QUALITY OF LIFE IN COVID-19 PANDEMIC: A KALEIDOSCOPE OF CHALLENGES AND RESPONSES OF VARIOUS POPULATION GROUPS DURING THE CRISIS

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1 CHALLENGES WITHIN SLOVENIA'S CARE REGIME DURING THE COVID-19 CRISIS

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Abstract

The chapter addresses the (temporary) changes in care in Slovenia in the period of the COVID-19 pandemic in terms of care regime embeddedness. Analysis of public policies, intervention measures, and data from available surveys leads to shifts being identified in the role played by different actors (state, market, family) concerning care. The chapter shows how measures like the closing of childcare facilities and schools, or the limits placed on home care services, saw the care role shifting from the state to individuals (emphasis on individual responsibility) and particularly to families (refamilialisation). This has left families with an especially challenging work-life balance, notably those belonging to the 'sandwich generation'. The conclusion discusses the implications of these changes for work-life balance policies and broader gender equality issues.

Key words: childcare, care for older people, work-life balance, Slovenia, COVID-19

Introduction

Changes in welfare systems in periods of global crisis are becoming a core topic in social policy studies (Schubert et al., 2016; Taylor-Gooby et al., 2017). Moreover, comprehensive research into the changes occurring within care regimes (for both childcare and older people care stemming from population ageing) is becoming a vital topic within both work-life balance studies and social policies. Therefore, the chapter identifies shifts in the role played by different actors (state, market, especially family) concerning care for children and older people during the COVID-19 pandemic based on analysis of public policies, intervention measures, and data from available surveys. We are also interested in what these shifts mean for the work-life balance of families with small children and older frail family members respectively in need of daily schooling and/or care. The effects of the COVID-19 intervention measures on the work-life balance of Slovenian families are analysed and discussed based on original data from a survey conducted by the CWS (Centre for Welfare Studies) in multi-apartment buildings in Ljubljana, along with a comparative perspective with other European countries using data from the Eurofound survey (Eurofound, 2020a, 2020c, 2020d).

The chapter's structure is as follows. In the first part, the care regime in Slovenia is presented, then analysis of the measures introduced due to the COVID-19 pandemic

with respect to care for children and older people in Slovenia, as well as a discussion of the Slovenian case in a comparative perspective with other European countries. Based on data from available surveys in the pandemic period, the implications held for work-life balance in Slovenia are discussed and, where the data allow, also in a comparative perspective with other European countries. Special focus is given to families belonging to the 'sandwich generation' as well as broader gender equality issues. We conclude by stressing the main findings with regard to the policy implications for future development of Slovenia's care regime.

The care regime in Slovenia

Care is becoming one of the most salient issues due to both ageing of the population and the increasing labour market participation of women, and increases in the retirement age (see Nieuwenhuis & Van Lancker, 2020). Care has traditionally been largely provided by informal social networks, such as parents in the case of childcare, children and spouses in the case of care for older people, alongside extended family members (Daly, 2002). With development of the welfare state, in many countries care provision has been taken on by different bodies. Esping-Andersen (1999, 2009) distinguish three different sources that can provide care: the state, family and market. In terms of care, Esping-Andersen theorises 'familialism', where the obligation is assigned to the household, defamilialism through the market where individuals rely on market sources for care, and defamilialism through the state, where the state is responsible for providing care (Esping-Andersen, 1999). In the last two decades, following the global economic crisis after 2008 the concept of refamilialism has been widely discussed, referring to changes in family policies towards the individual's increasing dependence on families by virtue of various ideological pressures as well as austerity measures. This is particularly evident in the case of care for older people where a trend towards refamilialism as a strategy can be observed according to which governments have coped with the Great Recession since 2008 (Deusdad et al., 2016). In contrast, in this period childcare policies have generally expanded in most European welfare states (Ferragina & Seeleib-Kaiser, 2015). Still, European states have varied in the ways they have approached care needs in the past and how they are continuing to address them in the changing demographic, economic and social circumstances, while there are significant differences in the development of childcare and older people care across Europe, forming different care regimes and support for defamilialism (Bettio & Plantenga, 2004; Haberkern & Szydlik, 2010; Leitner, 2003;

Rummery & Fine, 2012; Saraceno, 2016). Typologies distinguish countries that are more or less familialised in care, i.e. where care is mainly provided by the family, and the degree to which the family is supported by specific policies and measures. In the chapter, we analyse the Slovenian care regime within typologies based on the extent of familialism and defamilialism (see Leitner, 2003; Saraceno & Keck, 2010; Saraceno, 2016).

Slovenia is an example of a country with substantial differences in its arrangements for child and older people care (Filipovič Hrast & Rakar, 2021). Hence, placing Slovenia on a continuum of care regimes ranging from defamilialised to familialised is difficult, with care for children being highly defamilialised (Chung et al., 2018; Filipovič Hrast & Rakar, 2021) and older people care highly familialised (Filipovič Hrast et al., 2020; Hlebec et al., 2016). Its childcare policies build upon a historically well-developed system of public childcare provision and generous leave policies, together with a well-developed social protection system that targets families. These were retained and, in some cases, expanded up until the 2009 economic crisis when certain austerity measures were introduced (Blum et al., 2020; Filipovič Hrast & Rakar, 2017). On the other hand, the care policies for older people started to develop only later and, after initial growth, relatively stagnated (especially the social home care system) (Filipovič Hrast & Rakar, 2021; Hlebec & Rakar, 2017). A comprehensive long-term care system is yet to be implemented and the recently adopted Long-Term Act (2021) is part of ongoing public and political debates.

In line with the presented care regime developments, we can place Slovenia in different care regimes where the childcare regime is characterised as defamilialism through the state (Kanjuo Mrčela & Černigoj Sadar, 2011; Chung et al. 2018), while older people care can be categorised as familialism by default or implicit familialism, in which the support provided by the welfare state is minimal, and families are the main providers of care (also a hallmark of other central and eastern Europe (CEE) countries and southern European countries) (Filipovič Hrast & Rakar, 2021; Filipovič et al., 2020; Hlebec et al., 2016).

Care policy measures during the COVID-19 pandemic

The sudden and unexpected circumstances in the context of the COVID-19 pandemic have seen the introduction of policy measures in the direction of refamilialisation (limited to the period of the pandemic) in care throughout Europe as well

as globally, irrespective of care regime characteristics (see Blum & Dobrotić, 2021; Eurofound, 2020b, 2020d). The measures adopted to prevent COVID-19 infection (closure of childcare facilities and schools, limits on home care services, appeals to return nursing home occupants to their families, social distancing) shifted a large care burden for children and older people onto families (see Eurofound, 2020b, 2020d, 2022). The emphasis was moved to individual responsibility, meaning the burden of care following the restricted roles of other actors like the state and the market was largely transferred to the individuals and their family or informal networks. Meanwhile the widespread adoption of flexible work arrangements may have facilitated the reconciliation of work and family life. Still, on the other side, together with the measures that closed childcare facilities, schools and limited home care services, it may have exposed families to a particularly challenging work-life balance, especially those from the 'sandwich generation'. Hence, in the sections below we discuss the COVID-19 pandemic challenges for work-life balance in Slovenia, also in a comparative perspective by considering other European countries. First, various intervention policies that were introduced are described, followed by a discussion of the implications they hold for work-life balance.

Policy responses in childcare

During the COVID-19 pandemic in Slovenia, initially declared in March 2020, strict measures were introduced to prevent the spread of the virus (C. et al., 2020). Childcare crèches and kindergartens, primary and secondary schools were closed together with universities. Tele-/home working was widely promoted and remote schooling was introduced for all levels of education. In mid-May 2020, schools and other educational institutions gradually and partially started to reopen, beginning with preschool facilities and the first three years of primary school and the secondary school pupils in their last grade so as to prepare for the final examination, followed by other children in primary school, while students at secondary schools and universities continued with remote schooling until the school year ended (P. J. & K. K., 2020).

In the second wave of the pandemic, declared in October 2020, Slovenia applied similar measures with regard to care for children (P. J. et al., 2020). However, unlike in the first wave in which all forms of organised group childcare were prohibited (only for parents who had to go to work ("essential workers") was individual care for children organised by municipalities via volunteers), during the second wave emergency childcare was provided by preschool institutions and primary schools for children in the first three years for parents who could not take care of their children due to work obligations. At the end of January 2021, childcare facilities and schools

started to gradual reopen, similarly as in the first wave, initially preschool institutions and the first three years of primary schools, then other primary school grades, while secondary schools, except for the final grade, only partly reopened in March 2021, with universities only reopening towards the end of the academic year (Ministrstvo za izobraževanje, znanost in šport, 2021). In wave three of the pandemic, preschool institutions and schools were again closed in the lockdown period during the Easter holidays, but were reopened 11 days later (Š. & K., 2021). Still, educational institutions in Slovenia encountered comparatively one of the longest periods of closure (OECD, 2021).

The period of the pandemic has seen working parents need to deal with the challenge of an increased care burden that must be combined with working from home. If a parent could not organise childcare at home (due to the social-distancing measures and existence of groups more at risk from COVID-19 grandparents were advised not to care for their grandchildren), the intervention measures gave such working parents the right to compensation of 80% of their previous salary for the time they were unable to work by having to provide care for their children at home. Alongside this, the most important intervention measures to help working parents and families in Slovenia were the state-funded wage compensation for those temporarily laid off, as well as tax and loan payment deferrals, bonuses for essential workers, co-financing of a temporary waiver on social contribution payments, temporary basic income for the self-employed, and other transfers to families like solidarity supplements for children and new-borns, an increase in the special childcare allowance as well as allowances for large families, students and other vulnerable groups (Eurofound, 2020b; Kresal, 2020).

Similarly, almost all European countries introduced health policy measures to prevent the virus' spread; they closed preschool institutions and schools either fully or in part, offering the minimal provision of care for the children of essential workers. Governments also issued recommendations against or even prohibited care being given by grandparents as a COVID-19 risk group. With a view to easing the pressure on working parents' caring responsibilities, several countries adapted their existing parental or special childcare schemes, wage compensation arrangements and other employment-related benefits, especially sickness benefits (Eurofound, 2020b).

However, the COVID-19 pandemic also reveals substantial differences in countries' pandemic responses as concerns parents' support and care for children (Blum & Dobrotić, 2021; Eurofound, 2020b). As argued by Blum and Dobrotić (2021), the situation with COVID-19 is unique since childcare policy responses traverse existing conceptualisations that classify childcare policies by their care regime, "because they become (primarily) driven by public-health-related goals" not usually in their core focus (Blum & Dobrotić, 2021, p. 3). Their comparative analysis of policy responses

showed that countries chose a certain pandemic prevention strategy that also triggered a response to the initial shock in educational policies. Countries only later started to balance in different ways public health with other concerns more pertinent to their education systems (especially work-family reconciliation, employment, equal educational opportunities (Blum & Dobrotić, 2021)). Thus, responses varied particularly in the re-opening phase – both in terms of being softer or harsher, but also universal or selective. While the mechanisms underlying different childcare policies responses have yet to be discovered, Blum and Dobrotić (2021) conclude that what is important is that are signs that in some countries the pandemic has raised the importance of childcare for the economy and gender equality, placing the work-life balance perspective higher up the political agenda.

Policy responses in care for old people

Older people have generally been one of the most vulnerable groups during the pandemic, with those living in care homes having been one of the worst affected. Measures to protect this vulnerable group in Slovenia, like elsewhere in Europe, have included closing the facilities and limiting visitors and preventing visitations during the worst periods of the pandemic (Lobnik et al. 2021; Zavod Pristan, 2020, 2022), as well as following special protocols for protection and reducing the possibility of transmitting the virus within institutions, and reorganising homes into specific zones in the event of infection (Lobnik et al., 2021[1]). At the start of first wave, when a considerable share of infections was within care homes for older people, some appeals were made to families to again take care of their older family members, thereby taking them out from the institutions. State Secretary at the Ministry of Labour, Family, Social Affairs and Equal Opportunities (Slo. *Ministrstvo za delo, družino, socialne zadeve in enake možnosti*) Mateja Ribič stated that she "welcomed the appeal by Aleš Rozman the director of the hospital Golnik that families take care of their close ones if at all possible. Since the care homes are full, some additional capacities would enable them to prepare spaces for isolation and more efficiently limit the spread of the virus" (S., 2020). Still, as reported in the media in May 2020, the appeal was not followed by many families (Pihlar, 2020).

[1] The report from the Advocate of the principle of equality (Lobnik et al., 2021) lists how the government, the Ministry of Health (Slo. *Ministrstvo za zdravje)*, the Ministry of Labour, Family, Social Affairs and Equal Opportunities, the Human Rights Ombudsman and other stakeholders have prepared and issued several recommendations, information, specific orders and other ways for advising and managing the epidemic conditions in older people care homes.

The biggest problem facing nursing homes was the lack of skilled personnel, space constraints, and absence of a stockpile of personal protection equipment which at the beginning of the pandemic limited their ability to comply with all of the instructions and precautionary measures (see Oven, 2020). In particular, there were space problems as care homes needed to arrange specific zones for COVID-19-positive patients and those with high-risk contact with them[2]. This brought to the surface the existing problems of the often poor spatial conditions at care homes due to the large number of beds, which meant the spatial possibilities were unfavourable for containing the virus' spread if an infection occurred in the care home (as also commented on and criticised by experts in the media; Čeh, 2021). The Community of Social Institutions (Slo. *Skupnost socialnih zavodov*) notes that the pandemic has lifted the cover off the years of neglect and insufficient development of long-term care in Slovenia (Skupnost socialnih zavodov Slovenije, 2020). At the time, the problem of care homes and the conditions of care home residents was intensively discussed in public and parliament (Lobnik et al. 2021).

The situation in Slovenia also reflects experiences abroad where the care home sector was among the most problematic during the pandemic. As Daly (2020) describes for the UK, the response to the risk and reality of COVID-19 in care homes was slow, late and inadequate. Relevant structural factors for this include the institutionalised separation from the health system, the complex system of provision and policy for adult social care, and widespread market dependence. This may be coupled with the fact that logistical difficulties were exacerbated by years of austerity and resource-cutting and the weak regulatory tradition in the care home sector. The smaller number of visits by family members added to the social isolation of older people in care homes, and potentially also made them more vulnerable to neglect and abuse, as suggested by a study based in the USA (Gardner et al., 2020).

When looking at the pandemic and its effect on older people living in the community in Slovenia, their vulnerability was recognised and alongside general protection measures additional measures were introduced to protect them, e.g. reserving a specific time period of the day for them to go shopping.[3] Preventive home health care (Slo. *patronažno vartsvo*) was limited to new-borns, while other home health care services continued according to additional safety measures and protocols. Social home

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2 Further, also problems in financing the increasing care for those placed in 'red zones' due to COVID-19 since the Health Insurance Institute of Slovenia (Slo. *ZZZS*) has not categorised their care as the highest possible rate (Skupnost socialnih zavodov Slovenije, 2021).

3 For stores, the first two opening hours and the final closing hour were for groups particularly vulnerable to infections – *older people*, pregnant women, and *people with disabilities*; others could not shop during these times (Oven, 2020).

care services were also continued under specific directions and protocols.[4] However, problems with staffing affected access to the usual services (due to infections, or other measures taken – e.g. care for children by staff employed in the sector)[5]. The government generally recognised the difficult working conditions by introducing a specific salary supplement for those working in conditions with an increased risk to their health during the pandemic (Act Determining Intervention Measures to Assist in Mitigating the Consequences of the Second Wave of the COVID-19 Epidemic, 2020; STA & R., 2021)[6].

Problems accessing home care services were also encountered abroad (Lorenz-Dant, 2020). In Ireland, for example, over one-third (36%) of respondents had experienced the closure of day-care services, more than one in three (36%) the reduction or cancellation of home care services, and one in four (28%) the closure of respite services (Family carers Ireland, 2020). According to a Eurofound report (Eurofound, 2022), care arrangements have shifted from formal to informal long-term care and seen the tightening of informal care networks within a smaller family network with many informal carers taking on more care work. For instance, research in the UK shows that the clear majority of family carers (79%) indicated they had been unable to take any, or sufficient, breaks during the pandemic (Carers UK, 2020). As reported by Lorenz-Dant (2020), many countries[7] developed virtual support interventions for unpaid carers and the voluntary sector has been relevant for providing support across countries, while many have provided unpaid carers with guidance and resource documents. However, there is limited evidence of new or additional financial support being put in place to support unpaid carers during the COVID-19 pandemic. Family members in Slovenia were still able to provide care by being exempted from the restrictions requiring people to only move within the municipality of their own residence. Overall, the situation has added significantly to the burden on family carers. Slovenia also recognised the

4 Protocols were given by NIJZ (Huber et al., n.d.), also some more extensive protocols were published by the government, Ministry of Labour, Family, Social Affairs and Equal Opportunities (Ministrstvo za delo, družino, socialne zadeve in enake možnosti, 2021).

5 See the consultation organised by MLFSA and municipalities on the topic on 9.11.2020 (Združenje občin Slovenije, 2020).

6 The so-called supplement for working in dangerous conditions and under an additional burden during the pandemic according to the Act Determining Intervention Measures to Assist in Mitigating the Consequences of the Second Wave of the COVID-19 Epidemic (2020) (Slo. Zakona o interventnih ukrepih za pomoč pri omilitvi posledic drugega vala epidemije COVID-19), which was established as a share of salary. In the wake of the pandemic's fourth wave, discussions were underway to change this into a nominal supplement to make the supplements more equal.

7 19 countries were included from all over the world, including Slovenia.

greater financial vulnerability of older people during the pandemic and gave them a one-off solidarity supplement, paid in three different amounts (EUR 300, EUR 230 and EUR 130), depending on one's pension amount, as well as of those registered as family carers (*družinski pomočnik*), who were given a one-off solidarity supplement of EUR 150.[8]

The pandemic has also made it considerably difficult to maintain social relationships and added to the risk of especially already more isolated older people with respect to increased loneliness and isolation. During the pandemic, many countries have arranged various on-line and telephone support services to prevent anxiety, address mental health problems, offer information, and deal with loneliness (see Eurofound, 2022). In Slovenia, COVID SOS telephone lines for older people were established by Slovenian National institute of Public Health (NIJZ) in cooperation with Community Health Centres and several non-governmental organisations (NGOs)[9]. Here, it is important to note that the public service NIJZ was the primary coordinator of this in Slovenia, indicating the important role of the state, not just the NGO sector. Only rarely have countries been proactive, although some governments have systematically contacted older people not currently using their services to assess their needs, described by Eurofound (2022) as a good-practice example.

Despite the more familialised care for older people in Slovenia, family carers have only received limited support and largely been left to their own resources in order to cope with the new challenges of caring for older family members. Namely, in Slovenia, even though some (also financial) support has been received, the main burden is still left on families.

8 Source: articles 57 and 58a in Act Determining Intervention Measures to Assist in Mitigating the Consequences of the Second Wave of the COVID-19 Epidemic (2020).

9 The NGOs were: Društvo psihologov Slovenije, Rdeči križ Slovenije, Slovenska krovna zveza za psihoterapijo, Zaupni telefon Samarijan, Združenje zakonskih in družinskih terapevtov, Zveza prijateljev mladine Slovenija – TOM telefon. The telephone line was intended to offer support for those taken ill or having lost someone due to COVID-19, those experiencing difficulties at work or with working from home, experiencing personal difficulties and isolation. Due to improved epidemic conditions, the line stopped working on 30.6.2021. (NIJZ, 2021).

Implications of the COVID-19 crisis for work-life balance

The COVID-19 global crisis is not simply an economic crisis but a huge health and social crisis as well. It has and will have important consequences with regard to caring responsibilities and work-life balance issues affecting the well-being of families along with gender relations. As shown by research in many countries, the increases in caring responsibilities and household work have significantly affected families and, within them, especially women (Del Boca et al., 2020; Eurofound, 2020a; Queisser et al., 2020). Research from Spain (Farre & Gonzales (2020) in Del Boca, 2020) and the UK (Sevilla & Smith (2020) in Del Boca, 2020) during the pandemic's first wave reveals a shift towards a more balanced distribution of care for children and household work in terms of gender, albeit most of the additional household work and caring responsibilities arising from the COVID-19 crisis has fallen on women. The social-distancing measures have possibly impacted the caring responsibilities previously taken on by grandparents, putting an extra burden on the parents, especially in households where both parents are employed given that the employment of both parents is crucial for family survival in Slovenia (Eurofound, 2015). Yet, on the contrary, research from Eurofound (2022) shows the caring responsibilities of older people 65+ have remained near to the pre-pandemic levels for both (grand)children and older people care, while for older people aged 50-64 it has become more common to care for or educate (grand)children, and to care for elderly or disabled family members. Due to the social distancing, we would expect a decrease in care provision within the elderly population. Possibly, the stability seen in care provision might indicate that social distancing was less relevant in countries where multigenerational households are more common (and provide care for their grandchildren) and that many older people care for their spouses (like in Slovenia). Further, the increase in informal care could be explained as the need to overcome the restrictions placed on formal care provision (Eurofound, 2022). For example, research shows that older people have played key roles in reducing the pandemic's impacts, for instance in multi-generational households (Voľanská et al. (2020) in Eurofound, 2022). What is striking (also reflecting the COVID-19 pandemic measures' considerable familialising effects) is that at the same time there was a significant rise in the caring burden on parents, especially women. Research in Italy reveals that the closure of preschool facilities and schools significantly added to the care burden on parents, particularly mothers, and is not sustainable in the long term (Del Boca et al., 2020). Working from home also holds important consequences for the gender gap in care. On one hand, the flexibility of working from home makes work-life balance easier for both men and

women to achieve and, on the other, working from home might chiefly become "female choice": men are returning to the workplace in large numbers, while women continue to work from home and simultaneously assume all the family responsibilities. Moreover, research shows there was a marked increase in the frequency of providing personal care to frail old parents, having increased in almost all European countries (Eurofound, 2022), where informal carers are principally women. In addition, parental caregivers who increased the frequency of providing personal care reported having considerably more mental health problems (Bergmann & Wagner, 2021).

Work-life balance during the COVID-19 pandemic in Slovenia

Data for this part of the chapter originally come from a survey conducted by the CWS (Centre for Welfare Studies, Faculty of Social Sciences, University of Ljubljana) in multi-apartment buildings in Ljubljana. Since the study is presented in detail in Chapter 2, here we only outline the main characteristics. Data were collected between 5 May 2020 and 14 May 2020 using a self-administered web data collection mode. Invitations to participate were distributed to potential respondents using web platforms of the Faculty of Social Sciences at the University of Ljubljana, of the Municipality of Ljubljana, by an invitation sent to the Association of Real-Estate Owners, the Association of Tenants, and by personal invitations using the snowball sampling principle. Altogether, there were 826 initial contacts on the invitation page, among which 310 completed the survey (a response rate of 37%). The non-probabilistic characteristics of the sampling and recruitment strategies means the realised sample is biased in terms of demographic characteristics. Namely, 80% of the respondents had an education exceeding the medium secondary level; age averaged out at 41.9 years, 80% of the sample was female, and 70% were employed or self-employed. The sample is quite specific, featuring the outstanding presence of female, younger, employed and higher educated persons.

Results

Characteristics of the sample with regard to the topic analysed in the chapter are presented in Table 1.

Table 1

Frequency table for variables

Variables	Values	*f*	Valid %
Type of household	I live alone	51	19.17
	I live with my partner	88	33.08
	I live with my partner and children	95	35.71
	I live alone with my children	32	12.03
	Total	266	100.00
Employment status before the COVID-19 epidemic	Employed (private sector)	78	25.66
	Employed (public sector)	115	37.83
	Self-employed	20	6.58
	Unemployed	15	4.93
	Retired	32	10.53
	Student, high school student	27	8.88
	Other	17	5.59
	Total	304	100.00
Work activity during the COVID-19 epidemic*	Work on location	39	17.33
	Work remotely	146	64.89
	Caring for children + childcare allowance	9	4.00
	On hold + receiving compensation	29	12.89
	Unemployed	7	3.11
	Other	27	12.00
	Total	304	100

Notes. *answered only by participants who were employed or self-employed before the pandemic; source: authors' analysis based on original data.

With respect to the pandemic and lockdown policy, the majority of respondents was working remotely, with 17% still attending the workplace. Some were also caring for children or had been furloughed. While we are interested in the last two categories, the results should be interpreted with caution owing to the small sample sizes. Average hours spent on various activities before and during the pandemic lockdown are presented in Table 2 with regard to a respondent's type of household. Only mean values are presented in the tables since the full analytical report may be found in the Appendix 1.

Table 2

Average hours spent per day on a work-related activity by type of household

	Type of household			
Hours/day spent on a work-related activity	I live alone	I live with my partner	I live with my partner and children	I live alone with my children
While the measures against COVID-19 were still valid				
Job/paid work	5.59	6.15	6.01	4.88
Housekeeping	2.36	2.60	2.94	3.61
Care/activities for children	.40	.20	7.42	4.77
Care and nursing of an older frail family member	.69	.25	.37	.10
Sleep and rest	8.13	8.33	7.09	7.44
In normal circumstances before COVID-19				
Job/paid work	7.12	7.89	7.32	7.62
Housekeeping	1.94	2.00	2.23	2.69
Care/activities for children	.34	.35	5.13	3.62
Care and nursing of an older frail family member	.54	.35	.17	.38
Sleep and rest	7.72	7.86	7.24	7.26

Note. Source: authors' analysis based on original data.

The averages shown in Table 2 suggest that while respondents report spending fewer hours working this might be due to not having to commute or spend 30 minutes on a work break. All groups report having spent increasing hours on housekeeping while respondents with children report a substantial rise in average hours spent caring for children where it is interesting that people living with partners report a bigger increase (2.3) than single parents (an increase of 1.2). The two groups without children report spending more time on sleep and rest whereas parents report having slept less and single parents a little more sleep. Table 3 shows hours spent on these activities when looking at different employment categories.

Table 3

Average hours spent per day on a work-related activity by work activity during the COVID-19 epidemic

	Work activity during the COVID-19 epidemic					
Hours/day spent on a work-related activity	Work at workplace	Work remotely from home	Caring for children + childcare allowance	On furlough + receiving compensation	Unemployed	Other
While the measures against COVID-19 were still valid						
Job/paid work	8.57	7.75	3.75	2.74	.43	3.61
Housekeeping	2.54	2.41	3.67	2.91	3.57	2.85
Care/activities for children	3.10	3.00	8.11	4.17	3.00	4.78
Care and nursing of an older frail family member	.34	.23	.00	.70	.43	.05
Sleep and rest	7.31	7.94	7.22	7.52	8.43	8.57
In normal circumstances before COVID-19						
Job/paid work	8.60	8.56	7.78	8.00	7.29	7.13
Housekeeping	2.26	1.85	2.67	1.88	2.00	2.20
Care/activities for children	2.67	1.98	5.44	3.23	2.14	3.35
Care and nursing of an older frail family member	.41	.16	.00	.50	.43	.05
Sleep and rest	7.43	7.76	6.72	7.13	7.57	7.48

Notes. *Referring to those at home caring for children and receiving childcare allowance as compensation; ** referring to those at home due to a COVID-19-related temporary layoff and receiving layoff compensation; source: authors' analysis based on original data.

