience is not an innate trait, but a set of behaviours and attitudes that can be learned and supported. Health promotion strategies must incorporate the development of coping skills alongside physical care, enabling older people to respond more effectively to future challenges.

In sum, the pandemic revealed the need for a profound narrative shift: from viewing older people as passive and fragile to recognizing them as diverse, resourceful, and active contributors to society.

Declarations

Ethics approval and consent to participate

The study received approval from the Carlos III Health Institute Ethics Committee (CEI PI 67_2021-V4). All the participating regions obtained ethical clearance from their corresponding committees. All participants provided written informed consent before inclusion. Access to the data was restricted to authorized members of the research team through individual user credentials. The analytical database did not include directly identifiable personal information.

Consent for publication

Not applicable

Availability of data and materials

The datasets generated and/or analysed during the current study are not publicly available because the contextually rich nature of the interview and discussion group transcripts may compromise participants' confidentiality and anonymity. The data are available from the corresponding author on reasonable request, subject to appropriate ethical and confidentiality considerations.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

Study Management Committee: APM, AMPS, MRR, JMTA, YLB, MMC, MRB and SES developed the framework of the study. All authors conceived the study and participated in its design. Coordination and Methodological Group: APM, AMPS, MRR, JMTA, MGS and YLB. Writing Committee: APM, AMPS, MRR and YLB wrote the manuscript; JMTA, MGS, MMC, SES, MRB, MCCS, MACM, IFR, reviewed it. All authors in Cuidamos + 75 Group read and approved the final manuscript

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