While respondents who were working on location reported spending 8.6 hours on work, the distribution of hours spent on activities closely resembles the distribution of those who were working remotely. Interestingly, parents receiving childcare allowance on average spent more than 8 hours on childcare, but also spent nearly 4

hours on work and as much again on housekeeping. This category reports the least hours for sleep and rest. Unemployed and the other category (which includes the retired) spent a similar amount of time on activities, except of course for work. Table 4 presents average hours spent on the same activities grouped by sector of work.

Table 4

Average hours spent per day on a work-related activity by employment status before the COVID-19 epidemic

	Employment status before the COVID-19 epidemic						
Hours/day spent on a work-related activity	Employed (private sector)	Employed (public sector)	Self-employed	Un-employed	Retired	Student*	Other
While the measures against COVID-19 were still valid							
Job/paid work	6.11	7.39	4.78	.31	.45	2.65	4.89
Housekeeping	2.79	2.56	2.48	3.21	3.47	2.22	3.10
Care/activities for children	4.02	3.35	2.39	6.50	.80	.00	2.71
Care and nursing of an older frail family member	.32	.31	.20	.69	1.06	.00	.71
Sleep and rest	7.49	7.70	8.60	6.93	7.86	8.42	9.60
In normal circumstances before COVID-19							
Job/paid work	8.53	8.26	7.60	1.23	1.31	5.54	8.00
Housekeeping	1.89	2.02	2.15	3.07	2.86	1.53	2.00
Care/activities for children	2.83	2.38	2.00	4.71	1.53	.04	1.57
Care and nursing of an older frail family member	.18	.27	.21	.83	1.31	.00	.50
Sleep and rest	7.34	7.65	7.70	7.00	7.89	7.42	7.10

Notes. * Student at a high school or subsequently in education; source: authors' analysis based on original data.

All categories spent more time working before the COVID-19 lockdown, with the differences being up to 2 hours in the private sector, while among the self-employed and students an average difference of 3 hours. All categories spent more time housekeeping during the pandemic lockdown, and also on childcare (except for the retired and students). The time spent caring for older frail family members has not changed dramatically. Table 5 (see Appendix 1) shows Pearson correlation coefficients between hours spent on various activities and household size. It is no surprise that as household size increases hours spent on childcare also increase prominently, while the time for sleep decreases.

In sum, the presented small-scale explorative survey among multi-apartment buildings in Ljubljana showed that in the first wave of the COVID-19 pandemic in the spring of 2020 the burden on families grew, particularly as concerns care for children.

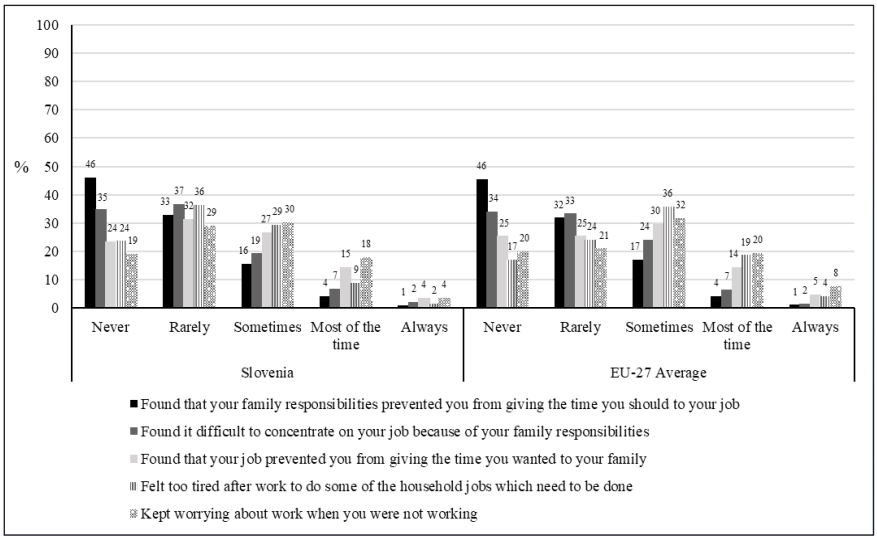
Work-life balance during COVID-19 in Slovenia in a comparative perspective

The Eurofound survey Living, working and COVID-19 (Eurofound, 2020c, 2020d) provides data for work-life balance issues in the EU-27 and thereby offers a comparative insight into the situation in Slovenia with respect to other EU countries. The survey includes a set of questions measuring work-life balance specifically designed to cover strain and time based demands leading to conflict. The questions reflect conflict stemming from the workplace that affects the non-work domain as well as questions addressing conflict arising in the home that affect work (Eurofound, 2020c). The survey shows that work from home during the pandemic blurred the boundaries between work and family and that work consumed family time, for example 27% of those who were working from home answered that they had worked in their free time to meet the work demands. The research also shows the greatest burden was placed on working parents with small children, where 22% of parents who were working from home with children under 12 years answered they had found it difficult to concentrate on the job because of family responsibilities. Among those with older children, only 7% had difficulties concentrating on the job, while among those without children 5% had these difficulties. The research also shows that women had the heaviest burden of care and household work, which prevented them from giving the time they should have for their job and led to difficulties in concentrating on their job (Eurofound, 2020a, 2020c).

When considering the implications held by the COVID-19 pandemic for work-life balance, Slovenia is comparatively near the EU-27 average as regards the question of experiencing difficulties concentrating on one's job due to family responsibilities given that 6.8% of respondents in Slovenia found it difficult most of the time to concentrate on their job because of family responsibilities (the EU-27 average is 7%), while 2.1% always found this to be the case (EU-27 average is 1.9%) (see Figure 1).

Figure 1

Work–life balance during the COVID-19 pandemic in both Slovenia and the EU-27 (period April-May 2020)



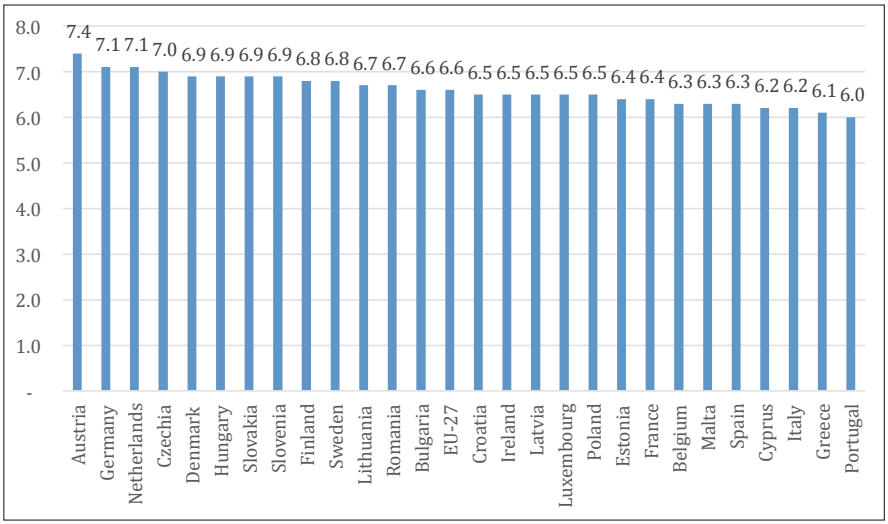
Note. Source: Living, working and COVID-19 dataset (Eurofound, 2020c).

However, Slovenians are above the EU-27 average with respect to working in free time to meet work demands; in Slovenia, 12% had worked in their free time to meet work demands everyday (the EU-27 average is 9.7%) and 9.1% every other day (EU-27 average of 7.7%) (Eurofound, 2020d). Still, in a summary indicator – the overall work-life balance score (see Figure 2) – Slovenia does well as regards the work-life balance conflict with its score of 6.9 for work-life balance exceeding the EU-27 average of 6.6, similarly to the Scandinavian countries (Denmark 6.9, Finland 6.8, Sweden 6.8) as well as some post-socialist countries like Hungary 6.9, Slovakia 6.9 and Czechia 7.0. The highest level of work-life balance was expressed by

respondents in Austria (7.4), Germany (7.1) and the Netherlands (7.1). Work-life balance received the lowest score in countries that were also the hardest hit by the COVID-19 pandemic in the first wave, such as Italy (6.2), Spain (6.3) and Portugal (6.0) (Eurofound, 2020d).

Figure 2

Summary indicator of work-life balance in EU countries (period: April-May 2020)



Note. Source: Eurofound report Living, working and COVID-19 (Eurofound, 2020d, p. 66).

A comparative view of the work-life balance data shows (see the tables given in the Appendix 2) that Slovenia is similar to the Scandinavian countries, being the most defamilialised, as well as to certain post-socialist countries with a more familialised regime. In general, the data reveal that the biggest difficulties in work-life balance were experienced by respondents in the southern European familialist regimes and which were also the countries hardest hit by the COVID-19 pandemic during the first wave like Italy, Spain and Portugal, all ranking below the EU average. Above the EU average (besides Slovenia) were countries such as Germany, Austria, the Netherlands and the Scandinavian countries (Denmark and Finland) and, as expected, Sweden, which applied the least restrictive approach in terms of COVID-19 pandemic measures. In other countries, the smaller burden on the work-life balance of families can on one side be linked to better access to different social

and family policies as well as some measures to prevent the COVID-19 pandemic from spilling over onto the work-life balance. In general, the data show that countries with the biggest share of workers in part-time employment amongst the vast majority are women (such as the Netherlands, Germany, Austria as well as all the Scandinavian countries) (Eurostat, 2021), ranked highest in the score for work-life balance during the COVID-19 pandemic. Interestingly, certain post-socialist countries characterised with a more familialist regime and low levels of especially mothers' employment (Eurofound, 2014) had a comparatively similar score to the more de familialised care regimes. Finally, with one of the highest shares of women in full-time employment (Eurostat, 2021) and one of the highest shares of mothers working full-time (Eurofound, 2014) Slovenia had a comparatively similar work-life balance score. All of this points to the conclusion from the research into policy responses in the EU countries conducted by Blum and Dobrotić (2021) that the situation with COVID-19 is unique since care policy responses traverse the existing conceptualisations of classifying policies according to their care regime.

Conclusion

Our findings show that the diverging trends observed in care policies for children and older people in Slovenia are also evident in the recent development of COVID-19 policy responses. These indicate policymakers' increased attention to the issue of childcare, thereby enabling parents to care for their children at home – also through the compensation for salaries, while little attention was devoted to the problem of care for older people where family carers were likewise affected by the reduced availability of social home care services. In its COVID-19 package of measures, Slovenia introduced compensation of 80% of the salary of parents who had to stay at home to care for their children, while for parents who had to go to work (essential workers) care for children was organised by municipalities via volunteers, and families with three or more children received an increase in child benefits. For the older people care, despite the serious limitations on social and home care services, no such additional measures in terms of services or financial benefits were put in place. The only additional measure was the one-off solidarity supplement for pensioners on the lowest pensions and the one-off solidarity supplement for registered family carers.

These trends in Slovenia seem to be in line with developments in Europe generally. The Eurofound analysis of policy responses showed that most European countries had introduced several measures to help families with children, with special emphasis on the reconciliation of work and family life (e.g. compensation for salaries

for taking care of children as a consequence of the closure of schools and pre-school facilities, vouchers for babysitting, an increase in child benefits, parental leave etc.) (Eurofound, 2020a), which may be labelled supported familialism in a period of special circumstances. Yet, in contrast, despite the limits on home and social care services for older people during the COVID-19 pandemic, most European welfare states did not introduce any additional services or benefits to support families in caring for older people.

Moreover, no policies were directed at gender equality issues, which were exacerbated during the COVID-19 lockdown as women took on most of the caring responsibilities (Eurofound, 2020b). This has left families with a particularly challenging work-life balance, especially those belonging to the 'sandwich generation', which is above all problematic in rapidly ageing societies like Slovenia. A model of defamilialised policies in existing approaches to the recognition of caring for children should also be applied to older people care. For example, part-time work and other flexibilities commonly found in Europe are still lacking relative to care for older people, particularly in CEE countries. Different leave policies or subsidised part-time working arrangements should apply to all dependent family members or, on the company level, a certificate of a family-friendly company that takes work and care reconciliation issues into consideration also with regard to older people care, require a better definition in the legislation to avoid the issue simply becoming a matter of employers' goodwill. In the future, such approaches would gradually help narrow the gap between the divergent trends in care for children and those for older people and move closer to a (de)gendered future for the Slovenian care regime.

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Appendix 1

Table 5

Hours spent per day on a work-related activity by type of household

	I live alone			I live with my partner			I live with my partner and children			I live alone with my children		
	M	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*
While the measures against COVID-19 were still valid												
Job/paid work	5.59	41	3.84	6.15	72	3.47	6.01	85	3.73	4.88	25	4.00
Housekeeping	2.36	49	1.21	2.60	83	1.34	2.94	85	1.32	3.61	27	1.99
Care/activities for children	.40	40	.90	.20	66	1.03	7.42	84	6.23	4.77	26	4.45
Care and nursing of an elderly family member	.69	39	1.59	.25	67	.70	.37	78	1.18	.10	22	.29
Sleep and rest	8.13	47	1.79	8.33	82	1.89	7.09	86	1.52	7.44	27	1.50
In normal circumstances before COVID-19												
Job/paid work	7.12	42	3.21	7.89	75	2.74	7.32	85	2.84	7.62	26	2.87
Housekeeping	1.94	49	1.09	2.00	81	1.14	2.23	85	.95	2.69	27	1.59
Care/activities for children	.34	38	.81	.35	66	1.05	5.13	84	4.62	3.62	26	3.41
Care and nursing of an elderly family member	.54	39	1.43	.35	65	1.11	.17	69	.42	.38	19	1.16
Sleep and rest	7.72	47	1.68	7.86	81	1.84	7.24	85	1.51	7.26	27	1.29

Note. Source: authors' analysis based on original data.

Table 6

Hours spent per day on a work-related activity by work activity during the COVID-19 epidemic

	Work activity during the COVID-19 epidemic																	
Hours/day spent on a work-related activity	Work on location			Work remotely			Caring for children + childcare allowance			Furloughed + receiving compensation			Unemployed			Other		
	M	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*
While the measures against COVID-19 were still valid																		
Job/paid work	8.57	35	1.61	7.75	138	1.93	3.75	8	3.73	2.74	25	3.18	.43	7	1.13	3.61	23	3.49
	(6.14)	(171)	(3.46)	(4.13)	(68)	(4.21)	(6.67)	(198)	(3.29)	(7.08)	(181)	(3.02)	(6.77)	(199)	(3.19)	(6.92)	(183)	(3.15)
Housekeeping	2.54	34	1.29	2.41	138	1.30	3.67	9	1.50	2.91	27	1.19	3.57	7	1.27	2.85	23	1.44
	(2.67)	(174)	(1.38)	(3.11)	(70)	(1.38)	(2.60)	(199)	(1.34)	(2.61)	(181)	(1.39)	(2.62)	(201)	(1.36)	(2.62)	(185)	(1.36)
Care/activities for children	3.10	29	4.83	3.00	126	5.02	8.11	9	4.04	4.17	23	4.74	3.00	7	4.93	4.78	23	4.31
	(3.59	(162)	(5.20)	(4.52)	(65)	(5.24)	(3.29)	(182)	(5.08)	(3.43)	(168)	(5.19)	(3.54)	(184)	(5.15)	(3.34)	(168)	(5.22)
Care and nursing of an elderly family member	.34	29	.55	.23	120	.66	.00	7	.00	.70	23	1.96	.43	7	1.13	.05	22	.21
	(.29)	(154)	(.99)	(.44)	(63)	(1.29)	(.31)	(176)	(.95)	(.25)	(160)	(.66)	(.30)	(176)	(.93)	(.34)	(161)	(.99)
Sleep and rest	7.31	35	1.66	7.94	137	1.92	7.22	9	.97	7.52	27	1.42	8.43	7	1.99	8.57	23	2.84
	(7.90)	173)	2.0)1	7.54)	(71)	(2.03)	(7.83)	(199)	(2.00)	(7.85)	(181)	(2.03)	(7.78)	(201)	(1.97)	(7.71)	(185)	(1.82)

In normal circumstances before COVID-19																			
Job/paid work	8.60	35	.98	8.56	138	1.49	7.78	9	1.56	8.00	27	2.24	7.29	7	1.80	7.13	23	4.12
	(8.21)	(174)	(2.19)	(7.72)	(71)	(2.75)	(8.30)	(200)	(2.06)	(8.32)	(182)	(2.02)	(8.31)	(202)	(2.05)	(8.42)	(186)	(1.58)
Housekeeping	2.26	35	1.01	1.85	137	.85	2.67	9	2.12	1.88	26	.99	2.00	7	1.00	2.20	23	.96
	(1.94)	(172)	(1.00)	(2.27)	(70)	(1.20)	(1.96)	(198)	(.92)	(2.01)	(181)	(1.01)	(1.99)	(200)	(1.01)	(1.96)	(184)	(1.01)
Care/activities for children	2.67	30	4.50	1.98	124	3.25	5.44	9	2.13	3.23	22	3.42	2.14	7	4.41	3.35	23	3.21
	(2.46)	(159)	(3.51)	(3.46)	(65)	(4.24)	(2.34)	(180)	(3.68)	(2.40)	(167)	(3.71)	(2.51)	(182)	(3.66)	(2.37)	(166)	(3.73)
Care and nursing of an elderly family member	.41	27	.84	.16	113	.41	.00	5	.00	.50	20	1.28	.43	7	1.13	.05	21	.22
	(.21)	(142)	(.65)	(.41)	(56)	(1.02)	(.25)	(164)	(.69)	(.21)	(149)	(.56)	(.24)	(162)	(.66)	(.27)	(148)	(.72)
Sleep and rest	7.43	35	1.65	7.76	137	1.78	6.72	9	.91	7.13	26	1.28	7.57	7	2.30	7.48	23	1.56
	(7.55)	(172)	(1.69)	(7.09)	(70)	(1.38)	(7.57)	(198)	(1.70)	(7.59)	(181)	(1.73)	(7.53)	(200)	(1.66)	(7.54)	(184)	(1.70)

Notes. Statistics without brackets include participants who chose a particular work activity, statistics in brackets include participants who did not choose a particular work activity; source: authors' analysis based on original data.

Table 7

Hours spent per day on a work-related activity by work activity during the COVID-19 epidemic

	Work activity during the COVID-19 epidemic																	
Hours/day spent on a work-related activity	Work on location			Work remotely			Caring for children + childcare allowance			On hold + receiving compensation			Unemployed			Other		
	M	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*
While the measures against COVID-19 were still vaild																		
Job/paid work	8.57 (6.14)	35 (171)	1.61 (3.46)	7.75 (4.13)	138 (68)	1.93 (4.21)	3.75 (6.67)	8 (198)	3.73 (3.29)	2.74 (7.08)	25 (181)	3.18 (3.02)	.43 (6.77)	7 (199)	1.13 (3.19)	3.61 (6.92)	23 (183)	3.49 (3.15)
Housekeeping	2.54 (2.67)	34 (174)	1.29 (1.38)	2.41 (3.11)	138 (70)	1.30 (1.38)	3.67 (2.60)	9 (199)	1.50 (1.34)	2.91 (2.61)	27 (181)	1.19 (1.39)	3.57 (2.62)	7 (201)	1.27 (1.36)	2.85 (2.62)	23 (185)	1.44 (1.36)
Care/activities for children	3.10 (3.59	29 (162)	4.83 (5.20)	3.00 (4.52)	126 (65)	5.02 (5.24)	8.11 (3.29)	9 (182)	4.04 (5.08)	4.17 (3.43)	23 (168)	4.74 (5.19)	3.00 (3.54)	7 (184)	4.93 (5.15)	4.78 (3.34)	23 (168)	4.31 (5.22)
Care and nursing of an elderly family member	.34 (.29)	29 (154)	.55 (.99)	.23 (.44)	120 (63)	.66 (1.29)	.00 (.31)	7 (176)	.00 (.95)	.70 (.25)	23 (160)	1.96 (.66)	.43 (.30)	7 (176)	1.13 (.93)	.05 (.34)	22 (161)	.21 (.99)
Sleep and rest	7.31 (7.90)	35 173)	1.66 2.0)1	7.94 7.54)	137 (71)	1.92 (2.03)	7.22 (7.83)	9 (199)	.97 (2.00)	7.52 (7.85)	27 (181)	1.42 (2.03)	8.43 (7.78)	7 (201)	1.99 (1.97)	8.57 (7.71)	23 (185)	2.84 (1.82)

In normal circumstances before COVID-19																			
Job/paid work	8.60	35	.98	8.56	138	1.49	7.78	9	1.56	8.00	27	2.24	7.29	7	1.80	7.13	23	4.12
	(8.21)	(174)	(2.19)	(7.72)	(71)	(2.75)	(8.30)	(200)	(2.06)	(8.32)	(182)	(2.02)	(8.31)	(202)	(2.05)	(8.42)	(186)	(1.58)
Housekeeping	2.26	35	1.01	1.85	137	.85	2.67	9	2.12	1.88	26	.99	2.00	7	1.00	2.20	23	.96
	(1.94)	(172)	(1.00)	(2.27)	(70)	(1.20)	(1.96)	(198)	(.92)	(2.01)	(181)	(1.01)	(1.99)	(200)	(1.01)	(1.96)	(184)	(1.01)
Care/activities for children	2.67	30	4.50	1.98	124	3.25	5.44	9	2.13	3.23	22	3.42	2.14	7	4.41	3.35	23	3.21
	(2.46)	(159)	(3.51)	(3.46)	(65)	(4.24)	(2.34)	(180)	(3.68)	(2.40)	(167)	(3.71)	(2.51)	(182)	(3.66)	(2.37)	(166)	(3.73)
Care and nursing of an elderly family member	.41	27	.84	.16	113	.41	.00	5	.00	.50	20	1.28	.43	7	1.13	.05	21	.22
	(.21)	(142)	(.65)	(.41)	(56)	(1.02)	(.25)	(164)	(.69)	(.21)	(149)	(.56)	(.24)	(162)	(.66)	(.27)	(148)	(.72)
Sleep and rest	7.43	35	1.65	7.76	137	1.78	6.72	9	.91	7.13	26	1.28	7.57	7	2.30	7.48	23	1.56
	(7.55)	(172)	(1.69)	(7.09)	(70)	(1.38)	(7.57)	(198)	(1.70)	(7.59)	(181)	(1.73)	(7.53)	(200)	(1.66)	(7.54)	(184)	(1.70)

*Notes. S*tatistics without brackets include participants who chose a particular work activity, statistics in brackets include participants who did not choose a particular work activity; source: authors' analysis based on original data.

Table 8

Hours spent per day on a work-related activity separated by whether participants were working on location or not during the COVID-19 epidemic

Hours/day spent on a work-related activity	Work on location			Don't work on location		
	M	*N*	*SD*	*M*	*N*	*SD*
While the measures against COVID-19 were still valid						
Job/paid work	8.57	35	1.61	6.14	171	3.46
Housekeeping	2.54	34	1.29	2.67	174	1.38
Care/activities for children	3.10	29	4.83	3.59	162	5.20
Care and nursing of an elderly family member	.34	29	.55	.29	154	.99
Sleep and rest	7.31	35	1.66	7.90	173	2.01
In normal circumstances before COVID-19						
Job/paid work	8.60	35	.98	8.21	174	2.19
Housekeeping	2.26	35	1.01	1.94	172	1.00
Care/activities for children	2.67	30	4.50	2.46	159	3.51
Care and nursing of an elderly family member	.41	27	.84	.21	142	.65
Sleep and rest	7.43	35	1.65	7.55	172	1.69

Note. Source: authors' analysis based on original data.

Table 9

Hours spent per day on a work-related activity separated by whether participants were working remotely or not during the COVID-19 epidemic

Hours/day spent on a work-related activity	**Working remotely**			**Not working remotely**		
	M	*N*	*SD*	*M*	*N*	*SD*
While the measures against COVID-19 were still valid						
Job/paid work	7.75	138	1.93	4.13	68	4.21
Housekeeping	2.41	138	1.30	3.11	70	1.38
Care/activities for children	3.00	126	5.02	4.52	65	5.24
Care and nursing of an elderly family member	.23	120	.66	.44	63	1.29
Sleep and rest	7.94	137	1.92	7.54	71	2.03
In normal circumstances before COVID-19						
Job/paid work	8.56	138	1.49	7.72	71	2.75
Housekeeping	1.85	137	.85	2.27	70	1.20
Care/activities for children	1.98	124	3.25	3.46	65	4.24
Care and nursing of an elderly family member	.16	113	.41	.41	56	1.02
Sleep and rest	7.76	137	1.78	7.09	70	1.38

Note. Source: authors' analysis based on original data.

Table 10

Hours spent per day on a work-related activity separated by whether participants were working remotely or not during the COVID-19 epidemic

Hours/day spent on a work-related activity	**Caring for children + childcare allowance**			**Not caring for children + childcare allowance**		
	M	*N*	*SD*	*M*	*N*	*SD*
While the measures against COVID-19 were still valid						
Job/paid work	3.75	8	3.73	6.67	198	3.29
Housekeeping	3.67	9	1.50	2.60	199	1.34
Care/activities for children	8.11	9	4.04	3.29	182	5.08
Care and nursing of an elderly family member	.00	7	.00	.31	176	.95
Sleep and rest	7.22	9	.97	7.83	199	2.00
In normal circumstances before COVID-19						
Job/paid work	7.78	9	1.56	8.30	200	2.06
Housekeeping	2.67	9	2.12	1.96	198	.92
Care/activities for children	5.44	9	2.13	2.34	180	3.68
Care and nursing of an elderly family member	.00	5	.00	.25	164	.69
Sleep and rest	6.72	9	.91	7.57	198	1.70

Note. Source: authors' analysis based on original data.

Table 11

Hours spent per day on a work-related activity separated by whether participants were on furlough or not during the COVID-19 epidemic

Hours/day spent on a work-related activity	**Furloughed + receiving compensation**			**Not furloughed + receiving compensation**		
	M	*N*	*SD*	*M*	*N*	*SD*
While the measures against COVID-19 were still valid						
Job/paid work	2.74	25	3.18	7.08	181	3.02
Housekeeping	2.91	27	1.19	2.61	181	1.39
Care/activities for children	4.17	23	4.74	3.43	168	5.19
Care and nursing of an elderly family member	.70	23	1.96	.25	160	.66
Sleep and rest	7.52	27	1.42	7.85	181	2.03
In normal circumstances before COVID-19						
Job/paid work	8.00	27	2.24	8.32	182	2.02
Housekeeping	1.88	26	.99	2.01	181	1.01
Care/activities for children	3.23	22	3.42	2.40	167	3.71
Care and nursing of an elderly family member	.50	20	1.28	.21	149	.56
Sleep and rest	7.13	26	1.28	7.59	181	1.73

Note. Source: authors' analysis based on original data.

Table 12

Hours spent per day on a work-related activity separated by whether participants were unemployed or not during the COVID-19 epidemic

Hours/day spent on a work-related activity	**Unemployed**			**Not unemployed**		
	M	*N*	*SD*	*M*	*N*	*SD*
While the measures against COVID-19 were still valid						
Job/paid work	.43	7	1.13	6.77	199	3.19
Housekeeping	3.57	7	1.27	2.62	201	1.36
Care/activities for children	3.00	7	4.93	3.54	184	5.15
Care and nursing of an elderly family member	.43	7	1.13	.30	176	.93
Sleep and rest	8.43	7	1.99	7.78	201	1.97
In normal circumstances before COVID-19						
Job/paid work	7.29	7	1.80	8.31	202	2.05
Housekeeping	2.00	7	1.00	1.99	200	1.01
Care/activities for children	2.14	7	4.41	2.51	182	3.66
Care and nursing of an elderly family member	.43	7	1.13	.24	162	.66
Sleep and rest	7.57	7	2.30	7.53	200	1.66

Note. Source: authors' analysis based on original data.

Table 13

Hours spent per day on a work-related activity separated by whether participants had chosen other work activity during the COVID-19 epidemic or not

Hours/day spent on a work-related activity	**Other**				**Not other**		
	M	*N*	*SD*		*M*	*N*	*SD*
While the measures against COVID-19 were still valid							
Job/paid work	3.61	23	3.49		6.92	183	3.15
Housekeeping	2.85	23	1.44		2.62	185	1.36
Care/activities for children	4.78	23	4.31		3.34	168	5.22
Care and nursing of an elderly family member	.05	22	.21		.34	161	.99
Sleep and rest	8.57	23	2.84		7.71	185	1.82
In normal circumstances before COVID-19							
Job/paid work	7.13	23	4.12		8.42	186	1.58
Housekeeping	2.20	23	.96		1.96	184	1.01
Care/activities for children	3.35	23	3.21		2.37	166	3.73
Care and nursing of an elderly family member	.05	21	.22		.27	148	.72
Sleep and rest	7.48	23	1.56		7.54	184	1.70

Note. Source: authors' analysis based on original data.

Table 14

Hours spent per day on a work-related activity by employment status before the COVID-19 epidemic

	Employment status before the COVID-19 epidemic																				
Hours/day spent on a work-related activity	Employed (private sector)			Employed (public sector)			Self-employed			Unemployed			Retired			Student*			Other		
	M	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*	*M*	*N*	*SD*
While the measures against COVID-19 were still valid																					
Job/paid work	6.11	73	3.73	7.39	108	2.77	4.78	20	3.33	.31	13	1.11	.45	11	1.04	2.65	26	3.60	4.89	9	3.52
Housekeeping	2.79	74	1.74	2.56	108	1.10	2.48	20	.99	3.21	14	1.12	3.47	30	1.70	2.22	26	1.32	3.10	10	1.29
Care/activities for children	4.02	70	5.59	3.35	100	5.02	2.39	18	3.60	6.50	14	9.02	.80	15	1.21	.00	26	.00	2.71	7	4.35
Care and nursing of an elderly family member	.32	65	1.21	.31	99	.75	.20	16	.75	.69	13	2.21	1.06	16	1.48	.00	26	.00	.71	7	1.50
Sleep and rest	7.49	74	1.45	7.70	108	1.91	8.60	20	1.73	6.93	14	1.98	7.86	28	1.43	8.42	26	1.42	9.60	10	4.09
In normal circumstances before COVID-19																					
Job/paid work	8.53	74	1.78	8.26	109	1.99	7.60	20	1.98	1.23	13	2.49	1.31	13	2.59	5.54	26	3.56	8.00	10	3.68
Housekeeping	1.89	74	.83	2.02	107	1.08	2.15	20	1.18	3.07	14	1.33	2.86	29	1.46	1.53	26	.86	2.00	10	.94
Care/activities for children	2.83	70	4.45	2.38	98	3.17	2.00	18	3.27	4.71	14	6.83	1.53	15	1.88	.04	26	.20	1.57	7	1.81
Care and nursing of an elderly family member	.18	60	.50	.27	91	.76	.21	16	.75	.83	12	2.29	1.31	16	1.96	.00	26	.00	.50	6	.84
Sleep and rest	7.34	74	1.60	7.65	107	1.74	7.70	20	1.63	7.00	14	1.71	7.89	27	1.31	7.42	26	1.39	7.10	10	1.52

Notes. *Student at a high school or subsequently in education; source: authors' analysis based on original data.

Appendix 2

Table 15

"Found that your family responsibilities prevented you from giving the time you should to your job" (%)

Country	Never	Rarely	Sometimes	Most of the time	Always
Austria	57.8	23.4	13.2	4.9	.8
Belgium	41.8	32.8	17.7	5.3	2.3
Bulgaria	50.3	31.3	13.2	3.4	1.8
Croatia	43.2	33.8	18.9	3.3	.8
Cyprus*	40.1	38.4	16.7	3.5	1.3
Czechia	51.8	26.7	16.4	3.5	1.7
Denmark	48.2	32.8	14.6	4.4	.0
Estonia	39.4	30.8	22.7	6.1	.9
Finland	44.3	36.0	13.5	5.8	.4
France	46.6	24.6	21.1	6.8	1.0
Germany	52.5	26.0	15.1	4.6	1.7
Greece	41.3	35.7	19.6	2.6	.8
Hungary	55.9	26.4	13.5	3.5	.7
Ireland	40.9	34.9	19.2	4.2	.9
Italy	40.8	34.6	19.4	3.9	1.3
Latvia*	38.4	37.4	16.0	5.6	2.6
Lithuania	52.5	26.5	16.1	4.4	.5
Luxembourg	41.4	32.8	16.8	7.5	1.5
Malta*	36.7	42.3	17.6	2.9	.5
Netherlands*	48.5	25.2	19.2	5.0	2.1
Poland	42.3	36.5	16.5	3.8	.9
Portugal	32.9	34.4	25.2	5.7	1.8
Romania	46.9	33.6	15.2	2.2	2.1
Slovakia	64.4	21.6	10.2	2.9	.8
Slovenia	**46.1**	**33.0**	**15.7**	**4.2**	**1.0**
Spain	39.0	35.7	21.2	2.9	1.2
Sweden*	45.3	33.5	18.4	1.7	1.1
EU-27 Average	45.5	31.9	17.1	4.2	1.2

Notes. * = low reliability; source: Eurofound (2020c).

Table 16

"Found it difficult to concentrate on your job because of your family responsibilities" (%)

Country	Never	Rarely	Sometimes	Most of the time	Always
Austria	42.0	30.7	20.6	5.5	1.3
Belgium	29.8	31.0	26.0	10.7	2.6
Bulgaria	37.4	36.4	19.9	5.1	1.2
Croatia	31.2	34.4	26.4	6.0	2.0
Cyprus*	29.9	40.9	21.7	6.5	1.0
Czechia	38.3	33.5	20.9	5.0	2.3
Denmark	35.8	39.6	19.6	4.6	.4
Estonia	35.1	30.7	23.5	10.0	.8
Finland	32.7	38.5	20.6	7.4	.7
France	37.6	26.3	23.3	9.2	3.5
Germany	41.4	29.3	19.9	7.5	1.8
Greece	28.9	38.0	25.1	6.7	1.4
Hungary	47.8	31.4	16.3	3.8	.7
Ireland	30.2	32.3	29.3	6.3	1.9
Italy	28.6	29.0	33.1	7.3	1.9
Latvia*	33.2	35.8	25.7	3.4	1.9
Lithuania	37.4	33.9	22.3	4.8	1.5
Luxembourg	31.7	26.5	29.7	10.0	2.2
Malta*	26.8	34.4	31.0	6.8	1.0
Netherlands*	43.6	24.8	21.1	9.1	1.4
Poland	28.0	42.5	22.9	5.5	1.1
Portugal	24.7	30.5	33.6	8.3	2.9
Romania	36.3	32.9	25.2	3.6	2.0
Slovakia	36.2	33.9	22.9	5.6	1.4
Slovenia	**35.0**	**36.7**	**19.3**	**6.9**	**2.1**
Spain	26.1	34.1	30.8	7.3	1.7
Sweden*	36.7	32.3	23.0	6.0	2.1
EU-27 Average	34.2	33.3	24.2	6.6	1.7

Notes. * = low reliability; source: Eurofound (2020c).

Table 17

"Found that your job prevented you from giving the time you wanted to your family" (%)

Country	Never	Rarely	Sometimes	Most of the time	Always
Austria	37.3	24.4	23.7	12.1	2.5
Belgium	27.2	22.4	28.0	16.3	6.0
Bulgaria	25.5	27.2	28.7	13.1	5.4
Croatia	21.0	22.6	31.8	16.8	7.8
Cyprus*	19.9	19.3	34.2	20.3	6.3
Czechia	30.9	28.2	24.8	11.3	4.8
Denmark	24.2	33.0	31.5	8.5	2.8
Estonia	22.0	28.3	30.5	15.8	3.4
Finland	23.7	32.0	29.4	12.9	1.9
France	29.2	20.2	29.6	18.0	3.0
Germany	33.6	27.0	25.0	10.9	3.5
Greece	16.3	23.3	32.9	20.7	6.9
Hungary	27.0	29.0	26.5	13.8	3.7
Ireland	25.1	24.9	34.4	11.9	3.7
Italy	22.2	20.0	33.4	18.3	6.2
Latvia*	26.8	23.5	26.1	18.6	4.9
Lithuania	29.0	24.6	26.0	13.9	6.7
Luxembourg	26.6	23.1	32.3	12.0	6.0
Malta*	22.9	22.9	36.1	12.9	5.2
Netherlands*	39.0	25.0	23.1	9.0	3.8
Poland	22.7	27.9	30.3	15.5	3.6
Portugal	16.6	25.1	36.6	14.3	7.4
Romania	23.4	24.1	33.2	13.2	6.1
Slovakia	29.6	26.6	25.9	12.9	5.1
Slovenia	**23.6**	**31.5**	**26.8**	**14.5**	**3.6**
Spain	19.0	23.1	36.3	15.7	5.8
Sweden*	23.0	27.9	25.8	17.9	5.5
EU-27 Average	25.5	25.4	29.7	14.5	4.9

Notes. * = low reliability; source: Eurofound (2020c).

Table 18

"Felt too tired after work to do some of the household jobs which need to be done" (%)

Country	Never	Rarely	Sometimes	Most of the time	Always
Austria	28.8	23.5	33.0	12.9	1.7
Belgium	15.8	24.7	33.9	20.2	5.4
Bulgaria	14.1	27.4	30.6	22.1	5.8
Croatia	18.8	25.0	31.0	19.6	5.6
Cyprus*	11.0	19.1	36.3	28.6	5.1
Czechia	19.4	26.6	31.8	17.3	5.0
Denmark	10.7	32.6	39.9	14.7	2.1
Estonia	11.6	21.0	42.8	18.5	6.2
Finland	15.7	29.3	36.5	16.5	2.0
France	22.7	20.7	30.7	21.8	4.1
Germany	22.4	23.7	33.5	17.5	3.0
Greece	10.8	21.5	34.2	25.8	7.7
Hungary	14.2	29.3	36.2	16.6	3.7
Ireland	17.3	21.9	39.3	17.8	3.7
Italy	19.4	21.4	37.2	17.7	4.2
Latvia*	15.6	24.6	37.5	19.9	2.5
Lithuania	16.3	20.8	35.3	21.7	6.0
Luxembourg	18.1	25.1	34.9	18.0	4.0
Malta*	14.1	16.2	43.0	23.5	3.3
Netherlands*	27.0	20.6	32.5	17.0	2.9
Poland	14.2	24.7	38.6	17.9	4.5
Portugal	12.9	22.3	41.2	18.1	5.4
Romania	17.5	23.8	37.5	15.9	5.3
Slovakia	18.5	24.9	35.1	16.3	5.3
Slovenia	**23.7**	**36.4**	**29.4**	**9.0**	**1.6**
Spain	17.4	23.3	36.7	18.0	4.5
Sweden*	11.7	21.9	39.4	23.4	3.7
EU-27 Average	17.0	24.2	35.9	18.8	4.2

Notes. * = low reliability; source: Eurofound (2020c).

Table 19

"Kept worrying about work when you were not working" (%)

Country	Never	Rarely	Sometimes	Most of the time	Always
Austria	45.7	20.6	18.0	12.0	3.6
Belgium	15.4	18.2	32.6	27.2	6.7
Bulgaria	16.2	22.4	30.0	21.5	9.9
Croatia	23.4	16.4	32.1	19.7	8.4
Cyprus*	21.2	14.3	29.5	21.0	14.1
Czechia	34.5	21.9	27.9	13.2	2.5
Denmark	19.7	30.0	38.3	10.9	1.3
Estonia	13.3	29.0	29.9	19.6	8.2
Finland	16.1	28.4	38.8	14.5	2.2
France	9.8	18.7	29.0	31.8	10.6
Germany	30.6	22.3	27.5	14.5	5.1
Greece	17.1	15.2	24.6	24.0	19.1
Hungary	17.4	23.0	32.6	18.4	8.7
Ireland	18.5	22.2	36.7	16.3	6.3
Italy	12.6	14.4	30.7	26.0	16.2
Latvia*	17.2	22.7	38.2	18.4	3.4
Lithuania	23.0	19.1	31.2	18.4	8.3
Luxembourg	20.0	24.3	32.6	16.7	6.5
Malta*	19.2	18.2	29.5	23.3	9.8
Netherlands*	20.4	22.3	38.0	16.1	3.1
Poland	18.0	18.6	31.6	24.7	7.1
Portugal	11.6	14.4	32.3	26.7	15.0
Romania	21.6	19.1	33.7	17.4	8.2
Slovakia	24.9	21.5	27.8	16.4	9.4
Slovenia	**19.2**	**29.1**	**30.2**	**17.9**	**3.6**
Spain	10.8	16.9	35.3	25.3	11.8
Sweden*	22.3	25.1	36.4	14.7	1.5
EU-27 Average	20.0	21.0	31.7	19.5	7.8

Notes. * = low reliability; Source: Eurofound (2020c).

2 CONTROL OVER ONE'S LIFE DURING THE COVID-19 EPIDEMIC: A CASE STUDY OF MULTI-APARTMENT BUILDINGS IN LJUBLJANA

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Abstract

The paper examines how the pandemic lockdown has affected people's daily lives and the sense of control they have over them. Based on original survey data from May 2020, our case study concerns Ljubljana's multi-apartment buildings (MAB) which, due to the physical proximity of the residents and the common spaces/facilities, are a distinct case with particular threats (infection spread) and potential resources (neighbourly support) for coping with epidemic-related problems. The aim was to examine the MABs' inhabitants' perceived control over life and how it varies while accounting for a range of epidemic-associated occurrences in the building and among the residents during the unique episode of the first lockdown in Ljubljana in early 2020. Our results show a dramatic drop in perceived control over one's life, from 75% of respondents in usual times to 35% during the pandemic. Contrary to expectations, groups with the highest levels of perceived control were those with the lowest education, in poor health, and single parents. Summarising the total impact of the neighbourly occurrences in the building, our regression analysis shows how strongly they impact the residents' sense of having control over their lives, namely up to twice the impact of the quality of life and basic socio-demographic characteristics. Although our study shows the setting of an MAB can provide a valuable layer of human action in times of crisis, further research is called for to permit generalisations.

Keywords: pandemic, perceived control over one's life, ontological security, multi-apartment buildings, well-being, control over one's life

Introduction

The COVID-19 pandemic has brought a host of new problems and issues of unprecedented scope and magnitude that question the ability of societies and individuals to deal with them. The outbreak has also produced an additional global health crisis and led to mental health problems like stress, anxiety, depressive symptoms, insomnia, anger and fear globally (Torales et al., 2020), social isolation, uncertainty or the exacerbation of depressive, anxiety, substance use and other psychiatric disorders (Sher, 2020). The pandemic has been shown to be associated with highly significant levels of psychological distress, post-traumatic stress disorders that often reach the threshold for clinical relevance (Xiong et al., 2020).

While public discourse on the pandemic has been dominated by bio-medical perspectives and seen it as a bio-medical phenomenon, social scientists may define and pfisterexamine the pandemic as a social phenomenon. Pfister (2020) maintains the pandemic has become a social phenomenon through various processes of social construction, where the emphasis is on certain risk categories while neglecting others, meaning the risk of the pandemic is the outcome of an interwoven assemblage of probabilities, categories, values and time-frames

Since the virus and the spread of the infection cannot be directly observed, for most people they have become evident through general information, social practices and particularly changes in their daily lives. Here, most crucially, the pandemic poses an unprecedented challenge to many of the assumed certainties in our lives since the habitual settings of our work and lives have been altered (Consolli, 2020). As contended by Repohl (2020), the abrupt threat posed by the pandemic in day-to-day life undermines the basic feeling of 'ontological security', the experience of the world as being stable, predictable and trustworthy. Schools, playgrounds and shops, once reliable places for making contacts and socialising, have during the pandemic suddenly turned into risk zones of infection and are better avoided. A deep feeling of discomfort and insecurity lies at the bottom of the global experience during the pandemic and, as described by Repohl, signifies the loss of ontological security, a basic existential need according to Giddens (1981).

In this paper, we discuss people's reaction to this COVID-19-driven uncertainty and examine how they have responded in terms of having control over their life during the epidemic. Control over one's life is a well-established concept, reflecting the constraints and opportunities in managing life and averting the tendency to become helpless in frustrating and aversive situations (Prenda & Lachman, 2001; Mirowsky & Ross, 2007). We focus on people's daily lives in a particular setting – the multi-apartment building (MAB). This is a special context because the residents' day-to-day life is characterised by physical proximity and the use of common spaces and facilities like corridors and lifts. Even with new practices of self-protection, distancing and watchfulness, with their more frequent contacts these spaces may indicate a hazard for the virus' spread, such as with New York's "towers of death" (Tamura et al., 2020). However, alongside its specific threats (i.e., infection spread), the MAB is a distinct case given its potential for neighbourly support among the building's residents to help them cope with COVID-19-related problems (like isolation and a greater need for emotional and service support). In other words, residents' actions may be seen as a collective response to the difficulties brought by COVID-19, a response that parallels the efforts made on other societal (e.g., individual or municipal) levels.

The aim of this paper is to gain insight into the role of neighbourly activity during the pandemic. More specifically, we consider the question of whether during the epidemic the neighbourly occurrences in the building have impacted the residents'

perceptions of having control over their lives. While it has already been established that residential action affects individuals' feeling of having control over common issues in a MAB (see Mandič & Filipovič Hrast, 2019), we wish to examine this role with regard to specific threats in the pandemic. To this end, we chose the case study method which, while observing a phenomenon, recognises the importance of its particular setting and its unique occurrences. Various data capturing the situation in the city of Ljubljana during the first lockdown in 2020 were therefore collected. The lion's share of this are original data gathered via an online survey of 310 residents in an MAB, a purposive sample. As a case study, the analysis does not intend to provide generalisations – even though that might help in formulating a hypothesis – but chiefly to understand the unique phenomenon in its complexity and specificity.

The structure of the paper is thus as follows. The first section provides the theoretical background to help understand the contingencies of control over one's life, with a focus on the social setting. The methodological section follows, discussing the case study method and presenting our research design. We then proceed to the presentation and analysis of the data that considers both the survey data and some general data on Ljubljana's response to the pandemic. In the conclusion, our findings and their implications are set out.

Perceived control over one's life and its versatile theoretical backgrounds

Perceived control over life is intuitively easy to understand and no doubt positively related to well-being and life management (Bond & Feather, 1988; Prenda & Lachman, 2001). Mirowsky and Ross (2007, p. 7) argue that "the sense of control links the socio-economic, interpersonal, behavioural and psychological systems" and summarise, among others, the following influences identified by various disciplines. Social psychologists see a low sense of personal control as an elementary form of alienation (along with isolation and meaninglessness), which can be enhanced by supportive interpersonal attachments; psychologists find that a sense of control averts the tendency to become helpless in tough situations; sociologists show that the average sense of personal control rises with education, earnings, employment and declines with unwelcome events like being fired, sick, injured or exposed to various hardships.

The sense of control in life can be measured relatively simply when articulated in terms of the individual's assessment of their degree of control, namely, perceived control. It implies a person's perception of their ability to have some control over

events and over wider forces that influence their life (Biron & Bamberger, 2010). Yet, understanding this sense of control is a very complex task, particularly while accounting for the broader context of complex social life. One must also confront the versatile theoretical and conceptual terrain of the social sciences and their plurality of approaches. There is the question of how to bring their vague and abstract notions closer to the specific setting of our case study to thereby help understand people's diverging responses to the adverse situation created by the pandemic. Below, three major relevant theoretical approaches are described that consider 'control over one's life' and seek to explain it from various perspectives. In our efforts to comprehensively explain our subject, we believe it is necessary to combine them. Still, we wish to elaborate on neighbourly activity as a specific domain that may contribute to how residents perceive their control over their lives. This issue has yet to receive any real attention.

Quality of life and well-being studies

In this strand of social studies, the issue of control over one's life is observed and explained within the context of "quality of life" or "well-being", to use a more recent popular term. Perceived personal control in this context is seen as a significant element of quality of life and at the same time as also being influenced by other elements of quality of life. These studies originated in the 1960s when Scandinavian countries undertook nationwide surveys of the level of living and quality of life, aiming to cover all basic elements of human well-being in advanced societies. Initially, the focus was on the resources available to individuals in various life domains. The issue of 'control over one's life' was recognised as the "individual's command over resources in the form of money, possessions, knowledge, mental and physical energy, social relations, security and so on, through which the individual can control and consciously direct his living conditions" (Erikson, 1993, p. 73). Later, in addition to (objectively defined) resources, the subjective perceptions (satisfaction) held by respondents were also included. A more recent version of this line of study is the European Quality of Life Survey, periodically carried out since 2002 (see Eurofound, 2013), that is still distinguished by its indicator-based and policy-monitoring commitment, seeking to provide "a reasonably complete picture of actual quality of life" and "measure people's well-being" (Stiglitz et al., 2009, p. 12). With the course of time, these studies reveal an increasing number of elements and domains by which well-being is defined and measured. This complexity also affects 'control over one's life', now narrowly understood as 'personal autonomy', but representing one of 26

indicators of subjective well-being (Eurofound, 2013). More precisely, it is an element of the 'eudaimonic dimension' of subjective well-being, along with 'evaluative well-being' and 'hedonic well-being'.

However, while growing to become an umbrella term with ever more elements, 'well-being' retains its simple conceptual core. It takes the micro perspective of people's life situations with a focus on the individual's conditions and their perceptions, and empirically establishes the relevant mutual influences between elements of well-being and describes their distribution across social groups. By serving policy monitoring, the approach recognises the inherent relationship between the individual's well-being and their social circumstance and wider structural determinants. Thus, in its most recent study on the impact of COVID-19, Eurofound (2020) found how the toll of the pandemic on subjective well-being levels differed among social groups, where particularly victimised were unemployed people, those up to the age of 49, and female respondents. In countries with a full lockdown and higher infection rates, the population's mental well-being was found to have been affected more and governments have been called on to pay attention to ways of mitigating mental health risks.

This line of studies is characterised by a universalistic approach that focuses on broad and relatively stable conditions and items, while more particular circumstances and situations require a more targeted approach.

Empowerment

With the concept of 'empowerment', the issue of one's control over one's life is observed in the context of power. Most generally, empowerment denotes the process by which individuals and groups that are otherwise powerless or deprived gain more control and influence over their lives and conditions (Kreisberg, 1992; Schulz et al., 1993; Zimmerman, 1990; Page & Czuba, 1999). By gaining more control and influence, they are able to improve their circumstances and quality of life. Empowerment is "the ongoing capacity of individuals or groups to act on their own behalf to achieve a greater measure of control over their lives and destinies" (Staples, 1990, p. 30).

Empowerment implies an understanding of power not as domination, but as a non-hierarchical relationship of collaboration that leads to the achievement of common goals, as a capacity to implement change and mobilise others for co-action (Kreisberg, 1992, p. 75). It requires an attitude of social involvement and the ability to act in concert with others (Koren et al., 1992; Kreisberg, 1992; Schulz et al., 1993; Schon, 1993). As a general concept, empowerment can be applied on the

individual level (personal perception of one's power and the ability to achieve one's own goals), on the organisational/interpersonal level (ability to influence others) or on the community /political level (social action) (Gutierrez et. al. 1998; Koren et al., 1992).

Individual empowerment refers to the perception of influence and "beliefs about one's ability to produce and regulate events in life" (Bandura, 1982, p. 122). Individual empowerment is a complex phenomenon that contains cognitive, personality and motivational domains (Zimmerman, 1990). It also includes behavioural and contextual components since the development of personal power and the ability to act are linked to opportunities for social support and the development of interpersonal and social skills (Schulz et al., 1993, p. 3). Empowerment is seen as the result of a combination of reflection and action, focusing on control over events and their expectation. The expectation that future events are uncontrollable leads people towards withdrawal, alienation and depression; conversely, with the expectation that future events are controllable, people are drawn towards increased psychological empowerment, proactive behaviour and reduced alienation (Zimmerman, 1990, pp. 73–74).

Empowerment is generally measured in two ways. The indirect approach concentrates on the preconditions for the personal empowerment to occur, such as personal skills and access to organisational, social and economic resources (Schulz et al., 1993). With the direct approach, the level of the individual's empowerment is measured by one's own perception of being in control, while the exact wording is adapted to the context (see Schulz et al., 1993; Mandič & Filipovič Hrast, 2018).

Structuration theory: the specific structural context of the multi-apartment building

Structuration theory provides a general explanatory framework for the social world beyond and past the quality of life and empowerment approaches. It also provides the grounds for addressing certain specific qualities of social life relevant to the site of our study – multi-apartment buildings and the residents' control over their lives. One's control over one's life has been found to correspond to ontological security, a notion of structuration theory (Giddens, 1981) that denotes one's sense of confidence in the certainty of one's social and material world. To better understand how this fits into the complex social framework, we now briefly sketch out the core premises of structuration theory before applying it to the specific site of our study – a multi-apartment building (MAB) and its residents.

According to structuration theory (Giddens, 1981), actors feel ontological security by way of experiencing some constancy and predictability in the environment in which they act, interact and utilise resources. They feel this security by drawing on their interpretative frameworks where their actions are attributed with specific meanings relative to rules and anticipated possible sanctions. To serve their purposes, reasons and motives in their action, actors employ the rules and resources available in the given structural context. Yet, the actors' ability to act and use these rules and resources depends on their capabilities and constraints. The ability to act is inherently tied to power, understood as an emergent outcome of the power game among actors; it is a product of actors' capabilities to utilise resources, which also includes knowing how to proceed in various social life contexts. Control results from relations of autonomy and dependence.

Structuration theory and its concept of "locale" can be applied to specific phenomena where actors' interactions are inherently related to a territory or physical space. In the case of an MAB, this relationship is established in the following way: by sharing common facilities and a physical space, residents develop some shared pertinent interpretations and meanings (shared problems, experiences etc.) Consequently, in the residents' life, the site represents a common specific structural context in which they can act based on particular shared meanings, knowledge and resources. This is a basis for diverse occurrences.

In a recent study relying on such an approach (see Mandič & Filipovič Hrast, 2019), two occurrences were found to significantly influence the residents' feelings of being in control in such a setting. The first is "trust in neighbours", which implies a complex set of relationships and ties between residents, including some level of sense of belonging, customs and habits, norms and social control developed in the specific setting. The second occurrence is about resident 'co-action', most notably the disposition to cooperate and join forces with others in achieving some common good. Both occurrences are instances where residents can act and use various resources to realise some control over parts of their daily lives. However, these instances imply some degree of collective control, which thus contributes to the individual's feeling of being in control in such a setting.

Methodology

The outbreak of the COVID-19 pandemic in spring 2020 presented an opportunity to observe and examine the unique phenomenon of daily life changing in response to the newly emerged risks and needs of people who reside in the specific setting of multi-apartment buildings in Ljubljana. To seize this special and time-limited

opportunity of the pandemic lockdown in Ljubljana, our team, with experience in quality-of-life research, decided to gather evidence in ways still feasible during the lockdown – an Internet survey questionnaire to which residents in Ljubljana's MABs were invited to participate in several ways. Namely, it is clearly nonprobability sampling, not *intended* to make inferences from the sample to the general population in statistical terms, but suitable for in-depth qualitative research where the aim is to understand complex social phenomena (Small, 2009). The sample was purposive and included Ljubljana's MAB residents willing to share their lockdown experience. These data entail rich and complex evidence that we find valuable and wish to a use in a case study of the unique social occurrences associated with the COVID-19 pandemic in a particular setting – Ljubljana's MABs.

Case study as a method

Generally stated, a case study is a research method that allows for an in-depth, holistic investigation of a complex issue through detailed analysis of a limited number of cases. Yin (1984, p. 13) described it is "an empirical inquiry that investigates a contemporary phenomenon within its real-life context ... and in which multiple sources of evidence are used". Unlike methods that seek to provide generalisations based on data acquired through large representative samples, a case study's strength lies in its ability to describe and understand phenomena in their natural settings and in their uniqueness/particularity. Case study methodology is especially useful when the current perspective and knowledge seem inadequate, like when new events occur, where a case study can provide a holistic perspective on real-life events in their complexity (Vissak, 2010). Case studies have recently become ever more recognised in many social studies, particularly in inquiries into social issues like poverty, drug addiction, illiteracy and community-based problems, where a more complete understanding is needed and the restrictions of quantitative methods are recognised (Zainal, 2007).

The case study methodology is often used in the presence of uncertainty and underutilised because, unlike other research strategies, it does not have a codified design (Yin, 2002). In contrast to Yin's proposal for a tighter and well-structured design, Stake (1995) argued for a more flexible design that pays attention to the issue's complexity and contextuality. In addition to differences among prominent authors on how to approach the research design and definition of the case (see Yazan, 2015), there is great variety in the kinds and types of case studies. Authors (see, for instance, Stake, 1995; Yin, 2002; Thomas, 2021; Gomm et al., 2000) propose a similar classification of case studies with regard to their basic features, most notably the kind

of data (qualitative or quantitative), the number of cases (single or multiple), the number of units, the primacy of the case or the issue (intrinsic and instrumental) and the category according to its purpose (exploratory, descriptive or explanatory). We note that while a case study usually refers to research that considers only one or a few cases, it is not necessarily limited to that case since various cases and units can be constructed out of a naturally-occurring social situation (Gomm et al., 2000). For a case to exist, a characteristic unit must be defined and observed and related to an analytical category or a theory (Thomas, 2021, p. 12)

Research design and data

We start by specifying the purpose of the study because this is very relevant for defining the research design. Our study aimed to provide insights into people's feelings of control over their lives during the pandemic, especially accounting for the context of living in an MAB in Ljubljana and the experience of the unique lockdown occurrences among residents in the building. It involves an in-depth investigation of a complex issue in its real-life context, also including the city environment. Limited in making generalisations to other settings and locations, we instead pursue a detailed account of these occurrences, capturing them holistically in their uniqueness/particularity. However, in-depth analysis of a small-N purposive sample or a case study also enables patterns and causal mechanisms of interest to be identified. Apart from the level of control over life, we wish to examine how it varies with respect to different characteristics of the residents. We seek possible explanations in terms of particular personal and quality of life occurrences and, specifically, in terms of the quality of the neighbourly actions. The study may thus be classified as mainly descriptive and explanatory.

We rely on extensive data that come from a survey conducted between 5 May 2020 and 14 May 2020 using a self-administered web data collection mode, with an on-line survey questionnaire to which Ljubljana's residents of multi-apartment buildings (MABs) were invited in various ways to complete. Although not a representative sample, it may be characterised as a purposive (reflecting the participants' deliberate choice due to their characteristics) and convenience (accessibility) sample (Etikan et al., 2016). Namely, we targeted residents of MABs containing at least nine apartments because such buildings must have a housing manager and during the pandemic this had an effect. While the survey also provides qualitative data from open questions, for this study only quantitative data are used as they relate to selected issues. The 310 surveys completed represent the 310 units for our case study.

The study is organised as follows. We start by describing specific changes occurring in Ljubljana during the lockdown in spring 2020 that affected quality of life and the possibilities to control it. In addition to the epidemiological restrictions that impacted the whole country, a number of specific local limitations and sources affected people's mobility options and access to services and other resources. The data used are, as mentioned, mostly quantitative and come from city documentation and local media.

The next section is descriptive. Data are presented about general characteristics of the sample, the crucial elements of quality of life, perceived control over life, and the various occurrences among neighbours in MABs during the lockdown. Alongside the general description, regularities are sought between the perceived control and other features.

The final section focuses narrowly on whether and to what extent the sense of control was affected by occurrences among neighbours in the MAB during the lockdown. This question was the last to emerge by virtue of "progressive focusing" (Jazan, 2015) as the problem areas became more clarified. Has positive action among neighbours significantly added to the feeling of control during the pandemic? The sufficiently large number of units involved makes regression analysis appropriate.

The case study – results

Ljubljana during the lockdown

Ljubljana as the capital of Slovenia is a hub of educational, cultural, commerce, administrative, healthcare and other institutions and facilities that add to the relatively high quality of life of its residents, together with the large green areas and natural resorts in close proximity. With a population of 295,000 people and 132,000 housing units (SiStat, 2021), Ljubljana is considered to be a medium-sized settlement whose smaller size means that most city facilities are relatively easily to reach. However, two specific lockdown restrictions utterly changed how the city functioned in terms of spatial accessibility and the citizens' mobility: public transport saw serious disruptions and moving around was practically limited to one's own municipality (Mestna občina Ljubljana, 2020a). People were thus left dependent on their own means of transport and restricted to their home municipality, with both dramatically impacting the functioning of social support networks that are generally recognised to play a considerable role, particularly family members.

The pandemic lockdown in Ljubljana (for a general description, see Mestna občina Ljubljana, 2020c; Žerdin, 2021) profoundly changed certain basic elements

of the inhabitants' quality of life. Healthcare services, generally high in quality, became quite restrained, with difficulties even in obtaining primary care and seeing the family doctor. Access to these and other public services started to depend on Internet use and having one's own transport. Unlike others, food and basic item stores remained open, while their Internet orders and home delivery to buyers increased considerably. Group sports and recreation were largely restricted, even in outdoor spaces, while the popular activity of hiking in the city's green surroundings was restricted to one's home municipality. MABs, which account for 12.7% of all of Ljubljana's buildings (SURS, 2018), were obliged to disinfect the common spaces while the residents were required to use masks and keep a distance if meeting in the common spaces (Mestna občina Ljubljana, 2020c).

For many households, this meant a new situation whereby those with jobs had to work from home; schools for most grades switched over to on-line classes, while kindergartens were generally closed. In a sizeable share of households, these changes created new pressures and demands to share time and space among the members. This proved quite difficult while parents working from home also had to care for their children or where there was insufficient living space.

Some occurrences were specific to Ljubljana in contrast with other Slovenian towns. The Municipality of Ljubljana responded to the situation by providing certain additional support, most notably by providing meals for children and elderly in need daily, childcare for those in need, home childcare, support for the mutual help among parents) and extra psychological support (Mestna občina Ljubljana, 2020b). Yet, Ljubljana's uniqueness also included the political climate on the national level. Shortly before the lockdown was declared, a new government was formed in Slovenia, one characterised by little popular support and one of the lowest levels of trust in the EU (see Eurofound, 2020). This was accompanied by plenty of criticism and 'cyclists' Friday protests' (see Žerdin, 2021), whereas, in certain neighbourhoods and MABs, at a designated time the residents gathered by their windows or on their balconies to protest or simply socialise while singing, playing music, making noise, displaying protest slogans or flags.

Residents in MABs: their life and control over it during the pandemic lockdown

As a once-in-a-life episode, the pandemic is responsible for countless challenges that people were unprepared for and regarding which they could not rely much on previous experience, their own or collective. Although personal experiences and

anecdotal accounts show that people's reactions to pandemic-associated issues have varied hugely, it was not possible to systematically observe them. This section brings general insights into various epidemic-driven occurrences, attitudes and actions of people in the specific setting of MABs in Ljubljana.

Table 1

Sample characteristics and perceived control over life

Variables	Sample characteristics			Perceived control over life (a)			
				In usual times		During the pandemic	
		f	%	% High level (4.5)	Mean	% High level (4.5)	Mean
Gender	Male	63	20.7%	68.3%	3.94	38.1%	3.21
	Female	242	79.3%	77.7%	4.11	40.1%	3.27
	Total	305	100.0%	75.7%	4.08	39.7%	3.26
Age	< 35	94	31.0%	67.0%	3.95	31.9%	3.11
	35–50	121	39.0%	75.8%	4.05	38.8%	3.24
	> 50	93	30.0%	84.4%	4.24	47.3%	3.42
	Total	308	100.0%	75.7%	4.08	39.3%	3.25
Education level	Secondary or less	64	21.1%	73.0%	4.11	50.0%	3.53
	Higher	239	78.9%	76.3%	4.07	36.8%	3.18
	Total	303	100.0%	75.7%	4.08	39.9%	3.26
Employment status	Employed, Self-employed	213	70.1%	76.8%	4.09	39.0%	3.25
	Other	91	29.9%	73.0%	4.04	40.7%	3.27
	Total	304	100.0%	75.7%	4.07	39.5%	3.26
Self-assessed health (b)	Poor (1,2)	12	4.0%	66.7%	4.08	50.0%	3.50
	Satisfactory (3)	75	24.8%	57.5%	3.74	25.3%	2.99
	Good (4,5)	216	71.3%	82.2%	4.19	44.0%	3.34
	Total	303	100.0%	75.6%	4.07	39.6%	3.26
Difficulties in making ends meet (c)	With no difficulty (1,2)	165	55.6%	77.2%	4.11	39.4%	3.32
	Tightly managing (3)	87	29.3%	74.7%	4.07	40.2%	3.21
	With great difficulty (4,5)	45	15.2%	70.5%	3.95	37.8%	3.13
	Total	297	100.0%	75.4%	4.08	39.4%	3.26

Type of household respondent is living in	Living alone	51	16.7%	86.3%	4.20	43.1%	3.45
	With partner	88	28.9%	74.4%	4.09	37.5%	3.25
	With partner and child	95	31.1%	77.7%	4.12	40.0%	3.22
	With child	32	10.5%	80.6%	4.16	53.1%	3.53
	Else	39	12.8%	56.4%	3.72	28.2%	2.90
	Total	305	100.0%	75.7%	4.08	39.7%	3.26

a) To what extent do you have control over your life, on a scale from 1 -"I have no control over my life" and 5 "I have control over my life", In usual times? During pandemic?

b) How would you rate your health in general? Answers were on the scale 1 – very bad, 2 – bad, 3 – satisfactory, 4 – good, 5 – very good).

c) How would you describe the situation with income in your household? Which of the following descriptions is most appropriate? 1 – we can manage without any difficulty, 2 – we can just manage, 3 – we can manage with great difficulty, to 4 – we can manage with extreme difficulty.

First, we describe how our sample is characterised: a high incidence of female, better educated, employed persons, mainly in good financial circumstances (55% declaring no difficulty in making ends meet on their income) and in sound health (70% rated it as good). In addition, younger and middle-age groups dominate and there is a high incidence (41%) of children among household members.

The residents' response to the pandemic in terms of their perceived control over their life is measured by a question contained in the Slovenian public opinion poll (Hafner Fink et al., 2020; Mandič, 2015). Respondents are asked to estimate the level of control over their life on a scale from one to five, where one means "I have no control over my life" and five "I have control over my life". The question was adapted and posed first with the specification "in usual times" and then later with the specification "during the pandemic". The results show variation in perceived control across the sample and its subgroups and are given in Table 1.

A high level of control during the pandemic is declared by 40% of respondents, with the mean value of 3.3 being in the upper part of the scale. There is some variation across subgroups. Contrary to expectations, very little or almost no variation is found with regard to gender, employment status or financial situation. More variation is found across age groups (with control increasing with age) and regarding the education level (greater control among lower educated). There are differences with respect to health, but they are not simple linear. What stands out is the high level of control among single and single-parent households.

Still, when the level of control during the pandemic is compared to usual times, an alarming decrease is evident: the share of respondents with a high level of control (1,2) dropped from 75% to 35% during the pandemic. At the other extreme, the share of respondents with no or very little control rose from a marginal 4% to a

substantial 28%. The mean value dropped from 4.1 to 3.3, with an average drop of 0.8. Groups indicating the biggest falls in control are those with the highest education levels (0.9 change), those who are only just managing with their current income (0.9) and those living with a partner and a child (0.9). On the other hand, groups seeing the smallest drops are those with a lower education (0.6), with poor health (0.6) and single parents (0.6).

Table 2

Assessment of risks

Item Responses on a scale from 1-not much to 5-very much	1,2	3	4,5	Mean
How much have you felt at risk while meeting neighbours?	230	37	37	1.88
How much have you felt at risk because of the Covid virus?	144	97	67	2.65
How much have you felt at risk because of Covid's financial consequences for you?	110	76	121	3.08
How much can you trust neighbours in usual times?	75	104	123	3.24
How much have you been able to trust neighbours during the Covid pandemic?	87	103	117	3.15
How safe have the common spaces in the building been regarding spread of the infection?	62	72	149	3.44

Perceptions of risk with respect to various occurrences are described in Table 2. The biggest risk was seen as arising from possible personal financial consequences of the pandemic, exceeding the risks posed by the virus, while the smallest risk was seen as coming from meeting one's neighbours. The level of trust in one's neighbours has decreased during the pandemic, but remains positive, indicating the persistence of trust among neighbours. The common spaces were not perceived to be very risky.

Table 3

Occurrences in the building during the pandemic as noticed by respondents

Item	No	Yes	%Yes	Total
A notice in a visible place that invites older residents to contact specified people /institutions if needing assistance getting food, transport etc	221	89	28.7%	310
Presence of humanitarian and voluntary organisations in the building or its surroundings	281	29	9.4%	310
Disrespect by residents of the measures against spread of the infection	214	96	31.0%	310
General increase in tension and conflicts in contacts between neighbours	271	39	12.6%	310
Increase in tension and conflicts within households	228	82	26.5%	310
Occurrence of neighbourly support/cooperation in getting things from shops, post etc.	200	109	35.3%	309
Occurrence of neighbourly support in care for vulnerable members (children, sick)	245	63	20.5%	308
Occurrence of psychological support among neighbours	257	51	16.6%	308
Joint singing or playing music on windows or balconies at 6 p.m.	256	52	16.9%	308

Further, we examined various possible occurrences and activities that might have had happened in the MABs during the lockdown and were noticed by the respondents, as shown in Table 3.

Close to one-third of them reported the emergence of neighbourly support and help (a call to older residents to get help and the occurrence of helpful neighbours bringing things). Somewhat less, but still reported by close to 20%, were other forms of support among neighbours, as well as the common gatherings with music etc. by windows and on balconies. While a significant rise in tension and conflict was noticed within the household and reported by 26%, a lower incidence (13%) was perceived in contacts with neighbours, but still witnessing a noticeable change during the pandemic. However, the quite high number of incidents of disrespect of the anti-infection measures by residents in the building is noted.

Impact of the occurrences in the building on perceived control over life – regression analysis

We observe the individual's perception of being in control over their life during the COVID-19 pandemic and in the specific setting of an MAB. We seek to explain control over one's life and identify the factors responsible for its variability; in particular, the dependent variable is a resident's perceived control over their life during the pandemic lockdown (CONTROLLIFE), modelled by hierarchical linear regression analysis where variables are added to the model in separate steps called blocks. Apart from the QOL block and sociodemographic block, we focus on quality of the neighbourhood's response to COVID-19. Variables are presented in Table 4.

Table 4

Variables in the regression analysis:

Construct	Variable names in the model	Variables and value labels
Control	CONTROLLIFE	At what level are you able to ascertain control over your life during the pandemic lockdown? Answers were on a 5-point Likert scale, with the following extreme values labelled (1 – I do not control my life, ... 5 – I control my life)
Quality of Life	HEALTH	How would you rate your health in general? Answers were on a 5-point Likert scale ranging from 1 – very bad to 5 – very good, 2 – bad, 3 – satisfactory, 4 – good).
	INCOME	How would you describe the situation with income in your household? Which of the following descriptions would be most suitable? (1 – we can manage with the household's income without problems, 2 – we can just manage with the household's income, 3 – we can manage with difficulty, to 4 – we can manage with the household's income with extreme difficulty).
	HOUSESPACE	Was calculated by dividing the apartment's size in m2 by the number of residents.
Control variables	AGE	Age measured in years

	EDUC	Education. (1 – elementary school, 2 – high school, 3 – higher education). For the purposes of modelling, the first two categories were collapsed and labelled 0 (high school or less), whereas the third category was labelled 1 (higher education).
	GENDER	Gender. Values: 0 – male and 1 – female
	SIZE	How many people are living in your household together with you?
	CHILD	Type of household: Type of household (response categories: Living alone, With partner, With partner and child, With child) recoded 0: not having children in household, 1 – having children in household
Quality of the neighbourly response to Covid	NEIGHSUP	Count of types of support on three items on reported occurrences of support in the building during the pandemic (bringing things from grocery shops or the post office, or the pharmacy, or maybe has started to receive or give psychological support, assist in giving or receiving help with care for a vulnerable person)
	TRUSTNEIGH	Perception of trust in one's neighbours during the pandemic lockdown (Answers on a 5-point Likert scale, with the following extreme values labelled (1 – not at all, 5 –can trust totally).
	OLDSUPP	Visible call by older residents about who to contact for help to get food, transport etc. (0 – no, 1 – yes)

QOL variables are entered in the first block, followed by sociodemographic characteristics and quality of neighbourhood experience in the last block.

The demographic variables hold relatively weak explanatory power since by themselves they explain just 5.7% of the variance in CONTROLLIFE. The second model, when taking the QOL predictors into account, explains 10.4% of the variability in CONTROLLIFE. The final model, comprising all of the previous variables plus quality of the neighbourhood's response to COVID-19, explains 19.7% of the variability of CONTROL. The adjusted R^2 is somewhat lower (16.6%).

In the final model, education (b = –.487) has a significant effect on perception of control. The QOL block contributes a significant variable, i.e. the subjective perception of health (b = .159) and HOUSEPACE (p = .008). The quality of the neighbourhood's response is contributed to by NEIGHSUP (b = 159), TRUSTNEIGH (b = .133) and OLDSUPP (b = .449). The biggest change from the first to last model is seen for the variable AGE, that is initially significant (p = .001) but, when controlled for neighbourhood, is no longer significant.

Table 5

Regression analysis

	Unstandardised Coefficients		Standardised Coefficients		Unstandardised Coefficients		Standardised Coefficients		Unstandardised Coefficients		Standardised Coefficients	
	b	Std. Error	Beta	Sig.	b	Std. Error	Beta	Sig.	b	Std. Error	Beta	Sig.
(Constant)	3.260	0.382		0.000	2.174	0.553		0.000	2.038	0.540		0.000
AGE	**0.013**	0.005	0.150	0.012	**0.012**	0.005	0.141	0.021	0.009	0.005	0.102	0.088
EDUC	**-0.374**	0.172	-0.129	0.031	**-0.482**	0.177	-0.166	0.007	**-0.487**	0.169	-0.168	0.004
GENDER	0.017	0.167	0.006	0.920	0.020	0.165	0.007	0.905	0.021	0.157	0.007	0.893
SIZE	-0.144	0.079	-0.147	0.068	-0.085	0.083	-0.086	0.310	-0.100	0.079	-0.102	0.207
CHILD	0.222	0.189	0.093	0.240	0.226	0.187	0.095	0.227	0.198	0.178	0.083	0.268
HOUSPACE					0.008	0.004	0.130	0.075	**0.008**	0.004	0.133	0.058
HEALTH					**0.242**	0.081	0.171	0.003	**0.159**	0.079	0.112	0.045
INCOME					-0.081	0.073	-0.067	0.267	-0.081	0.069	-0.067	0.243
NEIGHSUP									**0.159**	0.077	0.130	0.039
TRUSTNEIGH									**0.133**	0.057	0.137	0.021
OLDSUPP									**0.449**	0.152	0.172	0.003
Sig.Fchange	0.005				0.002				0.000			
R2	0.057				0.104				0.197			
Adjusted R2	0.040				0.079				0.166			

a. Predictors: (Constant). CHILD. AGE. GENDER. EDUC. SIZE
b. Predictors: (Constant). CHILD. AGE. GENDER. EDUC. SIZE. HEALTH. INCOME. HOUSPACE
c. Predictors: (Constant). CHILD. AGE. GENDER. EDUC. SIZE. HEALTH. INCOME. HOUSPACE. OLDSUPP. TRUSTNEIGH. NEIGHSUP

Discussion and conclusions

The pandemic has produced a host of new and unprecedented problems for countries, cities, organisations, social groups and individuals, which are responding to it in very different ways. As the pandemic continues, accounts are appearing about multiple adverse effects on people's lives and well-being. Numerous studies indicate the pandemic is associated with distress, anxiety, depression, uncertainty and economic difficulties, which may lead to psychiatric disorders (Sher, 2020). In Slovenia, a considerable rise in violent behaviour was reported in 2020 over 2019, namely a 9% rise in domestic violence, 22% in rape and 59% in the number of minors taken into custody (Garbajs, 2021). People have clearly been deeply affected.

Our study aimed to provide insights into people's perceptions of having control in life during the pandemic while living in an MAB. This setting is special due to its particular sources of pandemic-associated hazards and the resources they have for coping with them. Our case study relies on data from Ljubljana and a survey of a purposive sample of 310 MAB residents. The case study method was used due to its ability to offer a description and understanding of a phenomenon in its uniqueness/particularity, presenting a holistic perspective of real-life events in their complexity. The biggest challenge was to examine perceived control over life and its variation while accounting for diverse pandemic-driven occurrences in the building and among the residents during the lockdown in Ljubljana. It should be noted that the population under study is quite specific and represents a well-off part. The sample is characterised by the outstanding presence of female, younger, employed persons with a higher education and well off both economically and in terms of health.

Our results show a dramatic drop in perceived control over one's life, from 75% of respondents in usual times to 35% during the pandemic; at the opposite end, the very problematic state of the lowest level of control has skyrocketed from a marginal 4% to the alarming figure of 28%. Some people have been seriously impacted, others much less so. Three groups with the highest levels of control (mean equal to or higher than 3.5) were those with the lowest education, in poor health, and single parents; groups with the lowest perceived control (mean below 3.1) were those under the age of 35, those with satisfactory health, and those in atypical households. Among the sources of risks examined, the greatest perceived risk arose from possible personal financial consequences of the pandemic, somewhat less from the virus itself, and the least from meeting one's neighbours. Of the various occurrences and actions examined in the building during the lockdown, the most frequently reported (close to 30%) were manifestations of neighbourly support in providing transport and the delivery of things, and also the considerable incidence of neighbours disrespecting the anti-infection measures.

Finally, in summarising the overall impact of the occurrences and the neighbourly action in the building, our regression analysis shows its significant effect on how residents have perceived their control over their life. The analysis also indicates a significant impact of various elements of quality of life and of basic socio-demographic characteristics, although the impact of the neighbourly occurrences is statistically twice as large. While quality of life and basic sociodemographic characteristics are already well recognised for their impact on perceived control over one's life, the neighbourly occurrences in an MAB have yet to be sufficiently examined. Since they stem from a case study, our results cannot be generalised but provide the grounds for further consideration of the housing setting and how it impacts quality of life and the sense of control over it. This means we may hypothesise that the type of setting, whether an MAB, a single-family house in a city residential area, or something else, may have a considerable impact on the individual's perception of having control over their life.

However, our case study also exposes some of the broader factors that influence individuals' control over life, with some clearly arising from the wider context. Namely, the significance of the neighbourly action and support might be a result of the reduced availability of other support network members due to mobility restrictions requiring one's own transport and within the borders of the municipality. As shown by Šadl and Hlebec (2018), family members play a key role in social support networks in Slovenia and might have been cut off by the restrictions. Moreover, in Slovenia the feeling of safety in one's neighbourhood is high compared to other European countries and social networks in the neighbourhood are strong (Filipovič Hrast, 2008).

Our results clearly confirm how important it is to holistically consider the context of perceived control over one's life. As a "differential spatio-temporal configuration of constraints and opportunities" (Moulaert et al., 2016), the setting of an MAB, as a space for residents to communicate and act together, has been shown to play a substantial role in our case. Although our study clearly shows that the setting of an MAB has provided a significant layer of human action in times of crisis, further research is called to permit generalisations.

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3 TO BE OR NOT TO BE ... VACCINATED? THE VIEWS OF THOSE OPPOSED TO COVID-19 VACCINATION IN SLOVENIA

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Abstract

The aim of this paper is to shed light on the views of individuals who are hesitant to take a COVID-19 vaccine, however accounting for the specifics of the Slovenian environment. It has been characterised by an antagonistic political situation, strong hierarchical top-down communication, disagreements with the leading epidemiologists and especially by the ever-changing prohibitive measures. Compared to EU, the country reached a very low level of trust in government and very low vaccination rate.

To analyse interviews the interaction framing approach was used allowing us to detect a wide scope of issues of concern and reasons for distrust in vaccination which has not yet been publicly exposed. Another benefit of the approach is to detect the presence of various types of frames, revealing also the cognitive and discoursive potential for convergence or alternatively for further polarisation. Our results revealed how very polarised and emotional was the main public discussion of vaccination issues. The strong presence of identity and process framing in our interviews shows how divergent, contrasting and even conflicting are the views on the two sides – the authorities with their harsh and disrespectful addressing of the public, and those who are hesitant to become vaccinated. Moreover, considering the possible predictive capacity of the interactional framing approach one may assume that this polarisation is set to further expand alongside the growing distrust in the government.

Key words: vaccination, vaccination hesitancy, polarisation, framing, interactional framing approach

Introduction

Around the world, the issue of COVID-19 has been widely and thoroughly discussed, perhaps even reaching media oversaturation. It was thus quite surprising for an analyst to realise what little is known in Slovenia about the views that keep ordinary people from being vaccinated. Although this represents a serious health policy concern, such people have generally been addressed by the mainstream media as a group (supposedly sharing the same view), often in critical and unfavourable terms, sometimes even in a denigrating manner, and particularly accounting for the extreme voices of those who have stirred up anti-vaccination sentiment on social media.

However, the pandemic is a social phenomenon, deeply affected by the social context. In Slovenia, the context has been quite specific during the epidemics. It has been characterised by an antagonistic political situation, strong hierarchical top-down communication, disagreements with the leading epidemiologists and especially by the ever-changing prohibitive measures (see, for instance, Petrovec, 2021; Žardin, 2020). The already low trust in government has dropped further during the pandemic, reaching an extremely low level compared to other EU member states. The country has also had a very low vaccination rate. On 25 October 2021, the vaccination rate in Slovenia was 50.4%, the 5th-lowest level in the EU, while in Western European countries the rate was generally around 70% (European Centre for Disease Prevention and Control, n.d.; Kosec, 2021, p. 5).

This paper examines views on vaccination as held and expressed by people who do not support vaccination. We examine these views by highlighting the cognitive framework with which they define the vaccination situation, evaluate it and make choices about vaccination.

The aim of this analysis is to shed light on the views and beliefs of individuals who are hesitant to take a COVID-19 vaccine, accounting for some specifics of the Slovenian social context, including the dominant critical accounts of unvaccinated people found in mainstream media, and particularly the management of COVID-19, where we compare Slovenia with the successful case of Norway. Alongside general thoughts about COVID-19 vaccination, we wished to detect the full scope of issues of concern, worry and distrust that have yet to be comprehensively voiced in public. However, another intention is to benefit from the interaction framing approach that allows for a more detailed examination of views considering the types of frames used; moreover, it permits an assessment of the cognitive and discursive potential for convergence – or alternatively for further divergence and polarisation – in views on vaccination.

The social context: COVID-19 management, governance, trust and media

The COVID-19 pandemic is responsible for new and unprecedented problems and threats to society. Not much is known about the virus and its functioning and thus major decisions are being taken amidst deep uncertainty, with little reliance on previously acquired evidence. As a new, emerging and urgent issue, it calls for specific responses from crisis management and for governance to become more agile, adaptive and more inclusive (Ansell et al., 2020; Janssen & Van Der Voort, 2020; Rajan et al., 2020).

Governance and trust in the Slovenian context

This section presents the core characteristics concerning the way COVID-19 has been managed in Slovenia. Yet, we start by describing the very successful case of Norway, which we use as a Weberian 'ideal type' against which the case of Slovenia can be juxtaposed and compared. Norway's allegedly successful epidemic management is, according to Christensen and Lægreid (2020), based on a positive relationship between the crisis management capacity on one hand, and legitimacy on the other. This positive relationship combines the governance capacity with democratic legitimacy. While capacity is important, it is also essential that the measures taken against the crisis are accepted by the citizens to ensure that people follow the government's advice and instructions. Crisis management also involves perception, meaning the outcomes of the crisis are coproduced and depend on citizens' behaviour based on their trust in government as well as on government capacity. The COVID-19 crisis poses an acute threat to basic structures and fundamental values in society and because not much is known about the new virus major decisions are made amidst deep uncertainty and public measures have an experimental quality. Christensen and Lægreid (2020) describe other characteristics of the two dimensions and how they were successfully handled in the Norway's case.

Governance capacity entails preparedness (or analytical capacity), coordination, regulation, and implementation (or delivery) capacity. The Norwegian authorities were not particularly well prepared for the crisis, with responsibility for such preparation having been delegated to the regional health enterprises. The political leadership worked closely with career public servants and public health experts. In contrast to a confrontational policymaking style (like in the USA), the consensus-based and collaborative approach typical for Norway was used, based on relationships of considerable mutual trust between the political and administrative executives and expert bodies. Overall, the main decision-making style and handling of the outbreak was consensual and built on a pragmatic collaborative approach combining argumentation and feedback. The executives tried measures they thought might work, the experts assessed the consequences, and the course was adjusted if necessary; this made sense given the lack of evidence-based knowledge.

Governance legitimacy is about citizens' trust in government and implies accountability, support, expectations and reputation; in Norway, the key challenge was to sustain and restore trust in government arrangements for dealing with crises. This general rise in trust reflects the communication strategy in which political, administrative and professional executives appeared to take a common stance. Unlike in authoritarian regimes, where the focus is on a strong leader, the Norwegian approach was based more on working together across political parties, across the political and

administrative divide, across central and local government, and across the public and private sectors. This was reflected in the communication strategy, regarding which political, administrative and professional executives appeared to be in agreement. This led to increased greater trust in the government during the epidemic, even though trust was already high. Christensen and Lægreid (2020) emphasise how governance legitimacy and trust depend on participation as well as meaning-making of the situation. The Norwegian meaning-making process occurred in the setting of considerable mutual trust between political leaders and relevant central expert agencies, with the outcome that the political, administrative, and professional authorities managed to communicate a joint and coordinated message to the general public. The meaning-making process also followed Norway's collaborative governance style of involving affected stakeholders in society, entailing a number of hybrid and complex organisational forms in which different actors work together in networks and teams 'in the shadow of hierarchy'.

In Slovenia (for details, see Petrovec, 2021; Žardin, 2020), the start of the pandemic coincided with a change in government after the previously coalition government stepped down in spring 2020. The new ruling coalition and leading government politicians immediately started to replace the heads of relevant central expert agencies (such as the National Institute for Public Health), thereby introducing a climate of conflict and distrust from the onset. From its first major procurements of anti-epidemic equipment (ventilators and masks), the government's actions evoked suspicions regarding the possibility of corruption, which never came to be clarified. Since the start of the pandemic, the political context in Slovenia has thus been characterised by the presence of huge public distrust that has only intensified over time.

In terms of crisis management, the Slovenian government's response has been shown to be quite deficient. A comprehensive crisis management plan was lacking, while individual actors' insufficient crisis management competencies led to specialised ad hoc structures being set up, overnight decisions being made and then suddenly reversed, and often to inconsistent and inappropriate communication with the public (Ferlin et al., 2021). Particularly critical mistakes were found in communication that shaped trust in the official communicators and failed to motivate and encourage individuals to comply with the recommended and prescribed protective measures (Kamin & Perger, 2021).

Governance in Slovenia had previously been found to generally suffer from a lack of representation and accountability since the very beginning (Fink-Hafner, 2017). While some institutionalised forms of consultative politics have developed, the culture of consultation has remained weak and developed only in selected policy areas. However, autocratisation tendencies have lately been reported under Janša's government (Fink-Hafner, 2020). With regard to public participation overall and the inclusion of civil society organisations, major weaknesses have also been described.

According to Hafner Fink et al. (2014), the Slovenian population's political culture may generally be characterised by a very low propensity for public participation and weak interest in politics; people evaluate their political influence as very low and feel that as citizens they do not possess any political power. Rakar et al. (2011) argue that civil societies' small impact on public policies is complemented by the political system's lack of a mechanism for the direct inclusion and articulation of the interests of civil society; still, considerable weaknesses were also found in civil society's functioning, notably the lack of connectivity and the need to improve citizens' competencies for the civil dialogue.

To summarise, the biggest differences between the Norwegian and Slovenian approaches are the following. Compared to Norway, which combined high-capacity crisis management with democratic legitimacy, Slovenia seems to have been much less successful in both dimensions. With regard to governance capacity, involving the ability to coordinate, regulate and implement measures, the political leadership in Slovenia has taken a more confrontational style of policymaking, unlike the more consensus-based collaborative Norwegian approach. In short, Norway is shown to have more cooperative, horizontal and dialogical ways of governance that are less confrontational. With respect to governance legitimacy and trust-building, the response in these two countries diverges in the extreme. In contrast to Norway, where collaboration across political, administrative and professional divides led to the adoption of a common stance and the communication of a joint and coordinated message to the public, in Slovenia this seems to be the weakest point, with the communication often found to be unclear, contradictory, inconsistent and shifting. These differences add up in the final outcome – trust in government. Unlike in Norway, where during the pandemic trust in the governments has increased, in Slovenia it has gone down.

However, the issue of trust in national government is more complex. In Slovenia, a comparatively low level of trust in government and institutions was already reported some time ago (Iglič, 2004). Public trust in institutions compared to other European countries was found to be quite low in Slovenia and similarly low as in other new democracies in Central and Eastern Europe, where it is well below the levels seen in the established democracies of Western Europe (Haček, 2013).

On the other hand, according to Eurofound (2020) during the pandemic decreasing trust in the national government has been found in all EU member states, except Denmark. More specifically, trust in national governments fell from 4.6 in summer 2020 to 3.9 in spring 2021 for the EU as a whole; it also dropped in all member states except Denmark. In spring 2021, trust in the national government was highest in Denmark (7.0) and Finland (6.3) and lowest in Poland (2.1) and Croatia (2.5), while Slovenia (3.0) held the 7th-lowest position. Eurofound also found that countries with less trust in the national government are also those where there is greater vaccination hesitancy. A survey from 21 March 2021 shows data on hesitation to

become vaccinated (i.e. where the intention to take the COVID-19 vaccine was referred to as very unlikely or quite unlikely). In the EU-27 as a whole, hesitancy was declared by 28%; the lowest figures were seen in Denmark (8%) and Iceland (10%), the highest in Bulgaria (60%) and Latvia (48%), with Slovenia (42%) taking the 5th-lowest position.

The media

The media, as the 'fourth branch of government', also plays a significant role in dealing with social problems, particularly in terms of public opinion and individual attitude formation, also with respect to pandemic and vaccination. This section outlines some of the most characteristic inputs leading media establishments have contributed to the public discussion on management of the pandemic and specifically on vaccination. We also focus on how the media has treated individuals who were hesitant or even opposed to vaccination. We concentrate on the leading printed media, the Delo and Dnevnik newspapers, that have documented such references.

The media has reported that the population in Slovenia has been less receptive of COVID-19 vaccination than in most EU member states. According to national opinion polls, only 53% of respondents believed the benefits of vaccination outweigh the risks, as against 72% in the EU (Esih, 2021). Further, 57% of respondents were vaccinated, 12% were opposed to vaccination (declaring themselves to be strongly opposed to vaccination and that they would definitely not accept vaccination), while the rest (around 30%) were found to be hesitant. Among those opposed to vaccination, overrepresentation of the generation aged 36–45 years was reported, while other socio-demographic characteristics were not specific. Another survey identified the leading causes of vaccine hesitancy in the Slovenian population: personal health issues, lack of trust in the vaccine's safety, COVID-19 survival, vaccination is unnecessary, distrust in the institutions and in recommendations of the health authorities, rejecting vaccination in general (Knavs, 2021).

Vaccination hesitancy has become quite an issue in the media. Hesitant people were initially subject to only a limited and reticent discussion, while later discussions have intensified and in some instances even become offensive and denigratory (for instance, "The unbearable craziness of those anti-vaccination", Vesnaver, 2021). This was followed by a counter-attack by those opposed to vaccination and their advocates, including a distinguished physician and a constitutional legal expert.

The media has presented critical accounts of the anti-COVID-19 measures decided on by the government, especially their frequent changes, ambiguity, difficulties with implementation…. However, the media has also presented numerous contributions

of health experts repeatedly explaining the facts about vaccination, infection and the pandemic. Columnists and various social analysts also broadened the scope of the debate and the deliberation on relevant issues. They were often quite critical of the government's measures and highlighted the consequence of people rejecting the vaccination; for instance, headlines like "Distrust in government, distrust in vaccination" (Mastnak, 2021), "Action as the manifestation of two emotions – despair and powerlessness" (Lisjak Gabrijelčič, 2021). It should be added that the media also reported on the ongoing public gatherings and protests. Here, protesters requested the government to step down and allow for new parliamentary elections to be held, and also criticised particular decisions and measures, some of them dealing with the pandemic. Protesters have often claimed that the repressive anti-COVID-19 measures are farfetched and serve as a cover for the growing repression and authoritarianism.

Social media and the Internet have also played a significant role in shaping people's views on the pandemic and vaccination in Slovenia, where such forms of interaction are in wide use. Their inherent 'self-confirmation bias', i.e. whereby people search for and find only the views they initially held, social media and the Internet are often seen as the main media for disseminating anti-vaccination attitudes. According to Eurofound (2020), the rate of hesitancy in becoming vaccinated among people for whom social media is their primary news source is 40%, thereby significantly exceeding the 18% rate found among those who use traditional media as their primary source of news (press, television, radio).

Conceptual background: Framing

'Framing' is a well-established concept dealing with meaning-making and its communication and is broadly used across many social disciplines. While in sociology it is credited to E. Goffman's early work on communication, framing has grown and diversified after application in many disciplines, approaches and techniques, particularly in relation to qualitative inquiries. As already established by Goffman, several 'frames', rather than just one, are always at work in any social situation (Ranci, 2021). Most generally, framing refers to the manner in which a particular topic is seen and discussed (Parkinson et al,. 2026). Frames are tools that are used in communication to decide which elements of reality are selected and how are they organised to make sense of an issue, through a narrative. Framing is a process where individuals and groups come to understand and define a social situation in a specific manner and by attributing meaning to it. When examining people's attitudes to an issue, different approaches are in use while trying to explain why a particular frame was used and which factors affected it.

Several approaches emphasise a range of factors. Some authors stress the impact of the culture and thus framing is seen to be only partly a conscious process of an individual; it is their culture that possesses a repertoire of symbols and world-views, whose members can use it as a toolkit for giving meaning to various events and issues; when people frame a message, they connect a topic to notions that form part of this 'common ground' within a particular culture, such as values, archetypes and shared narratives (Van Gorp, & Vercruysse, 2012). The background is similar in interpretive anthropology, which seeks to explain social phenomena by placing them within "local frames of awareness" and focusing on "local knowledge" (Geertz, 2008).

The cognitive approach focuses on the cognitive processes and resources that impact how framing occurs. Emphasis is given to how cognitive resources (including chunks of memory, knowledge, images) are stored in the memory and can be recalled and mobilised to frame a situation (Dewulf et al., 2009). According to another approach (Lindenberg, 2001), the way a frame is configured depends on an individual's goal in a specific situation. Namely, three main types of operational frames are distinguished: the hedonic frame (serving the goal 'to feel better', e.g. instant gratification), the gain frame (serving the goal to increase one's resources like money, time etc.) and the normative frame (serving the goal to act appropriately and follow some higher values like helping the needy). Lindberg also distinguishes the master frame that dominates in a given situation from the background frames, which may come to dominate in other situations.

The interactional framing approach (van Eck et al., 2020) provides another perspective on framing and concentrates on the creation of frames in ongoing interactions. In the centre of attention here is the quality of arguments that emerge through the framing process. This interactional framing approach is most relevant for our analysis of views on vaccination because these views are created and shared in the context of an enflamed and polarised public discussion on vaccination, which has affected them. Our respondents were actually caught in the middle of a discursive fight between infuriated advocates of and opponents to vaccination.

The interactional perspective on framing considers the dynamic enactment of frames in ongoing interactions. The approach is concerned with how people deal with situations in which they are confronted with frames that are different from and even incompatible with their own frames (van Eck et al., 2020). As an analytical approach, it was developed to help examine the climate change debate underway between those concerned by and those denying human-driven global warming. The approach is chiefly occupied with identifying shifts and turning points that may occur in framing, leading to a new meaning emerging that is co-constructed. They distinguish three types: 1) Issue frame focuses on the very problem, with the meanings attached to being agenda items, events or problems in the relevant domain or context. An example of such framing in climate change debates is a specific

temperature rise, the adaptation of species etc.; 2) Identity/relationship frame: here, the meanings attached concern oneself and one's relationships with a counterpart(s') discussants, such as competences and knowledge or lack thereof. Most often it is about an opponent's limited competencies and lack of specific knowledge and information. This may take the form of negative labels like 'climate believers' or climate sceptics'; and 3.) Process frame: here, disputants assign meanings to their interaction process. Opponents are typically criticised for lacking understanding, undemocratic behaviour, and insufficient respect and attention.

Most importantly, van Eck et al. (2020) relate the occurrence of these types of frames with the outcome of the discussion. Is a specific type of frame likely to lead the discussant to converge or diverge in their views? Authors determine various outcomes. Frame incorporation/accommodation implies that a previously challenging element is incorporated/accommodated into the opponents' own issue framing. Frame disconnection occurs when the challenging element from the ongoing conversation is abandoned and omitted as irrelevant, unimportant, or the like. Frame polarisation happens when the difference is reaffirmed or even upgraded in the issue framing. Frame reconnection occurs when the elements representing incompatibility between discussants are taken away.

In their empirical study, van Eck et al. (2020) showed how the types of frames deployed during an ongoing debate impact the debate's outcome. They found that polarisation frequently occurred with identity and relationship and/or process framing. Namely, when users shifted to identity and relationship framing, they generally attributed a negative denotation to the other's identity. In addition, when users shifted to process framing, they frequently assigned interpretations to their ongoing interaction that the other user was solely criticising others or that their own words were misunderstood.

Their findings suggest that when users deploy identity/relationship and process framing, debates are more likely to further polarise the framing differences. On the other hand, frame incorporation and frame accommodation were shown to be mostly related to issue framing. The findings thus indicate that if discussants maintain issue framing throughout the entire interaction sequence they are more likely to solve the framing differences. The risk of frame polarisation is that the discussants keep reinforcing their own framing; instead of becoming able to resolve the framing differences, groups holding opposing views might only drift apart further.

Methods and data

The aim of this analysis is to shed light on the views and beliefs of people who are hesitant about taking COVID-19 vaccines, accounting for the specifics of the social context in Slovenia, including the prevailing critical accounts of unvaccinated people found in mainstream media. Besides general thoughts about COVID-19 vaccination, we wished to detect the full scope of issues of concern, worry and distrust that have yet to be comprehensively voiced in public. We also wanted to benefit from the interaction framing approach that allows for a more detailed examination of views, accounting for the types of frames used and an assessment of the cognitive and discursive potential for further convergence or, alternatively, divergence and polarisation in the understanding of vaccination.

Applying the interactional framing approach, the views expressed in interviews were examined with regard to the arguments/statements used. Arguments/statements were further classified as belonging to three types of frames:

1. issue frame (statements about the disease and vaccination);
2. identity frame (statements referring to characteristics of subjects/agents appearing in the social context of vaccination, such as politicians, scientist, media, members of one's own social support, self etc.); and
3. process frame (statements referring to the ways people's actions and views have been treated during the pandemic.

Accordingly, a simple qualitative analysis was performed to support the interactional framing approach. However, being aware of the effect that the interaction with us might have on the interviews, we were particularly cautious about how they were conducted. To ensure authentic views uncontaminated by the interview, the interviews were framed as follows. They were completely unstructured and initiated by a single question: How do you view vaccination against COVID-19? Any other questions would have interfered with their story and contaminated their cognitive frames. The interviews were carried out after the giving of prior consent and upon a clear agreement that they would share their views about vaccination, for a maximum of 30 minutes, without any further questions or even arguments on my part. The considerable public pressure at the time to undergo vaccination meant that an agreement of this nature was needed for recruiting the interviewees.

Interviews were conducted by telephone, limited to 30 minutes. The interviewing period was between July 15 and August 15, at a time when the epidemic was at a relatively low level and prior to the 4th wave being announced. Potential interviewees were selected from among a wide circle of direct and indirect acquaintances who the author knew they were not in favour of vaccination. Out of nine people

contacted, seven agreed to take part in an interview. As planned, the interviewees were very mixed, coming from different regions and urban settlements, residents of five towns and three regions. Except for two, these people were not connected and hence were not members of the same social network (formal or informal) or discussion group that could influence each other. The interviewees thus represent a set of fairly independent points of observation.

The interviewees are a heterogeneous group according to basic demographic and socio-economic criteria and were fairly representative, at least in the sense that substantial overrepresentation of any particular characteristics was avoided. Three of the interviewees were female and four were male. By age group, one person was 20–29 years, one was 30–39 years, three were 50–59, one was 60–69 years and one was 70–79. Occupation ranged from unemployed (two), employed (three – an accountant, a teacher, and a private plumber) and retired (two). Education level ranged from secondary school (two), higher education (one) to university degree (three) and master's degree (one). Namely, the collection of interviewees was intentionally extremely varied to compensate for its small size. In addition, two curiosities detected among the interviewees should be mentioned. There was already one sufferer of COVID-19 ("as easy as the flu") and someone who had already been vaccinated against COVID-19 (but was regretting it).

Results

Handwritten records of the interviews provided us with the original interviewees' accounts and narratives. However, their lines of reasoning had to be broken down into individual statements, views and claims to allow them to be classified according to the types of framework they served, where some arguments were grouped together for the sake of clarity. The results are presented schematically and listed below.

Issue framing

1. Criticism of the COVID-19 vaccine: it has not been sufficiently tested/is only experimental/when it enters your body it is like a car on top of a hill but without brakes and a steering wheel/it changes your genetic code.
2. Negative effects of COVID-19 vaccination:

   - Worldwide: "because of it, 7,800 people have died/a number of people died because of it/I have heard that down there around Israel 2 million people or something like that died"
   - Among acquaintances: a person has nightmares after getting vaccinated/a person remained weak for a long time
   - Own negative experience: for a number of days a high temperature, headache, cramp, vomiting, very poor condition for a few months (breathless, cramps in the jaw, psychological problems like 'not feeling yourself'; regrets for having taking the vaccine following pressure of the employer; never felt that the vaccine offered any protection
3. Negative effects of other vaccinations
   - own negative consequences of having received the 'live vaccine' against early childhood diseases; suffered serious medical problems
   - own negative consequences of having been vaccinated against 'variola vera' while serving in the army; had a very bad reaction and could have died.
   - relative's negative experience when he received a flu vaccine for the first time in life yet in that year suffered the flu for the only time in life.
4. Counter-indication for vaccination against COVID-19: due to prior thrombosis, was advised against it/a previous oncological patient understood that doctors have suggested that he not become vaccinated
5. Examples: "in hospital Y, a number of medical staff got injected with physiological liquid, not the vaccine, just to obtain the certificate for having been vaccinated"/"in hospital XY, neither the doctors nor the nurses wanted to be vaccinated"/"my dentist also did not want to get vaccinated".
6. Better alternatives to vaccination: "we become immune through our own antibodies"/"blood cells achieve a balance by themselves"/"everyone is responsible for their own health"/"the solution is robotisation + virtualisation + digitalisation + crypto-valorisation of values"/"I would accept being vaccinated if they guarantee that I will get compensation if they damage my health".

Identity framing

1. Own characteristics:
   - In possession of special information and resources: "my masseur told me that he had heard from doctors, that…"/"one guy, who fixes machines in hospitals, was told there…"/"you can find this on the Internet"/"you can read it there"/"there are lots of negative effects of vaccination, they said so on British TV"/"I started following and reading various sources, one would go crazy if limited to the mainstream media".

- Knows the truth and the background: "The truth is that mRNA can encrypt itself into genes, it has the ability to encode itself back into the nucleus"/"I am surprised to see the best educated people so willing to be used as laboratory test rabbits"/"but we know there is big pharmaceutic industry with its appetites in the background"/"so why then do they want you to sign that you are solely responsible?"/"it is all only about money"/"everything is prepared in advance, like with computer viruses, they first make the virus and afterwards sell the cure"/"I opened my eyes and see through them, they are making just a show, a puppet theatre, a bluff".
- 'Conspiracy uncovered': "all of this is a global conspiracy, everything is going the way it was planned, that by 2025 everything is finished and the whole world is frightened; when a person is scared it is easy to manipulate them, they will bend, it is easy to be lead … these vaccinated people are marked, metal items remain stuck to their arms"/"I do not believe in conspiracy, but do believe that politicians took the huge advantage and opportunity to gain in material and political power".
- Firmness of one's own beliefs: "I have heard that some vaccines are better than others, but nobody can talk me into any of them"/"I will never take the vaccine, unless they come for me with a gun, so it would be a must, not before then"/"nobody can convince me that vaccination is of any help, I am not joining in this game".
- Fear: "to be honest, I admit I am scared of getting vaccinated …. There was so much negligence in vaccination in the past and even today".

2. Characteristics of the other side:
   - "they will never guess the right strand of the mutating virus, just like they don't guess it with the flu vaccination"/"they don't know themselves what are they doing; one time they say one thing, later they say something different"/"there is so much dirt here, I don't believe anything that these sold souls say"/ "in hospitals they get money for every person they declare to have COVID-19".

Process framing

"They shouldn't be taking our freedom away"/"when they call us to come for vaccination, they expect that we will sacrifice ourselves for the community, as if we are some national heroes"/"They have closed and shut us down, scared us, all of this is about frightening us; this is the biggest danger that society becomes filled with fear"/"This obsession in Slovenia, such obsession and indoctrination as in Slovenia cannot be

found anywhere else"/"It is not right that they blame us for not being responsible towards others; I will not infect anyone, I am healthy, others only can infect me".

Discussion and conclusions

A small, but mixed group of interviewees provided several reasons for not being in favour of COVID-19 vaccination. With regard to COVID-19 and vaccination, the arguments stated are mostly already known and discussed in the media, typically that the vaccine is not needed/safe/effective/counter-indications for health reasons/ trust in one's own immunity system. Relatively less known and publicly discussed are examples of non-vaccination among medical staff and harmful experiences of taking vaccine in the past (live vaccine against early childhood disease and against Variola vera in 1972). The scope of arguments surrounding the COVID-19 issue can fit into a framework schematically defined by two points: on one side, there is a huge and immediate danger of vaccination, while on the other there is the smaller and more distant potential danger of becoming ill with COVID-19. This is quite in line with the explanation of a medical expert (Pokorn, 2021) who argued that perhaps in the background of most arguments opposing vaccination there lies only a childish fear, meaning people are more afraid of vaccination than of COVID-19.

A number of arguments were identified that fit into identity framing. These arguments are assigning meaning to subjects and agents that are active with regard to vaccination. These subjects basically appeared bluntly split between "me"/"us" (unvaccinated people) and "them", referring to authorities with power and to all those who decide on and enforce the anti- COVID-19 measures. It was surprising how all of them were referred to as 'they' – undiversified, without any more specific labels like government, ministers, health authorities etc., except for 'politicians' in a couple of instances. The characteristics attributed to that side are critical without exception and imply various negative characteristics that range from a lack of competency ("they don't know what are they doing") to profit-seeking ('sold souls') and being part of a conspiracy against people. On the other hand, the identity-related arguments the interviewees voiced about themselves very often imply being in possession of special, exclusive knowledge and information, which they acquired from rare personal sources (close to medical circles) or special media (the Internet). These arguments indicate how significant this issue has been for them and how much effort they have invested to obtain information they deem to be proper, true, reliable and sincere.

Finally, several arguments were also detected for the third type of framing – process framing. These arguments refer to the relationship between the authorities

("them") and those opposed to vaccination or ordinary people generally. According to the interviewees, this relation is seen as unacceptable for a democratic society – as sheer power ("they locked us down", "they are scaring us", "they shouldn't be taking our freedom away"). These arguments indicate that there is a power relationship whereby the interviewees or "us" are unreasonably overpowered by "them". The power relationship is thus seen as clear domination, 'power over', and not in terms of 'power with' (Kreisberg, 1992), as empowerment and mutual collaboration to achieve the common goal of fighting the pandemic. This is also in line with the traditionally low trust in authorities. These findings correspond to the accounts of unsuccessful management of the pandemic, the prevailing top-down confrontational style where governmental measures have mostly been seen as acts of force, intimidation and threats to the people. The government's decision-making style has been far from a consensus-based collaborative and dialogical approach that would provide greater legitimacy to the measures and their acceptance by the people. The despair, powerlessness and anger voiced in the interviews reflect the extent to which the distrust in the authorities has grown. As noted in a reader's letter (Korošak, 2021), "from politics that is arrogant, offends and intimidates people, lies to people and cheats them, people do not want to receive anything". The intensity of the emotions revealed also indicates how polarised and emotional was the main public discussion of vaccination issues. While people could voice and express their position at public protests and on social media in quite a polarised way, there were insufficient venues for any more thoughtful deliberation and exchanges of views with others.

Considering the occurrence of all three types of framing in our interviews, we may draw a conclusion in line with the interactional framing theory. Namely, the strong presence of identity and process framing shows how divergent, contrasting and even conflicting are the views on the two sides – the authorities with their harsh and disrespectful addressing of the public, and those who are hesitant to become vaccinated. Moreover, taking the possible predictive capacity of the interactional framing approach into account, one may assume that this polarisation is set to expand alongside the growing distrust in the government.

However, surprising and worth mentioning are also the issues not expressed in the narrative of non-vaccination. More precisely, these elements did not enter into the master frame of non-vaccination, but very likely remained only in the background. What we found missing were concepts related to other social groups, the common good, and to the community. COVID-19 and vaccination were largely seen as an issue for the individual, while the pandemic – primarily a collective social problem – was neither recognised nor mentioned. No relationship was established with community activity, with concerns and pay-offs for the community and for the common good.

While this absence of community from the vaccination narratives in our interviews is certainly a challenge for further analysis, in conclusion we wish to draw

attention to some points. Verčič (as cited in Bandur, 2021), a mainstream commentator, maintains that countering vaccination "represents a form of denial of community, a morally intolerable action". Unlike this opinion where the lack of a community orientation is assigned to individuals, we believe many features of the social context play a significant role in creating and sustaining this attitude. This includes the only weak articulation of the common good and public interest in public policies ever since the country's transition (Filipovič et al., 2005), together with the undeveloped forms of participatory and deliberative democracy and community practices.

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4 THE SECOND WAVE OF THE COVID-19 EPIDEMIC IN SLOVENIA: STRESSORS AND COPING WITH COVID-19-RELATED DISTRESS

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Abstract

The COVID-19 pandemic has transformed modern societies with the threats its poses as well as the government-imposed restrictions on social life aimed at containing the disease. The pandemic is responsible for various impacts on individuals with regard to practical changes in everyday life, economic destabilisation, ambivalent information etc. In this chapter, we explore how stressors (related to health, the work sphere, social relationships, state measures, the general situation) have impacted perceived distress and coping with the COVID-19 challenges in the second wave of the COVID-19 epidemic in Slovenia. Participants in the second wave of the COVID-19 epidemic on average were experiencing moderately intense distress and were coping with it moderately successfully. Stressors related to social relations and societal situations were assessed as the most burdensome, followed by health-related stressors, working changes, and lastly loss of work/income. The results indicate that stressors explain most of the variance of distress and coping perceptions, whereas the control variables, encompassing demographic variables as well as being ill with COVID-19, have very little impact. Psychological inflexibility and social support make a minor contribution to perceived distress and coping beyond the stressors and the controls.

Keywords: COVID-19, pandemic, distress, stressors, coping, psychological inflexibility, social support

Introduction

The global outbreak of the coronavirus SARS-CoV-2 and its disease COVID-19 is a disaster unlike any other in recent human history. The World Health Organisation declared the outbreak of COVID-19 a pandemic on 11 March 2020 (World Health Organization, 2020). In Slovenia, the first wave of the epidemic occurred between 12 March and 31 May 2020 and wave two between 19 October 2020 and 15 June 2021. During the period of field work to collect the data used in this manuscript (November 2020 – January 2021), daily reported new cases and deaths were high, for example: numbers of reported new daily COVID-19 positive test results (from 1342 to 3512 between November 2020 and January 2021) and deaths per day (25 to 66 in this period) were high (Sledilnik.org – Slovenia COVID-19 Data Collection); lockdown policies were very strict (e.g. non-essential shops were closed as were

educational institutions, services and public transport, curfew, restricted movement within one's municipality, obligation to wear masks outdoors etc.) and constantly changing. However, certain economic measures were applied at the same time to mitigate the loss of residents' income.

The COVID-19 pandemic has the characteristics of a mass crisis with multiple and enduring stressors: potential illness and even loss of life (one's own and that of loved ones), economic destabilisation, social isolation and loneliness, lifestyle changes (e.g. in the areas of work and leisure, coordination of medical and childcare, restricted movement), limited access to different kinds of support (medical treatment, religious support, different services etc.), unpredictability, uncertainty, loss of control, and the ambiguity of information. COVID-19-related stressors have been categorised, in several ways, in attempts to develop comprehensive instruments for measuring stressor exposure and/or stressfulness, e.g. such as infection, activity and financial stressors (Park et al., 2020), infection fear, economic, grief and lockdown stressors (Kira et al., 2020) or infection-related, daily activity, and financial/resource-related stressors (Tambling et al., 2021).

These challenging circumstances can add to levels of psychological distress. Psychological distress has been defined as a state of emotional suffering associated with stressors that are difficult to cope with in daily life and can impact one's level of functioning (Arvidsdotter et al., 2016; Ridner, 2004). Psychological distress can be reflected in symptoms of depression and anxiety, coexisting with common somatic complaints as well as medically unexplained syndromes (Arvidsdotter et al., 2016; Qiu et al., 2020). In Lazarus and Folkman's (1984) transactional model of stress and coping, it is not exposure to stressor(s) but individuals' perception, or appraisal, of a stressor(s) that determines the impacts they may experience. Individuals' psychosocial resources and coping responses lessen their subjective appraisal of stressor intensity. Further, perceived stressfulness is a significant determinant of long-term mental health outcomes.

The negative consequences of the COVID-19 crisis for psychological functioning and well-being in the general public around the world and also in specific population groups have already been demonstrated by many studies, not only individual studies but also systematic reviews. Most of the currently available data, even longitudinal, stem from the early months of the pandemic. The majority of reviews show the pandemic has increased levels of psychological distress, lowered well-being and led to an upsurge of mental health problems (Clemente-Suárez et al., 2021; de Sousa Júnior et al., 2021; Cooke et al., 2020; Luo et al., 2020; Rajkumar, 2020; Salari et al. 2020; Şimşir et al., 2021; Vindegaard & Benros, 2020; Wu et al., 2021). Also worth mentioning is the Gloster et al. (2020) study with a sample of almost 10,000 respondents from 78 countries. This study found that the pandemic had been experienced as at least moderately stressful for most of those surveyed and simultaneously the well-being of the majority had decreased, with more than one-tenth reporting very high levels of

stress and mental health difficulties. Some authors (e.g. Kira, 2021; Yuan et al., 2021) even suggest that COVID-19's cumulative and continuous impact may entail a one-off trauma not currently accounted for in the dominant traumatic stress paradigms.

Stressful and potentially traumatic events raise the issue of short- and long-term psychological adjustment, which is related to individuals' resilience (Bonanno et al., 2008; Bonanno et al., 2010). The American Psychological Association (2012) defines resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress", whereby this process is very complex. Resilience is not simply a personal trait or outcome; it is "a process of harnessing biological, psychosocial, structural and cultural resources to sustain well-being" (Panter-Brick & Leckman, 2013, p. 335). Hence, resilience is determined by numerous factors found on multiple levels that intertwine with each other: individual (biological, psychological), interpersonal and socio-cultural, strengthening or reducing the negative effects of stressors on psychological distress and mental health issues (e.g., Reed et al., 2012; Southwick et al., 2014). Many factors predicting how resiliently people respond to adverse events or stressors are fluid – they are likely to change over time (Bonanno & Diminich, 2012). Greater psychological resilience was shown to be positively associated with the individual's psychological well-being/distress during the COVID-19 pandemic (Chen & Bonanno, 2020; Coulombe et al., 2021; Kavčič et al., 2021b; Zager Kocjan et al., 2021b). The level at which exposure to pandemic-related stressors brings psychological distress and mental health problems vs. a resilient, healthy adjustment varies and depends on several risk and protective factors (Chen & Bonanno, 2020; Coulombe et al., 2020; Lenzo et al., 2020; Oryan et al., 2021; Panzeri et al., 2021).

An obvious set of factors likely to inform psychological outcomes are socio-demographic variables. Studies demonstrate that specific population groups are at higher risk for psychological distress and other negative mental health outcomes, e.g. older and younger adults; women; the unemployed or people with a low socio-economic position; people in occupations with frequent and direct contact with people, especially COVID-19 patients, such as frontline healthcare workers; minority and migration status; single parents (e.g. Rahman et al., 2020; Casagrande et al., 2020; Kavčič et al., 2021a; Losada-Baltar et al., 2020; Oryan et al., 2021; Pearman et al., 2021; van Dorn et al., 2020; Qiu et al., 2020).

A pandemic's psychological impact on individuals also varies according to their intrapersonal psychological characteristics. Especially people with a prior history of adversity and resulting lower self-regulation capabilities and/or mental health conditions have a greater risk of encountering considerable distress particularly in new challenges (e.g., Rahman et al., 2020; Kolacz et al., 2020; Shanahan et al., 2020). Personality traits like neuroticism (Zager Kocjan et al., 2021b) and compulsivity (Hampshire et al., 2021) can also predict less adaptive psychological functioning.

Among risk factors for a higher likelihood of pandemic-related distress and poor coping at the personal psychological level, we highlight psychological inflexibility because it was defined as a transdiagnostic process associated with the presence of stress, worry as well as a wide range of psychopathologies (Levin et al., 2014; Nolen-Hoeksema et al., 2008; Tavakoli et al., 2019; Wersebe et al., 2018). Furthermore, it can be modified by different interventions, across diagnoses and other forms of poorer psychological functioning (Levin et al., 2014). Psychological inflexibility entails experiential avoidance of undesirable experiences, thoughts, feelings, and situations, and/or a tendency towards rigid and inflexible psychological or behavioural strategies, including dysfunctional coping strategies, such as behavioural disengagement, denial, excessive substance use, rumination about situations associated with distress, leading to a lower likelihood of taking values-based actions (Hayes et al., 1996). Experiential avoidance and rigid strategies were shown to be related to less adaptive psychological functioning following adverse life events (e.g. Orcutt, Pickett, & Pope, 2005; Marx & Sloan, 2002; Plumb et al., 2004). Psychological inflexibility was demonstrated to exacerbate the negative psychological effects of the COVID-19 pandemic (Arslan et al., 2020; Crasta et al., 2020; Dawson & Golijani-Moghaddam, 2020; Hernández-López et al., 2021; Kroska et al., 2020; Pakenham et al., 2020; Smith et al., 2020).

In addition to socio-demographic and intrapersonal individual risk and/or protective factors, a pandemic's psychological impact on individuals varies with respect to their interpersonal resources, such as supportive and caring relationships in one's social network (Tindle & Moustafa, 2021). The amount to which people believe others are available for them and care about their needs is referred to as social support (Kogovšek & Hlebec, 2009). The perception of social support depends on a person's unique stable patterns of perceiving themself, significant others, and relational expectations in general. It reflects the broad sense of support and is relatively stable over time (Sarason et al., 1994, pp. 93–95). The size of supportive networks should function such that, all things being equal, large networks hold several advantages over smaller ones. In large networks, it is easier to reach support, individual relationships are, in principle, under less strain regarding demands for support, they contain members with specific expertise, and potentially provide a wider perspective on a given problem as well as relevant information. Large networks are generally more likely to be able to meet a range of support needs (Vaux, 1988, pp. 50–60). However, the sheer size of a network, without a thorough examination of its composition, density, other characteristics, and actual supportive behaviour, is unlikely to automatically predict the described outcomes, making its empirical application limited. Methodological examinations of several measurement approaches show that the enumeration of network sources can provide a relatively good estimate of network composition (Kogovšek & Hlebec, 2008; 2009).

The perceived availability of social support from one's family, friends, colleagues and neighbours not only plays a key role in well-being (e.g. Sarason et al., 1994; Vaux, 1988; Cohen & Wills, 1985) but, according to the buffering model (Cohen & Wills, 1985; also see Field & Schuldberg, 2011), can also protect against the potentially adverse effects of stressful events. The protective role of social support for psychological functioning is especially emphasised during times of crisis (Chan et al., 2015; Pietrzak et al., 2014), and vice versa, psychological symptoms following disasters are intensified by a lack of social support (Wang et al., 2018). Several studies (e.g. Bonanno et al., 2010; Saltzman et al., 2018; Sippel et al., 2015; Xu & Ou, 2014) report that social support promotes resilience following exposure to adversity. These conclusions are supported by neurobiological findings showing that social connections can inhibit threat responses and promote affiliative safety states (Kolacz et al., 2020). Evidence for the buffering hypothesis primarily arose from the assessment of the availability of close relationships, rather than assessing the number of available social support providers (Cohen & Wills, 1985). Moreover, factors like type of stress, life domain, the characteristics of stressful situations themselves, and self-esteem predict the buffering effects of social support (see Cutrona & Russell, 1990).

In the ongoing pandemic, the main preventive measures and/or individual decisions taken to reduce COVID-19's spread include distancing, quarantine and isolation, thereby potentially limiting people's access to social support. Nonetheless, the COVID-19 pandemic is also characterised by the widened access to technology that enables individuals to connect (Saltzman et al., 2020). Perceptions of social support have been found to be strongly associated with lower psychological distress during the pandemic (Grey et al., 2020; Margetić et al., 2021; Yu et al., 2020; Zysberg & Zisberg, 2020).

In the present study, we explore the extent to which epidemic-related stressors (related to health, work domain, social relationships, governmental actions, general situation) predict overall subjective perceptions of epidemic-related distress[1] and coping with distress[2] among adult Slovenians during the COVID-19 epidemic's second wave, including the perception of the distress in wave two compared wave one and the pre-pandemic period. Since subjective assessments of the intensity of their epidemic-related distress and coping with distress are expected to vary with regard to their socio-demographic and psychosocial characteristics, in the current analysis we focus on selected socio-demographic factors, psychological inflexibility as a potential

1 The survey asked for an appraisal of *distress* (*stiska* in the Slovenian language), but without giving a definition of this notion. Distress may be understood as a subjective experience of stress, anxiety, powerlesness etc. which is a response to threatening or unfavourable circumstances or situations. The closest term found in the literature is psychological distress (e.g. Arvidsdotter et al., 2016).

2 Some of coping theory's pioneers, Lazarus and Folkman (1984), defined coping as constantly changing cognitive and behavioural efforts to manage specific external and internal pressures that are assessed as demanding or exceeding the individual's resources.

risk factor, and the number of support sources as a potential protective factor. We expect psychological inflexibility and number of support sources are significantly associated with the perceived epidemic-related distress and coping with distress over and above the socio-demographic factors, being ill with COVID-19 (oneself and/or close ones), and epidemic-related stressors. At the same time, we assume that the perception of stressors remain significant even when psychological inflexibility and the number of support sources are added to the model.

Methods

Survey data were collected online between November 2020 and January 2021 (3 December 2020 to 4 January 2021) as part of the Action framework to offer psychological support during the COVID-19 epidemic (in Slovenian: *Akcijski načrt za izvajanje psihološke pomoči v razmerah epidemije*) by the National Institute of Public Health. The study was carried out as part of the activities of monitoring and analysing data coordinated by the Slovenian Psychological Association[3]. The study's main purpose was to investigate the psychological distress of residents of Slovenia and how they had been coping with their distress, as well as which sources of psychosocial support people had available and/or desired. Invitations to participate were posted on the websites of various organisations, individuals, social media and included in emails and web newsletters. Recruitment of participants was facilitated by a range of organisations in fields education, social and health care. Use of these nonprobability sampling strategies means the targeted and realised sample is not statistically representative. The sampling bias results in a large share of women, higher educated and younger respondents. While in total there were 3,556 respondents, only 3,138 completed the questionnaire. The study was approved by the Committee for Ethics in Research at the Faculty of Arts, University of Ljubljana (no. 212-2020, approved 10 December 2020). The study was led by Patricija Kerč, Nina Krohne, Dr. Tanja Šraj Lebar and Mateja Štirn MSc.

In this study, as dependent variables we considered four items assessing both the level of distress brought by the COVID-19 pandemic and the level of coping with the distress. The variables were modelled in four hierarchical regression models aimed at establishing the total amount of variance explained by the dependent variables as well as the contribution of four distinct blocks of variables (i.e. control variables – demography, four stressors, psychological inflexibility and social support).

[3] Participating organisations: University of Ljubljana, Faculty of Arts, Department of Psychology; University of Koper, Andrej Marušič Institute, Department of Technology, Department of Mathematics, Department of Information Science and Technologies, Department of Psychology.

The variables and their values are shown in Table 1. Stressors were Likert indexes for numerous individual items, as outlined in Table 1. The indexes were constructed based on the dimension reduction factor analysis presented in the Results section.

Table 1

Variables in the regression analysis

Construct Variable names in the model	Variables and answers/value labels
Distress	
	How much distress you been feeling during the second wave of the COVID-19 epidemic? Values: 0 - none, 1 – very little, ..., 4 – moderately, ..., 7 – very much.
	How much distress you been feeling during the COVID-19 pandemic compared to the time before it? Values: 1 – much less, …, 4 v the same, ..., 7 – much more.
	How much distress have you felt during the second wave of the COVID-19 epidemic compared to the first wave (March–May 2020)? Values: 1 – much less, ..., 4 – the same, ..., 7 – much more.
	How successfully have you been coping with your distress so far during the second wave of the COVID-19 epidemic? Values: 1 very unsuccessfully, …, 4 moderately successfully, …, 7 very successfully.
Control var.	
Gender	Gender. Values: 0 – Male and 1 – Female.
Age	Age measured in years.
Education	Education. Answers: Elementary school or less, Vocational school (2- or 3-year vocational school), Four-year high school, Institution of higher education, college or first Bologna degree, University education (previous) or second Bologna degree, Master of Science or PhD. In the analysis we used two recoded values: 0 – High school at most, 1 – Higher education at least.
Having school-age children	Do you have any school-age children? Values: 0 – No and 1 – Yes.

Living environment	The environment in which you live. Values: 0 – Rural, 1 – Urban and 2 – Other. Most of the answers under Other were recoded, following a substantive assessment, as 0 or 1.
Been ill with COVID-19	Have you been ill with COVID-19? Values: 0 – No and 1 – Yes.
Close ones been ill with COVID-19	Have any of your close ones been ill with COVID-19? Values: 0 – No and 1 – Yes.
Stressors	
Loss of work/income	Please indicate which problems have been burdening you, and to what extent, during the COVID-19 epidemic. Variables used as a proxy for Loss of work/ income, rated by the participants were: Concerns about declining revenues and material security, Fear of losing one's job/student job, Unemployment, Not feeling that my work is beneficial and contributes to society and Moving to a shared household due to loss of income. Answers were on a 7-point scale with the following values: 0 – does not apply for me, 1 – very little, …, 4 – moderately, …, and 7 – very much.
Working changes	Please indicate which problems have been burdening you, and to what extent, during the COVID-19 epidemic. Variables used as a proxy for Working changes, rated by the participants were: Changed scope of work, Work in stressful circumstances, Performing work remotely, Poorer interpersonal relationships at work, and Coordination of work and family responsibilities. Answers were on a 7-point scale with the following values: 0 – does not apply for me, 1 – very little, …, 4 – moderately, …, and 7 – very much.
Health	Please indicate which problems have been burdening you, and to what extent, during the COVID-19 epidemic. Variables used as a proxy for Health, rated by the participants were: Health issues, Fear that I will contract COVID-19, and Fear that my close ones will contract COVID-19. Answers were on a 7-point scale with the following values: 0 – does not apply for me, 1 – very little, …, 4 – moderately, …, and 7 – very much.

Social relations and societal situation	Please indicate which problems have been burdening you, and to what extent, during the COVID-19 epidemic. Variables used as a proxy for Social relations and the societal situation, rated by the participants were: Distress due to isolation, Fear of an uncertain future, Separation from family members, Poorer interpersonal relationships in private life, Fear of breaching ordinances, and Fear of freedoms being lost/restricted. Answers were on a 7-point scale with the following values: 0 – does not apply for me, 1 – very little, …, 4 – moderately, …, and 7 – very much.
Psychological inflexibility	
Psychological inflexibility	Below you will find a list of statements. Please rate how true each statement is for you IN GENERAL and not just during the epidemic and mark it on the scale. The Acceptance and Action Questionnaire – II (The AAQ–II; Bond et al., 20111) was used which is a general self-report measure of experiential avoidance and psychological inflexibility. Answers were on a 7-point scale with the following values labelled: 1 – Never true, 2 – Very rarely true, 3 – Rarely true, 4 – Sometimes true, 5 – Often true, 6 – Almost always true, 7 – Always true. The items were translated into Slovene by Hlavs (2017 & Baković, 2019); Baković (2019) tested this measuring instrument and reports acceptable psychometric characteristics. The internal consistency for the present sample was excellent (Cronbach's alpha = 0.911).
Psychological support	
Number of support sources	Who in your social network can you turn to for support in times of distress? You may choose multiple answers. Answers: To family members, To friends, neighbours or acquaintances, To co-workers, I prefer to rely on myself, I don't have anyone to turn to, Other (specify to whom). The calculated number of support sources was from 0–4.

Results

The characteristics of the realised sample are presented in Table 2. The sample comprises 83.2% female and 16.8% male respondents, the age span is between 18 and 86 years; 40.5% of the respondents are aged between 35 and 50 years, with 32.9% younger and 26.5% older. Further, 77.7% had at least a higher education, 29.7% had children while 43.5% were living in rural areas while 56.5% in urban areas.

While only 9.3% had themselves been ill with COVID-19, 33.8% reported that a person close to them had been ill with COVID-19. The realised sample is therefore somewhat biased towards well-educated women of mostly working age. The purpose of the statistical analysis is not to infer to the entire population of Slovenia, but to gain insights into the driving forces of distress and coping with it during the second wave of the epidemic.

Table 2

Sample characteristics

Variables	Sample characteristics		
		f	%
Gender	Male	616	16.8
	Female	3043	83.2
	Total	3662	100.0
Age	< 35	1,208	32.9
	35–50	1485	40.6
	> 50	969	26.5
	Total	3662	100.0
Education	High school at most	817	22.3
	Higher education at least	2850	77.7
	Total	3667	100.0
Have school-age children?	No	2576	70.3
	Yes	1091	29.7
	Total	3667	100.0
Living environment	Urban	2070	56.5
	Rural	1595	43.5
	Total	3665	100.0
Been ill with COVID-19?	No	2897	79.0
	Yes	342	9.3
	Total	3239	88.3
Some close ones been ill with COVID-19?	No	2,001	54.6
	Yes	1238	33.8
	Total	3239	88.4

The descriptive distributions of dependent variables are presented in Tables 3–6. During the second wave of the COVID-19 epidemic, just 61.4% of respondents felt distress only moderately to very little or not at all, 38.6% felt distress, 8.7% even to a considerable extent. Only 27.5% had felt much less to about the same distress during the COVID-19 pandemic compared to the time before it; 72.5% felt more distress than before the COVID-19 pandemic. Further, 44.3% felt less to about the same distress during the second wave of the COVID-19 epidemic compared to the first wave (March–May 2020) and 55.7% felt greater distress the second time around. Having at least moderately coped with distress in the COVID-19 epidemic's second wave was reported by 44.3%, with 55.7% feeling that they had coped well to very well.

Table 3

How much distress have you been feeling during the COVID-19 epidemic's second wave?

	f	valid %	*cp %*
0 none	205	5.6	5.6
1 very little	460	12.5	18.1
2	289	7.9	26.0
3	356	9.7	35.7
4 moderately	942	25.7	61.4
5	723	19.7	81.1
6	373	10.2	91.3
7 very much	319	8.7	100.0
Total	3667	100.0	

Table 4

How much distress have you felt during the COVID-19 pandemic compared to the time before it?

	f	valid %	*cp %*
1 much less	135	3.7	3.7
2	160	4.4	8.1
3	177	4.8	12.9
4 the same	534	14.6	27.5
5	1053	28.7	56.2
6	769	21.0	77.2
7 much more	839	22.9	100.1
Total	3667	100.1	

Table 5

How much distress have you been feeling during the COVID-19 epidemic's second wave compared to the first wave (March–May 2020)?

	f	valid %	*cp %*
1 much less	237	6.5	6.5
2	258	7.0	13.5
3	453	12.4	25.9
4 the same	674	18.4	44.3
5	796	21.7	66.0
6	665	18.1	84.1
7 much more	584	15.9	100.0
Total	3667	100.0	

Table 6

How successfully have you been coping with your distress so far during the second wave of the COVID-19 epidemic?

	f	valid %	*cp %*
1 very unsuccessfully	87	2.5	2.5
2	126	3.6	6.1
3	268	7.7	13.8
4 moderately successfully	1030	29.8	43.6
5	782	22.6	66.2
6	795	23.0	89.2
7 very successfully	373	10.8	100.0
Total	3461	100.0	

Stressors were calculated as Likert indexes and represent the average value of the items covered by each factor. The composition of the indexes was determined by factor analysis of 19 variables (principal axis extraction, Oblimin rotation). Results of the factor analysis are presented in Table 7. Among the stressors posed to participants, some were rated quite low with mean values around 2 (on the 0–7 continuum), with the lowest rated being fear of moving to a shared household due to loss of income with a mean value of 0.80 (*SD* = 1.8), and unemployment with a mean value of 1.47 (*SD* = 2.3). Health fears were not as strong for respondents themselves (fear

of contracting COVID-19 M = 2.4, SD = 2.1) than for their close ones (fear that someone close would contract COVID-19 M = 4.2, SD = 2.2). Fears or distresses rated higher concerned losing freedom (M = 4.0, SD = 2.7), uncertain future (M = 4.0, SD = 2.3), separation from family members (M = 3.6, SD = 2.5), changed scope of work (M = 3.5, SD = 2.5), working under stressful circumstances (M = 3.5, SD = 2.5), and isolation (M = 3.5, SD = 2.4). Factor analysis revealed four dimensions labelled as: loss of work/income-related stressor, working changes-related stressor, health-related stressor, and social relations and societal situation-related stressor.

Mean values and standard deviations of the main independent and dependent variables, followed by bivariate Pearson correlation coefficients are presented in Table 8. Most correlations are low, with a few exceptions. Loss of work/income, working changes and health-related stressors are moderately correlated with the perception of distress in the second wave of the epidemic vs. prior to the pandemic (r = .38; .49; .35); social relations and societal situation-related stressor is strongly correlated with this distress (r = .65). Psychological inflexibility is moderately correlated with the perception of distress in the second wave of the epidemic vs. prior to the pandemic (r = .38), and with coping (r = .36). The perception of distress during the second wave is strongly correlated with the perception of distress before the pandemic (r = .63) and with the perception of distress during the first wave (r = .56).

Table 7

Descriptive statistics and factor loadings from the factor analysis

	Descriptive statistics		Factors and factor loadings			
	M	*SD*	Loss of work / income	Working changes	Health	Social relations and societal situation
Health issues	2.0	2.0			.32	
Fear that I will contract Covid-19	2.4	2.1			.87	
Fear that my close ones will contract Covid-19	4.2	2.2			.74	
Distress due to isolation	3.5	2.4				–.79
Fear of an uncertain future	4.0	2.3				–.54
Separation from family members	3.6	2.5				–.46
Changed scope of work	3.5	2.5		.73		
Work in stressful circumstances	3.5	2.5		.90		
Performing work remotely	2.7	2.5		.65		
Concerns about declining income and material security	2.9	2.5	.68			
Fear of losing a job/student job	1.8	2.4	.81			
Unemployment	1.5	2.3	.89			
Lack of perception that my work is beneficial and contributes to society	2.3	2.4	.45			
Moving to a shared household due to loss of income	.8	1.8	.56			
Poorer interpersonal relationships in private life	2.1	2.3				–.34
Poorer interpersonal relationships at work	1.6	2.1		.38		
Coordination of work and family responsibilities	2.2	2.6		.53		
Fear of breaching ordinances	2.3	2.3				–.52
Fear of freedoms being lost/ restricted	4.0	2.7				–.78

Notes. Extraction Method: Principal Axis Factoring; Rotation Method: Oblimin with Kaiser Normalisation; $N = 3667$.

Table 8

Descriptive statistics and correlations between variables

	M	*SD*	1	2	3	4	5	6	7	8	9	10
Loss of work/ income	1.9	1.8		.35**	.23**	.57**		–.14***	.25**	.38**	.25**	–.25**
Working changes	2.7	1.8			.24**	.46**		0.04***	.35**	.49**	.30**	–.23**
Health	2.9	1.6				.34**	.27**	–.04***	.24**	.35**	.21**	–.17**
Social relations and societal situation	3.2	1.7						–.08***	.51**	.65**	.46**	–.36**
Psychological inflexibility	2.9	1.2						–.22***	.21**	0.38**	.23**	–.36**
Number of support sources	1.6	0.9							–.01*	–.08**	–.07**	0.15**
Distress in the 2nd wave	5.2	1.6								.63**	.56**	–.20**
Distress in epidemic vs. before	3.8	2.0									.57**	–.42**
Distress in the 2nd wave vs. the 1st wave	4.6	1.7										–.24**
Coping with distress in the 2nd wave	4.8	1.4										

Notes. *$p < .05$; **$p < .01$; ***$p < .001$.

All dependent variables are modelled with the same blocks of predictors. Tables 9–12 present hierarchical regression analyses for all four dependent variables. For the purposes for ease of interpretations, only R^2 are interpreted as they are nearly identical as R^2 adjusted.

All predictors explain 50% of the variability in the perceived distress during the second wave of the COVID-19 epidemic (Table 9). The control variables explain a small amount of variability (4%), even though four variables show a significant contribution; being female increases the distress (b = .25), being older decreases the distress (b = –.03), living in urban areas increases the distress (b = .17) and having been ill with COVID-19 increases the distress (b = .05). The second block of stressors is clearly the strongest contributing block (R^2 = .50), and all stressors, except loss of work/income, are significantly associated with distress (working changes, b = .26, health, b = .15, social relations and societal situation, b = .58). Among control variables, only age remains significant. The third block contributes a small amount of explained variability (R^2 = .51), with psychological inflexibility significantly contributing to distress (b = .21). The number of support sources does not add significantly to the model.

Table 10 presents the hierarchical regression analysis for the second dependent variable, modelling the amount of distress felt during the COVID-19 epidemic's second wave compared to the time before it. The complete model explains 33% of the variability. The demographic variables explain only about 4% (R^2 = .04), with age reducing the distress (b = –.02) and living in urban areas adding to distress (b = .21). The four stressors are again the most prominent block, explaining 30% of the variability. All stressors are significant (loss of work/income, b = –.09, working changes, b = .15, health, b = .09, and social relationships and societal situations, b = .42). As the second block enters the regression, education becomes significant (b = .18). The third and fourth blocks do not help explain the distress.

Table 11 shows the hierarchical regression analysis for the third dependent variable, modelling the amount of distress felt during COVID-19 epidemic's second wave compared to the first wave. This variable has a smaller share of explained variability (22%). However, this time, all four blocks contribute significantly to the explained variability, albeit the second block is again the most important one. The control block contributes just 2% (R^2 = .02), with age and education reducing distress significantly (b = –.01; –.25, respectively). Close ones having been ill with COVID-19 increases the distress significantly (b = .18). The second block contributes roughly 20% (R^2 = .22), with three stressors significantly increasing the distress (working changes, b = .12, health, b = .04, social relationships and societal situation, b = .41). Psychological inflexibility contributes significantly to distress, although its explanatory power is very modest (R^2 = .22). Having various sources of social support significantly reduces distress (b = –.09), yet its explanatory power is low (R^2 = .22).

Table 9

Hierarchical regression analysis: How much distress have you been feeling during the second wave of the Covid-19 epidemic?

	B	SE	β	b	SE	β	b	SE	β	b	SE	β
(Constant)	4.48***	.18		1.04***	.15			.17			.18	
Gender		.11			.08			.08			.08	
Age	–.03***	.00	–.17***	–.01***	.00	–.05***	–.01***	.00	–.03***	–.01***	.00	–.04***
Education	–.09***	.10	–.02***		.08			.08			.08	
Having school-age children		.09		–.03***	.07	–.01***	–.01***	.07			.07	
Living environment		.08			.06			.06			.06	
Been ill with Covid-19		.14			.10			.10			.10	
Close ones been ill with Covid-19		.09		–.01***	.06			.06			.06	
Loss of work/income				–.02***	.02	–.02***	–.03***	.02	–.03***	–.04***	.02	–.03***
Working changes					.02	.23***		.02	.23***		.02	.23***
Health					.02	.13***		.02	.11***		.02	.11***
Social relations and societal situation					.02	.51***		.02	.48***		.02	.48***
Psychological inflexibility								.03	.12***		.03	.11***
Number of support sources										–.05***	.03	–.03***
Sig. F. Change			.000			.000			.000			.12
R^2			.04			.50			.51			.51
Adjusted R^2			.04			.50			.51			.51

Notes. *$p < .05$; **$p < .01$; ***$p < .001$; $N = 2271$; Values for Gender: 0 = Male, 1 = Female; Education: 0 = High school at most, 1 = Higher education at least; Having school-age children: 0 = No, 1 = Yes; Living environment: 0 = Rural, 1 = Urban; Been ill with Covid-19: 0 = No, 1 = Yes; Close ones been ill with Covid-19: 0 = No, 1 = Yes.

Table 10

Hierarchical regression analysis: How much distress have you been feeling during the Covid-19 pandemic compared to the time before it?

	b	SE	β	b	SE	β	b	SE	β	b	SE	β
(Constant)	5.78***	.14		3.69***	.14		3.79***	.16		3.78***	.17	
Gender	–.01***	.09		–.14***	.07	–.03***	–.13***	.07	–.03***	–.13***	.07	–.03***
Age	–.02***	.00	–.18***	–.01***	.00	–.09***	–.01***	.00	–.09***	–.01***	.00	–.09***
Education		.08			.07			.07			.07	
Having school-age children		.07		–.06***	.06	–.02***	–.06***	.06	–.02***	–.06***	.06	–.02***
Living environment		.06			.05			.05			.05	
Been ill with Covid-19		.11		–.05***	.09	–.01***	–.05***	.09	–.01***	–.05***	.09	–.01***
Close ones been ill with Covid-19		.07			.06			.06			.06	
Loss of work/income				–.09***	.02	–.11***	–.09***	.02	–.10***	–.09***	.02	–.10***
Working changes					.02	.17***		.02	.17***		.02	.17***
Health					.02	.10***		.02	.10***		.02	.10***
Social relations and societal situation					.02	.47***		.02	.47***		.02	.47***
Psychological inflexibility							–.04***	.03	–.02***	–.03***	.03	–.02***
Number of support sources											.03	
Sig. F. Change			.000			.000			.203			.804
R^2			.04			.33			.33			.33
Adjusted R^2			.04			.33			.33			.33

Notes. *$p < .05$; **$p < .01$; ***$p < .001$; $N = 2271$; Values for Gender: 0 = Male, 1 = Female; Education: 0 = High school at most, 1 = Higher education at least; Having school-age children: 0 = No, 1 = Yes; Living environment: 0 = Rural, 1 = Urban; Been ill with Covid-19: 0 = No, 1 = Yes; Close ones been ill with Covid-19: 0 = No, 1 = Yes.

Table 11

Hierarchical regression analysis: How much distress have you been feeling during the second wave of the Covid-19 epidemic compared to the first wave (March–May 2020)?

	b	*SE*	β	*b*	*SE*	β	*b*	*SE*	β	*b*	*SE*	β
(Constant)	5.13***	.17		3.09***	.17		2.85***	.20		3.00***	.21	
Gender	–.06***	.10	–.01***	–.16***	.09	–.03***	–.17***	.09	–.04***	–.14***	.09	–.03***
Age	–.01***	.00	–.07***		.00			.00			.00	
Education	–.25***	.09	–.06***	–.16***	.08	–.04***	–.14***	.09	–.03***	–.12***	.09	–.03***
Having school-age children	–.11***	.08	–.03***	–.15***	.07	–.04***	–.14***	.07	–.04***	–.13***	.07	–.03***
Living environment		.07			.07			.07			.07	
Been ill with Covid-19		.13		–.06***	.11	–.01***	–.06***	.11	–.01***	–.06***	.11	–.01***
Close ones been ill with Covid-19		.08			.07			.07			.07	
Loss of work/income				–.03***	.02	–.03***	–.04***	.02	–.04***	–.04***	.02	–.04***
Working changes					.02	.12***		.02	.11***		.02	.12***
Health					.02			.02			.02	
Social relations and societal situation					.03	.40***		.03	.39***		.03	.39***
Psychological inflexibility								.03			.03	
Number of support sources										–.09***	.04	–.05***
Sig. F. Change			.000			.000			.014			.021
R^2			.02			.22			.22			.22
Adjusted R^2			.01			.22			.22			.22

Notes. *$p < .05$; **$p < .01$; ***$p < .001$; $N = 2271$; Values for Gender: 0 = Male, 1 = Female; Education: 0 = High school at most, 1 = Higher education at least; Having school-age children: 0 = No, 1 = Yes; Living environment: 0 = Rural, 1 = Urban; Been ill with Covid-19: 0 = No, 1 = Yes; Close ones been ill with Covid-19: 0 = No, 1 = Yes.

Table 12

Hierarchical regression analysis: How successfully have you been coping with your distress so far during the second wave of the Covid-19 epidemic?

	b	*SE*	β	*b*	*SE*	β	*b*	*SE*	β	*b*	*SE*	β
(Constant)	4.28***	.13		5.74***	.15		6.66***	.16		6.49***	.17	
Gender	**–.15*****	.08	**–.04*****	**–.12*****	.07	**–.03*****	**–.09*****	.07	**–.02*****	**–.12*****	.07	**–.03*****
Age		.00	.09***		.00			.00	**–.02*****		.00	**–.01*****
Education		.08	.14***		.07	.12***		.07	.09***		.07	.09***
Having school-age children	**–.03*****	.06	**–.01*****		.06		**–.02*****	.06	**–.01*****	**–.03*****	.06	**–.01*****
Living environment	**–.04*****	.06	**–.02*****		.06		**–.01*****	.05		**–.01*****	.05	
Been ill with Covid-19	**–.10*****	.10	**–.02*****	**–.08*****	.09	**–.02*****	**–.06*****	.09	**–.01*****	**–.06*****	.09	**–.01*****
Close ones been ill with Covid-19	**–.07*****	.06	**–.02*****	**–.01*****	.06		**–.06*****	.06	**–.02*****	**–.07*****	.06	**–.03*****
Loss of work/income				**–.01*****	.02	**–.01*****		.02			.02	
Working changes				**–.09*****	.02	**–.11*****	**–.08*****	.02	**–.10*****	**–.08*****	.02	**–.11*****
Health				**–.05*****	.02	**–.06*****	**–.02*****	.02	**–.02*****	**–.02*****	.02	**–.02*****
Social relations and societal situation				**–.23*****	.02	**–.28*****	**–.19*****	.02	**–.23*****	**–.19*****	.02	**–.23*****
Psychological inflexibility							**–.32*****	.03	**–.25*****	**–.30*****	.03	**–.24*****
Number of support sources											.03	
Sig. F. Change			.000				.000			.000		.002
R^2			.04				.17			.22		.22
Adjusted R^2			.03				.16			.21		.22

Notes. *$p < .05$; **$p < .01$; ***$p < .001$; $N = 2143$; Values for Gender: 0 = Male, 1 = Female; Education: 0 = High school at most, 1 = Higher education at least; Having school-age children: 0 = No, 1 = Yes; Living environment: 0 = Rural, 1 = Urban; Been ill with Covid-19: 0 = No, 1 = Yes; Close ones been ill with Covid-19: 0 = No, 1 = Yes.

Table 12 presents the hierarchical regression analysis for the fourth dependent variable, modelling the extent of successful coping with distress during the COVID-19 epidemic's second wave. Again, all four blocks of predictors explain about 22% of the variability in coping. Age and education are significant, both contributing positively (R2 = .04) to coping (b = .01; .49, respectively), with education remaining significant in all models. While among the stressors, the loss of work/income is not significant (R2 = .17), the other three reduce successful coping with distress (working changes, b = –.09, health, b = –.05, social relationships and societal situation, b = –.23). Psychological inflexibility significantly reduces successful coping (R2 = .22; b = –.32). The amount of social support sources significantly increases successful coping (R2 = .221; b = .10).

Discussion

In this study, we explored the extent to which the subjective perception of distress in the epidemic's second wave, also comparing the perception of distress with respect to the first wave and to the period prior to the pandemic, and adults' coping with distress in Slovenia can be explained by having been ill with COVID-19 (oneself and/or close ones) and the self-assessment of epidemic-specific stressors, as well as which stressors best explain these outcomes. We also explored whether psychological inflexibility and the number of support sources were associated with all four dependent variables over and above the socio-demographic factors, having been ill with COVID-19, and epidemic-related subjectively assessed stressors.

Participants in the second wave of the COVID-19 epidemic on average were experiencing moderately intense distress. In the second wave, they felt greater distress compared to the time prior to the pandemic (72.6% report greater distress than before it) and greater distress than in the epidemic's first wave (55.8% report greater distress in the second wave). They were coping with the distress experienced moderately successfully (56.3% reported successful coping). Studies in Europe also reveal higher than usual levels of psychological distress during the COVID-19 pandemic (e.g. Casagrande et al., 2020). However, a 3-month follow-up of a group of Slovenians during the epidemic's first wave (Kavčič et al., 2021a) shows that people successfully adapted to new and threatening circumstances and experienced less and less distress. The stronger experience of distress in the second compared to the first wave (comp. Kavčič et al., 2021a) or the time prior to the pandemic is not surprising. In the second wave of the epidemic, for example, the numbers of reported new daily COVID-19 positive test results and deaths per day, and other stressful circumstances had been high and accumulating. The reported coping during the second wave is also

moderate (not low). These both findings speak in favour of adaptation capacities, at least for part of our sample (comp. Chen & Bonanno, 2020; Zager Kocjan et al., 2021b).

The control variables have a relatively small impact on the perception of distress during the COVID-19 epidemic's second wave, perceived distress during COVID-19 compared to the time before it, and the perception of distress in the COVID-19 epidemic's second wave compared to the first one, and they have a small impact on coping with distress. Among the control variables, age seems to reduce the perceived distress in the second wave and distress in the second wave compared to the time before it and increase coping. The health hazard induced by COVID-19 does not seem to have much association with distress or coping as only the respondents' fear of contracting COVID-19 slightly increases the distress perceived during the COVID-19 epidemic's second wave and fear of close ones contracting COVID-19 was related to the perceived distress during the second wave of COVID-19 compared to the first wave. It is quite possible that the fear regarding close ones is related to the devastating conditions in residential care for older people where the virus spread uncontrollably after it entering the facilities. Since the sample characteristics do not reflect the population in terms of age, gender, education, and type of living setting, if the sample would be more balanced one would expect the dependent variables to be more strongly associated with age, gender, education and living environment or fear of contracting COVID-19.

Of the perceived stressors, those related to social relations and societal situations were assessed as the most burdensome, followed by health-related stressors and working changes, and loss of work/income in the last position.

As expected, the results showed that individuals more concerned about various epidemic-related factors experienced higher levels of distress (in the second wave itself compared to both the period prior to the epidemic and its first wave) and lower levels of coping with distress when controlled by socio-demographic characteristics and fear of contracting COVID-19 (oneself and/or close ones).

Still, appraisals of the intensity of the burden of diverse epidemic-related stressors do not play the same role in explaining the different perceptions of distress and coping. Distress in the epidemic's second wave, also when compared to the first wave, and coping with distress were most strongly predicted by stressors related to social relationships and the societal situation (distress related to social isolation, fear of freedoms being lost/restricted, fear of an uncertain future). This finding is not surprising given the strict and changing state measures in place during the survey period (e.g. closed schools, closure of non-essential shops and services, curfew, public transport halted, closed borders, restriction of movement within municipalities). These changes directly affected people's daily routine and required considerable adjustments. Distress during the second wave of the epidemic was also predicted by

stressors related to work changes, followed by stressors related to health – which is also expected given that around 20% of employees worked from home or in an office/home combination during the survey period (Brodnik, 2021) as well as the high prevalence of infections, hospitalisations and deaths (Sledilnik.org – Slovenia COVID-19 Data Collection). Kavčič et al. (2021a) and Zager Kocjan et al. (2021a) similarly found that in the first wave in Slovenia subjective levels of distress were most strongly predicted by concerns about the changed life circumstances, slightly less so by concerns about the pandemic's long-term consequences, and most weakly by concerns about the threat to one's own health.

Distress in the second wave compared to the period prior to the pandemic was, as expected, predicted by all stressors. Coping with distress was, in addition to the stressors related to social relationships and the societal situation, predicted by stressors related to work changes. Perhaps the respondents' health concerns were not so disturbing that they led to a lower capacity to cope with distress, as many spent most of their time at home and 'socially distanced' due to the general measures in place. Distress in the second wave compared to the first one was, besides the stressors related to social relationships and the societal situation, predicted by the stressors related to work changes. During the survey period, there were many stressful working circumstances, including remote work and the need to reconciliate work and family responsibilities. Apparently, at this stage of the epidemic, given the pattern of work/income loss concerns were not as pronounced despite many services being closed – this might be explained by the financial assistance provided by the state.

Psychological inflexibility in the current study is a significant predictor of both distress during the second wave of the epidemic and coping with that distress. Other studies to date (e.g. Dawson & Golijani-Moghaddam, 2020; Pakenham et al., 2020) have also shown that psychological inflexibility has increased psychological distress, especially due to avoidant coping styles. Maladaptive coping styles together with the tendency to ruminate and worry, characteristic of psychological inflexibility, add to stronger feelings of helplessness, despair and thus to poorer adjustment (Kashdan, 2010; Levin et al., 2014). Psychological inflexibility showed modest additional predictive power beyond socio-demographic characteristics, COVID -19 illness (self and/or close ones) and epidemic-specific stressors, particularly for coping distress during the second wave of the epidemic. For the distress during the second wave of the epidemic and for the distress during the second wave compared to the first wave, the proportion of explained variance increased only slightly (up to 1%), which may be explained by the fact that our measure of distress was not clinical in nature, and psychological inflexibility represents an extreme point on the continuum of psychological flexibility that often indicates psychopathology (Kashdan, 2010). Epidemic-related stressors also remained significant when psychological inflexibility was added to the models. Nevertheless, our findings support the relevance of

psychological inflexibility as a target for interventions (Levin et al., 2014); namely, to develop its opposite – greater psychological flexibility – i.e. the ability to openly engage in difficult internal experiences and engage in meaningful behaviours and actions in accordance with one's values, which is especially important amid challenging or stressful circumstances.

Social support makes a small yet significant contribution to the perceived distress during the second wave compared to the first one as well as to coping in the expected directions. It reduces the distress and increases the perceived coping.

Limitations

Since the research is limited to the first months of the second wave of the epidemic, it does not cover the long-term consequences of the epidemic's second wave in Slovenia. Early in the second wave, it was easier for people to apply coping mechanisms since most did not expect that this wave in Slovenia with such strict measures would last too long. Given the ongoing global crisis, recent studies have noted concerns about phenomena like pandemic fatigue, a tendency that people grow weary of the rules they are supposed to follow to prevent the spread of COVID-19 and that their adherence to the rules might be declining (Michie et al., 2020; Petherick et al., 2021).

The current study used non-probability online sampling. This implies the sample is not representative of the larger Slovenian population. Only people who use the Internet, for example, could be contacted, potentially resulting in the participants' self-selection, particularly among the elderly. Certain demographics (e.g. females, highly educated, middle-aged people) are overrepresented. The convenience sample means distressed individuals might also be overrepresented, and at the same time those who were seriously afflicted by COVID-19 (or whose loved ones were) might not have participated in the survey.

The majority of the stressors investigated were COVID-19-specific. Other persistent stressors in the individual respondents' lives may have exacerbated their level of distress throughout the epidemic waves. Besides, the list of stressors was not exhaustive. For example, the study did not examine in more detail attitudes to the measures introduced during the epidemic (e.g. restriction of movement, dissatisfaction with the way in which they were decided and communicated). The cross-sectional nature of the study makes it impossible to more objectively demonstrate whether distress has escalated beyond pre-pandemic levels. Psychological distress was measured only by a subjective assessment. However, subjective self-assessments can be a good indicator and even a better predictor of different life outcomes than more objective

measures. Ideally, levels of distress and the appraisal of the stressors would be measured longitudinally.

Additional potentially relevant individual risk factors were not examined in this study, such as an individual's prior exposure to adversity and/or chronic stress, physical and psychological health vulnerabilities, poor economic resources, selected behaviours (e.g. media use), single-parent status, migration status, being at work entailing frequent face-to-face contact, and being quarantined, among others. The social support measures included in the models were not as elaborate as would be desired in terms of evaluation of the support networks, exchanges, and evaluation of the social support (Vaux, 1988). The existing measure referred generally to people in their social network the respondents turn to for support in psychological distress and not specifically to the period of the epidemic and the perception of receiving support. Moreover, among intrapersonal measures the survey covered only psychological inflexibility. Since psychological flexibility has already been identified as a useful indicator showing how individuals may be affected by pandemic stressors and at the same time a resilience factor that can help mitigate its short- and long-term negative psychological impacts, future research should also include this aspect (Dawson & Golijani-Moghaddam, 2020; McCracken et al., 2021, comp. Pakenham et al., 2020). Psychological inflexibility as a theoretical and empirical construct seems more relevant in contexts with respect to the pursuit of one's values and not so much in the context of a pandemic.

At the time of this survey, COVID-19 vaccination was not an individual or collective issue yet, and no measures to distinguish between the vaccinated and unvaccinated were in place. Undoubtedly, this aspect also has a significant impact on psychological distress and coping, as further research is likely to show.

Conclusions

Stressors are key factors involved in perceived distress (during the epidemic's second wave, as well as when comparing it to the distress prior to the outbreak of COVID-19 and to the distress during the first wave) and coping with distress. Coping with distress is impeded by psychological inflexibility. Socio-demographic characteristics and being ill with COVID-19 (oneself or close ones) contribute only a small part to the explained variance in coping. Psychological inflexibility and social support were shown to make a minor contribution to perceived distress and coping above the controls and stressors.

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5 SOCIAL SOURCES OF EMOTIONAL AND INSTRUMENTAL SUPPORT DURING THE COVID-19 EPIDEMICS IN SLOVENIA

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Abstract

This study focuses on two types of social support – emotional and instrumental – in the context of the everyday challenges created by the COVID-19 pandemic. We aim to identify social sources of support, i.e., the main providers of emotional and instrumental support during the COVID-19 epidemics in Slovenia using case study data from May 2020 regarding a survey of residents of Ljubljana's multi-apartment buildings (MABs). The study results showed that for the residents of Ljubljana's MABs the network made up of family members outside the household and friends continues to play a fundamental role in providing emotional and instrumental support that individuals can count on in both 'normal' and epidemic circumstances. Neighbourhood ties are very rarely a source of emotional support or not at all, irrespective of the specific residential setting of the case study; still, the instrumental support given by such ties for older people, people living alone, or people in poor health remains important.

Key words: emotional support, instrumental support, social support, COVID-19, family

Introduction

The COVID-19 pandemic and ensuing public health measures imposed by many national governments around the world have seriously impacted people's lives, especially their daily routines and usual ways of connecting with others. The preventive measures on the global and national levels such as social distancing, lockdowns, contact tracing, travel restrictions and mandatory quarantines have led to vast numbers of people being confined to their homes, obliged to stay physically disconnected. Slovenia has been no exception in this respect. A COVID-19 epidemic was declared on 12 March 2020 with different measures, including restrictions on social interactions in the country, being introduced by the Slovenian government to contain the virus' spread. The sense of being confined and cut off from direct face-to-face interactions can bring serious social, psychological and emotional consequences like pronounced isolation and loneliness, an increased feeling of stress, greater anxiety, depression etc. Several recent studies and reports indicate that 2020, the first year of the pandemic, was experienced as stressful in many countries (Schaffler et al., 2021) and that COVID-19 affects negative feelings and

mental health outcomes (Klümper & Sürth, 2021; Pandey et al., 2021, p. 2; Salari et al., 2020; World Health Organization [WHO], 2020), with depression and anxiety being commonly experienced (Cugmas et al., 2021, p. 2). "The results of recent studies suggest that social distancing has a negative impact on emotional well-being, especially by causing individuals to feel nervous, restless, and lonely while staying at home during the pandemic" (Skałacka & Pajestka, 2021, p. 275; see also Choi & Choung, 2021, pp. 2398, 2399). Social support networks, as one type of coping resources, protect individuals from emotional distress by providing benefits like comfort and reassurance and thereby buffering the effects of stress in both 'normal' (difficult) circumstances and in acutely critical and stressful moments such as COVID-19.

Successful coping with stress and unpleasant emotional states associated with pandemic-related worries (about becoming infected, the safety of one's family, job losses, financial pressures, the future; grieving over the loss of loved ones etc.) as well as the restrictions requires individuals to share their experiences and feelings with others able to offer emotional support. During this pandemic, mediated communication has become an important way for many individuals of staying (emotionally) connected with others beyond the household. In a pandemic, instrumental support is also needed in the form of practical help; for example, with household activities and shopping in the case of illness, demands of working life (workload of parents working from home with child(ren) around), or because one has been advised not to leave the house (elderly and other vulnerable groups). This study concentrates on these two types of social support – emotional and instrumental – in the context of the everyday challenges created by the COVID-19 epidemic. We seek to identify social sources of support, i.e., the main providers of emotional and instrumental support during the COVID-19 epidemic in Slovenia. The study participants were asked the following questions: (1) During the time of pandemic-related restrictions, who would you first ask for help with urgent household chores in the event you were sick and confined to bed for a few days? (instrumental support); (2) Who would you first ask for help to talk with you in case you were lonely? (emotional support); and (3) Who would you first ask to go do urgent shopping for you? (instrumental support).

The stay-at-home orders due to COVID-19 have limited the usual sources of support such as friends, extended family, or professionals (WHO, 2020). Many older adults, for instance, have been deprived of their typical ways of connecting with their support networks (Kotwal et al., 2021). In Slovenia, families represent a fundamental support network offering emotional and practical support in both 'normal' situations and crises (Kogovšek et al., 2003; Pahor et al., 2011; Šadl & Hlebec, 2007, 2009). Other sources of emotional support like friends are also important (Šadl, 2005; Šadl & Hlebec, 2009). Slovenia has a high share of the

most intense, direct, i.e., face-to-face, contacts between adult children and their parents. Indirect contacts maintained by telephone, letters or e-mail are also common among family members (Šadl & Hlebec, 2007). In the current study, we expect that at the outbreak of the COVID-19 epidemic, when the social-distancing measures were first introduced in Slovenia, the sources of emotional support remained in place because physical proximity is not strictly needed for emotions to be expressed through social ties and thus for upholding relationships and feelings of social connection. The restrictions restricted face-to-face interactions among family members not living in the same household, relatives, friends, co-workers. However, anyone wishing to stay connected can these days seek social contact and support using a phone call, online chat, video calling/chatting or network social media (see for example Meier et al., 2021). The role of mediated communication has become important more than ever with research showing the communication technologies used for interpersonal communication play a role in reducing loneliness and, in turn, enhancing psychological well-being (Choi & Choung, 2021). It is expected that the provision of instrumental support has become much more limited by the 'only within the same household' contact rules, and that the usual providers of instrumental social support have been replaced by those living within permitted geographical proximity (such as neighbours in MABs). In terms of the supply of instrumental support, we expect some neighbourhood ties may have been activated even in urban MABs, especially for people whose relatives live in other municipalities, given that this was a restriction imposed by the Slovenian government to prevent the virus spreading across municipal borders. We also examine the impact of demographic variables on the respondents' choice of social sources of emotional and instrumental support.

Conceptualisations and research overview

Social support has been described in various ways, yet most conceptualisations include the same key description of the aid: the supply of tangible or intangible resources individuals gain from their network members (Song et al., 2011). Perceived social support can be defined as the extent to which individuals perceive others in their social networks as being available to them and as individuals who are attentive to their needs. In other words, social support "indicates the perception and experience that one is cared for, loved, and valued by others and part of a social network, including assistance and commitment" (Klümper & Sürth 2021; Wills, 1991). Studies in the last few decades show that social support is an effective resource for

coping with stress and health challenges (Pahor et al., 2011), with perceived social support being more closely related to positive coping mechanisms and psychological well-being than actual support (Li & Xu, 2020).

There are four categories of social support: emotional, informational, socialising and instrumental (Kogovšek et al., 2003, pp. 106–107), which respectively provide comfort, information, encouragement and practical assistance. These are all greatly needed in a time like the COVID-19 pandemic (Kanekar & Sharma, 2020). Emotional support is regarded as one of the most crucial types of support since it facilitates coping with crises and specific stressors while promoting well-being throughout life (Ryan et al., 2005, p. 146). Perceived emotional support involves the belief that members of one's social network will provide comforting words in times of need and loneliness. This type of support thus focuses on emotions and feelings and is a typical communication activity that in-and-through the talk-in-interaction improves coping with stressors, helps to cope with difficult life situations and transitions, assists in preventing feelings of loneliness and isolation, and promotes psychological well-being. Diener et al. (1999) define the latter as the absence of negative emotional states, the presence of positive experiences and global life satisfaction. The link between perceived emotional support and psychological well-being is established in numerous studies (Burleson, 2003; Morelli et al., 2015; Reis & Collins, 2000; Vandervoort, 1999; Wills & Shinar, 2000; Thoits, 1995, p. 64). As Burleson (2003, p. 557) notes: "effective emotional support assists us in coping with a variety of stressors and upsets, contributes to our mental and physical well-being (…)". The author also states that "At one time or another, all of us are seekers and providers of emotional support"; some people may need extra support. This is especially true in the circumstances of the COVID-19 pandemic that have affected everybody and in which people have needed to "rely on each other for connection and coping strategies to ease the weight of the public health on their mental health" (Li et al., 2021, p. 2). Instrumental support refers to the perceived availability of social ties that can provide material help and services if required (Mai et al., 2021); i.e., help in performing daily practical tasks. A study by Eisenbeck et al. (2022) indicates that people who had maintained their positive physical and psychological health during the COVID-19 pandemic were those who, among others, proactively coped with the crisis (we can add here that emotional support is a crucial resource for regulating/adjusting one's emotions and remaining resilient, and that positive psychological states increase motivation for positive coping strategies) and received instrumental support. Perceived social support plays an important role in (emotional) well-being and mental health (Mai et al., 2021).

Individuals' social support can come from family members, one's partner, friends, neighbours and other close significant persons. Research has shown the necessity and value of social and emotional support provided to individuals by their social

networks, in particular close family members and friends, who typically provide the emotional type of social support (for an overview of the significance of emotional support in everyday life, see, for example, Burleson, 2003; Li et al., 2021; Tyler, 2011). Research in Slovenia also indicates the presence of family sources of emotional support. For elderly parents, ties with their adult children constitute an important source of emotional support (Kogovšek et al., 2003). Research of emotional support in networks of the middle and older generation in a time perspective in Slovenia shows the importance of emotional support for easing the emotional burdens on individuals and valuable role of the family in offering comfort (Šadl & Hlebec, 2007; Šadl & Hlebec, 2009). Friendship is also an important source for meeting people's emotional needs; friends are especially important for young adult people (aged 18 to 24 years) and single people (Šadl, 2005). Research looking at the frequency of social interaction (direct and indirect contacts) between younger and older generations in the family in a comparison of European countries (Šadl & Hlebec, 2007) shows the existence of reliable and intensive intergenerational associative solidarity in Slovenia. In the categorization of European countries, Slovenia is a country with strong intergenerational ties and frequent direct and indirect contacts between adult children and their parents. With respect to close ties being overly important in Slovenia, geographical limits in terms of 'no travel across municipal borders' may be expected to prevent continuous instrumental support across municipal borders and, on the other hand, would have no or only a small effect on the provision of emotional support. In such a situation, we expect neighbourhood ties to be a valuable source of social support, especially for older people. The findings of certain previous research on neighbouring networks in Slovenia and European countries are outlined as follows. The study by Filipovič et al. (2005) showed that neighbours entailed a modest share by way of important sources of social support in Slovenia; their role was significant in smaller material support but negligible in emotional forms of support. It also showed a consistent difference between rural and urban environments, with stronger ties found between neighbours in the rural environment than between those in the city (ibid., 218). A study by Seifert & König (2019) on neighbourhood help among the older European population using representative data for 17 countries taken from the Survey of Health, Ageing and Retirement in Europe (SHARE), including Slovenia also revealed that "neighborhood help was clearly not a primary source of social support" (p. 8) and that "in general, ~6% of all respondents provided recently neighborhood help, and 4% received help" (p. 1). However, the situation varied considerably among countries – help among neighbours in both directions (given and receiving) in Slovenia was comparatively low (p. 7, see Figure 1).

Methodology

The data for this part of the chapter comes from a survey conducted by the CWS (Centre for Welfare Studies) in multi-apartment buildings (MABs) in Ljubljana. Since the study is presented in detail in chapter (Mandič & Hlebec, 2021), here we only present the data set's main characteristics. Data were collected between 5 May 2020 and 14 May 2020 using a self-administered web data collection mode. Invitations to participate were distributed to potential respondents using web platforms of the Faculty of Social Sciences at the University of Ljubljana, the Faculty of Social Sciences at the same university, the Municipality of Ljubljana, by an invitation sent to Association of Real Estate Association to tenants, and tenants and through personal invitations using snowball sampling. Altogether, there were 826 initial contacts on the invitation page, of which 310 completed the survey (a completion rate of 37%). The non-probabilistic characteristic of the sampling and recruitment strategies used means the realised sample is biased in terms of demographic characteristics. The sample characteristics are presented in detail in Table 1: 80% of respondents had more than a asecondary level of education; the average age was 41.9 years, 80% of the sample was female, and roughly 20% was living alone, 33% had a partner, 36% had a partner and child(ren) and about 12% were single parents. Roughly 2/3 of them were living in smaller MABs (up to 29 apartments). About 71% self-valuated their health as good. Some 56% consider that the household income is enough to make to make ends meet easy. The sample is quite specific, featuring the disproportionate presence of female, younger, healthy persons surviving quite comfortably on their income, and having a higher education.

Results

The sources of social support available in various situations are presented in Table 2. The questions were formulated in such a way as to mirror the restrictions on one's household as the government had imposed measures to limit contacts between households with a view to curtailing COVID-19's spread. The exact wording asked for the first person that the respondent would turn to during the pandemic-related restrictions to give help with household chores in the event the respondent was sick and confined to bed for a few days. Not surprisingly, the vast majority (69.2%) would turn to a family member within the household, 16.7% would ask a family member outside the household, 11.4% a friend, and only 2.7% a neighbour. A

similar distribution (except for 21.3% for a family member outside the household) was found with regard to doing urgent shopping for the respondent. Quite oppositely, emotional support was not limited that much to one's household since 33.3% would turn to a friend and 12.4% to a family member outside of the household. Still, 54% would turn to a family member within the household for conversation.

Table 1

Sample characteristics

Variables	Values	*f*	Valid %
Gender	Male	63	20.7
	Female	242	79.3
	Total	305	100.0
Age	Up to 34	96	31.0
	35–49	121	39.0
	50+	93	30.0
	Total	310	100.0
Education	High school	61	20.3
	University at least	239	79.7
	Total	300	100.0
Type of household	I live alone	51	19.2
	I live with my partner	88	33.1
	I live with my partner and children	95	35.7
	I live alone with the children	32	12.0
	Total	266	100.0
Self-perception of the current household income	Easy to make ends meet	165	55.6
	Struggling to make make ends meet	87	29.3
	Very difficult to make make ends meet	45	15.2
	Total	297	100.0
Number of housing units	9–29	177	57.3
	30+	132	42.7
	Total	309	100.0
Self-perception of health	Bad	12	4.0
	Satisfactory	75	24.8
	Good	216	71.3
	Total	303	100.0

Table 2

Frequency table "For each of these situations, tell us who you would first ask for help during the pandemic-related restrictions…"

Who would you first ask for help during the pandemic-related restrictions …	Support sources*	*f*	valid %
… with urgent household chores in the event you were sick and confined to bed for a few days?	FW	207	69.2
	FO	50	16.7
	F	34	11.4
	N	8	2.7
	Total	299	100.0
… to talk with you in case you were lonely?	FW	157	54.0
	FO	36	12.8
	F	97	33.3
	N	1	.34
	Total	291	100.0
… to do urgent shopping for you?	FW	191	64.5
	FO	63	21.3
	F	33	11.2
	N	9	3.0
	Total	296	100.0

Notes. *FW – A family member within the household, FO – A family member outside the household, F – A close friend, N – A neighbour.

Table 3 shows support sources cross-tabulated with age. There are substantial variations in sources of support across age groups for all three items, Support sources outside one's household become more frequent as age increases. Thus, 22.7% of respondents aged 50+ would ask a relative outside the household for help with urgent household chores in the event of being confined to bed and 4.6% would ask a neighbour. Friends would be asked for emotional support by 41.2% of respondents aged 50+. Further, 31.5% of respondents aged 50+ would ask relatives from a separate household to do urgent shopping, 14.61% would ask friends and 6.7% neighbors. It seems that, as age, increases sources outside of the household provide important support, while neighbours, apart from friends, gain in importance.

Table 3

Support sources in different situations during the pandemic-related restrictions corss-tabulated by age

Who would you first ask for help during the pandemic-related restrictions …	Support sources*	Age of participants (in years)					
		Up to 34		35–49		50+	
		f	%	*F*	%	*f*	%
… with urgent household chores in the event you were sick and confined to bed for a few days? *(1)*	FW	66	71.7	89	74.8	52	59.1
	FO	13	14.1	17	14.3	20	22.7
	F	11	12.0	11	9.2	12	13.6
	N	2	2.2	2	1.7	4	4.6
… to talk with you in case you were lonely? *(2)*	FW	48	53.3	71	61.2	38	44.7
	FO	13	14.4	12	10.3	11	12.9
	F	29	32.2	33	28.5	35	41.2
	N	0	.00	0	.0	1	1.2
… to do urgent shopping for you? *(3)*	FW	62	68.9	87	74.4	42	47.2
	FO	17	18.9	18	15.4	28	31.5
	F	10	11.1	10	8.6	13	14.6
	N	1	1.1	2	1.7	6	6.7

Notes. *FW – A family member within the household, FO – A family member outside the household, F – A close friend, N – A neighbour; The significance of differences evaluated with Pearson's chi-squared test: *(1):* χ^2 (6) = 7.19, p = .304; *(2):* χ^2 (6) = 8.06, p = .234; *(3):* χ^2 (6) = 20.11, p = .003.

Table 4 shows gender differences across support sources. The distributions of support choices are relatively uniform between gender, i.e. family members within the household are a preferred choice of social support for urgent household chores when sick and confined to bed for a few days during the pandemic-related restrictions (male 71.7%, female 68.2%), followed by family members outside the household, friends and neighbours. Similarly, the sources of emotional support have a uniform distribution across support choices, except for friends where men turn to their friends less often (25.9%) than women (35.7%). Larger differences between the distributions are observed for urgent shopping. Namely, women (67%) more frequently ask a family member within the household than men do (53.3%), while men more frequently ask a family member outside the home (26.7%) than women do (20.1%); they also turn more frequently to their friends (16.7%) than women do (9.9%).

Table 4

Support sources in different situations during the pandemic-related restrictions cross-tabulated by gender

Who would you first ask for help during the pandemic-related restrictions …	Support sources*	Gender			
		Male		Female	
		f	%	*f*	%
… with urgent household chores in the event you were sick and confined to bed for a few days? *(1)*	FW	43	71.7	161	68.2
	FO	9	15.0	41	17.4
	F	7	11.7	27	11.4
	N	1	1.7	7	3.0
… to talk with you in case you were lonely? *(2)*	FW	34	58.6	120	52.2
	FO	9	15.5	27	11.7
	F	15	25.7	82	35.7
	N	0	.0	1	.4
… to do urgent shopping for you? *(3)*	FW	32	53.3	156	67.0
	FO	16	26.7	47	20.2
	F	10	16.7	23	9.9
	N	2	3.3	7	3.0

Notes. *FW – A family member within the household, FO – A family member outside the household, F – A close friend, N – A neighbour; The significance of differences evaluated with Pearson's chi-squared test: (1): χ^2 (3) = .54, p = .909; (2): χ^2 (3) = 2.46, p = .483; (3): χ^2 (3) = 4.29, p = .232.

Table 5 show differences with respect to education. Interestingly, emotional support sources have a uniform distribution across support sources, while household chores and urgent shopping show similar differences as for education. The higher educated turn more often to family members outside the household (HE – 18.8%, LE – 10.5%) and friends (HE – 12.4%, LE – 7.0%) than the less educated, and less frequently to a family member within the household (HE – 66.2%, LE – 79%) and neighbours (HE – 2.6%, LE – 3.5%) than less educated. Quite similar characteristics are observed for urgent shopping, where the higher educated less often ask family members within the household (HE – 61%, LE – 75.4%) and less often their neighbours (HE – 3%, LE – 3.5%) and more often ask family members outside the household (HE – 22.9%, LE – 11.8%) and friends (HE – 13%, LE – 5.3%) than less educated respondents.

Table 5

Support sources in different situations during the pandemic-related restrictions cross-tabulated by education

Who would you first ask for help during the pandemic-related restrictions …	Support sources*	Education			
		High school		College at least	
		f	%	*f*	%
… with urgent household chores in the event you were sick and confined to bed for a few days? *(1)*	FW	45	79.0	155	66.2
	FO	6	10.5	44	18.8
	F	4	7.0	29	12.4
	N	2	3.5	6	2.6
… to talk with you in case you were lonely? *(2)*	FW	30	55.6	120	52.4
	FO	7	13.0	29	12.7
	F	17	31.5	79	34.5
	N	0	.0	1	.4
… to do urgent shopping for you? *(3)*	FW	43	75.4	141	61.0
	FO	9	15.8	53	22.9
	F	3	5.3	30	13.0
	N	2	3.5	7	3.0

Notes. *FW – A family member within the household, FO – A family member outside the household, F – A close friend, N – A neighbour; The significance of differences evaluated with Pearson's chi-squared test: (1): χ^2 (3) = 4.22, p = .239; (2): χ^2 (3) = .44, p = .932; (3): χ^2 (3) = 4.99, p = .173.

Table 6 shows the distributions of support sources across household types where major (yet expected) differences are observed since people living alone cannot turn for support to someone within the household for any type of support.[1] With regard to urgent household chores in the event the respondent was confined to bed, respondents would ask a family member outside the household (55%) if living alone, a family member within the household otherwise (83.9%, if living with a partner, 88.2% if living with a partner and children, and 62.5% if living alone with children). When living alone with children, 28.1% would turn to a family member outside the household. Friends as a source of household support account for a 31.9% share for people living alone. When living alone, neighbours are also an important source of support within the household (10.6%; for those living alone with children 6.3%). Emotional support (talking to someone if feeling a little depressed) is available to the

[1] Nevertheless, some indicated that the turn to support to someone from inside the household – perhaps to themselves.

respondents who have a partner by their partner (a person within the household), whereas for respondents living alone or with children emotional support is available from friends (67.3%, 53.3%). Friends are a source of emotional support for 15.1% respondents who live with a partner and to 18.9% of respondents who live with a partner and child(ren). Respondents would ask members of their own household to do urgent shopping except of course if they are living alone. In this instance, they would turn to a family member living outside of the household. This is also quite a frequent option for single parents (36.7% as opposed to 56.7% who would ask a family member from their own household). People who live alone would also turn to a friend quite frequently (23.9%) and to their neighbours (13%).

Table 6

Support sources in different situations during the pandemic-related restrictions cross-tabulated by type of household

Who would you first ask for help during the pandemic-related restrictions …	Support source*	Type of household							
		I live alone		I live with my partner		I live with my partner and children		I live alone with the children	
		f	%	*f*	%	*f*	%	*f*	%
… with urgent household chores in the event you were sick and confined to bed for a few days? *(1)*	FW	1	2.1	73	83.9	82	88.2	20	62.5
	FO	26	55.3	8	9.2	5	5.4	9	28.1
	F	15	31.9	6	6.9	5	5.4	1	3.1
	N	5	10.6	0	0.0	1	1.1	2	6.3
… to talk with you in case you were lonely? *(2)*	FW	1	2.2	66	76.7	61	67.8	10	33.3
	FO	13	28.3	7	8.1	12	13.3	4	13.3
	F	31	67.4	13	15.1	17	18.9	16	53.3
	N	1	2.2	0	0.0	0	0.0	0	0.0
… to do urgent shopping for you? *(3)*	FW	2	4.4	64	74.4	81	86.2	17	56.7
	FO	27	58.7	11	12.8	8	8.5	11	36.7
	F	11	23.9	10	11.6	4	4.3	1	3.3
	N	6	13.0	1	1.2	1	1.1	1	3.3

Notes. *FW – A family member within the household, FO – A family member outside the household, F – A close friend, N – A neighbour; The significance of differences evaluated with Pearson's chi-squared test: (1): χ^2 (9) = 127.04, p = .000; (2): χ^2 (9) = 85.48, p = .000; (3): χ^2 (9) = 104.34, p = .000.

Table 7 shows the distribution of support sources for self-perceived household incomes. Respondents coming from households which find it easy to make ends meet and or who are struggling to make a living have quite similar distributions in all situations, except for emotional support where those who perceive that they can easily make ends meet select a family member from the same household a little more frequently (59% vs 50.6%) and those who are struggling to make it with the household income select friends somewhat more frequently (38.6% vs 28%). For respondents who reported having serious difficulties making ends meet with the household income, family members from outside the household, and friends are much more frequent sources of support.

Table 7

Support sources in different situations during the pandemic-related restrictions cross-tabulated by self-perceived current household income

Who would you first ask for help during the pandemic-related restrictions …	Support sources*	Self-perception of current household income					
		Easy to make a living with it		Struggling to make a living with it		Very difficult to make a living with it	
		f	%	*f*	%	*f*	%
… with urgent household chores in the event you were sick and confined to bed for a few days? *(1)*	FW	116	71.2	61	70.9	22	53.7
	FO	25	15.3	15	17.4	10	24.4
	F	16	9.8	10	11.6	7	17.1
	N	6	3.7	0	.0	2	4.9
… to talk with you in case you were lonely? *(2)*	FW	95	59.0	42	50.6	13	33.3
	FO	20	12.4	9	10.8	7	18.0
	F	45	28.0	32	38.6	19	48.7
	N	1	.6	0	.0	0	.0
… to do urgent shopping for you? *(3)*	FW	107	66.1	55	64.7	21	53.9
	FO	34	21.0	19	22.4	10	25.6
	F	17	10.5	9	10.6	5	12.8
	N	4	2.5	2	2.4	3	7.7

Notes. *FW – A family member within the household, FO – A family member outside the household, F – A close friend, N – neighbour; the significance of differences evaluated with Pearson's chi-squared test: (1): χ^2 (6) = 8.18, p = .225; (2): χ^2 (6) = 10.60, p = .101; (3): χ^2 (6) = 4.19, p = .651.

Table 8 presents the distributions of support sources within larger and smaller MABs where the number of units indicates the number of apartments in the building. The main finding is that the number of apartments in an MAB is not related to the distribution of support sources.

Table 8

Support sources in different situations during the pandemic-related restrictions cross-tabulated by number of housing units

Who would you first ask for help during the pandemic-related restrictions …	Support sources*	Number of housing units			
		9–29		30+	
		f	%	*f*	%
… with urgent household chores in the event you were sick and confined to bed for a few days? *(1)*	FW	125	72.7	81	64.3
	FO	24	14.0	26	20.6
	F	19	111	15	11.9
	N	4	2.3	4	3.2
… to talk with you in case you were lonely? *(2)*	FW	90	54.2	67	53.6
	FO	21	12.7	15	12.0
	F	55	33.1	42	33.6
	N	0	.0	1	.8
… to do urgent shopping for you? *(3)*	FW	117	68.4	73	58.9
	FO	30	17.5	33	26.6
	F	20	11.7	13	10.5
	N	4	2.3	5	4.0

Notes. *FW – A family member within the household, FO – A family member outside the household, F – A close friend, N – A neighbour; The significance of differences evaluated with Pearson's chi-squared test: (1): χ^2 (3) = 2.92, p = .405; (2): χ^2 (3) = 1.36, p = .741; (3): χ^2 (3) = 4.56, p = .207.

Table 9 shows the distributions of support sources with respect to self-perceived health. Not surprisingly, respondents in poor health turn to a family member within the household for all kinds of support. Although family members within the household are the dominant sources of support for those whose health is satisfactory and good, they also ask other sources of support, like a family member outside the household, as the second-most frequent for urgent household chores when confined to bed and for urgent shopping. Friends are the second-most frequent choice for emotional support.

Table 9

Support sources in different situations during the pandemic-related restrictions cross-tabulated by self-perceived health

Who would you first ask for help during the pandemic-related restrictions …	Support sources*	Self-perception of health					
		Poor		Satisfactory		Good	
		f	%	*f*	%	*f*	%
… with urgent household chores in the event you were sick and confined to bed for a few days? *(1)*	FW	10	83.3	47	64.4	145	69.4
	FO	0	.00	18	24.7	32	15.3
	F	1	8.3	7	9.6	26	12.4
	N	1	8.3	1	1.4	6	2.9
… to talk with you in case you were lonely? *(2)*	FW	9	81.8	31	44.9	112	54.4
	FO	1	9.1	14	20.3	21	10.2
	F	1	9.1	24	34.8	72	35.0
	N	0	.0	0	.0	1	.5
… to do urgent shopping for you? *(3)*	FW	10	90.9	41	57.8	135	64.6
	FO	0	.0	22	31.0	41	19.6
	F	0	.0	7	9.9	26	12.4
	N	1	9.1	1	1.4	7	3.6

Notes. *FW – A family member within the household, FO – A family member outside the household, F – A close friend, N – A neighbour; The significance of differences evaluated with Pearson's chi-squared test: (1): χ^2 (6) = 7.88, p = .247; (2): χ^2 (6) = 9.40, p = .152; (3): χ^2 (6) = 10.91, p = .091.

Conclusion

The most salient findings of this study are the following: as we initially expected, the study shows that the measures requiring social distancing have a greater impact on social sources of instrumental support than on emotional support (which people we talk to). Emotional support is shown to depend less on the stay-at-home and social-distancing measures than instrumental support (help with housework chores, urgent shopping) since a larger share of practical help is provided by neighbours. However, the effect of the limits on physical contacts outside the household is also seen in instrumental support as most respondents would turn to a family member within the household for help with urgent household chores and shopping. Family members outside the household also play a role in providing this type of support, but to a much smaller degree. The least perceived instrumental support is from friends and

neighbours. On the other hand, friends are more frequent providers of emotional support given that more than one-third of the respondents regard friends as their primary source of support when they feel lonely. This may not come as surprise since we know that in stressful situations emphatic listening is given by friends simply because 'that is what friends do'. In addition, friends – and other close ties outside of one's household – can be reached with mobile phones or are digitally online every day, giving individuals the chance to (emotionally) connect despite the physical-distancing restrictions. Yet, the family (both within and outside the household) is still the main source of emotional support. This finding shows that under stay-at-home orders the family becomes (or remains) "the most available source for meaningful, face-to-face social interaction and connections" (Li & Xu, 2020, p. 2). This study suggests that close ties with family and empathy with friends may increase positive emotions, which can help improve one's coping abilities while faced with stressful situations caused by the epidemic itself and the associated preventive measures.

Our findings suggest that restrictions on face-to-face interpersonal interactions do not limit social connectedness and the flow of emotional content through social ties – via mediated communication. This pandemic has created a unique situation in which digital contact has become more common than in-person, direct contact, i.e., "the new norm for social interaction" (Skałacka & Pajestka, 2021, p. 2). Has digital communication helped individuals connect with their close ones and thereby reduced feelings of social isolation and loneliness during the pandemic? Research findings have been mixed on this question. Some have found that frequent phone calls through social media platforms have provided strength and mental support (Moore & March, 2020; Pandey et al., 2021) and that digital technologies have a positive effect on (older adult) users' psychological well-being by reducing loneliness (Choi & Choung, 2021; Quan-Haase et al., 2017, p. 970), maintaining social connectedness (Pandey et al., 2021) and meaningful social relationships (Gabbiadini et al., 2020). Yet, there is also negative relationship between digital contacts and mental health. Although the emotional benefits of digital interaction and support cannot be denied, digital technology for communication and virtual meetings is not inherently beneficial for psychological well-being and mental health. Studies comparing digital vs non-digital forms of communication prior to the pandemic show that in-person communication is more effective and produces greater emotional benefits than digitally-mediated alternatives; the latter cannot compete with "old-fashioned" in-person communication (Holtzman et al., 2017). Given that during the COVID-19 pandemic in-person support may not be available due to the contact restrictions, social interaction and support have shifted to digital. However, mediated communication is not the same as – or not socially and emotionally similar to – face-to-face communication. A study of how the altered frequency of using in-person and digital communication has influenced mental health in older adults

during the pandemic (Skałacka & Pajestka, 2021) reveals that the in-person mode of interpersonal communication has benefited mental health more than the digital one. This may be explained by the fact that the use of digital communication technologies may remind elderly people of their feelings that ultimately they are alone during the pandemic. "When they hang up or turn off the communication application, they are left feeling alone again" (Skałacka & Pajestka, 2021, p. 279); this is especially so in communication with children as communication with a friend is based on different rules than communication with family members. The authors claim that "frequent digital communications can, paradoxically, increase the feeling of isolation and loneliness, because this form of communication can reduce the emotionality of existing relationships, making them shallower and forcing them into a more restrictive time frame" (Skałacka & Pajestka, 2021). Digital and/or telephone communication (support) might provide some emotional or psychological relief or some improvements by way of feeling more socially connected, but it can be lacking – due to the loss of certain cues that aid with communication such as touch, bodily movement, physical context, smell – social presence, warmth, impressions and thus a richer social experience.

We also found that there are small differences among the observed variables as the only significant variable proved to be the type of household, which is linked to different sources of emotional support. Those living with a partner or with a partner and children turn to their partner for emotional support (i.e., conversation), while those who live alone or alone with children (i.e., in single-parent families) ask their friends for support. The finding is not surprising and is consistent with reasonable expectations and theoretical understanding that emotional support is provided by persons who are emotionally closest to individuals and whom the individual perceives to be trustworthy – in the case of a quality partnership it is the partner, in case of living alone it is a friend. Single parents living alone with their children do not talk to their children about their negative experiences (in our case, feeling lonely), perhaps because they do not wish to trouble them or be an emotional burden on them, but they do rely on them to complete daily tasks and do shopping if needed.

The following observations can be made for the other variables: certain differences are indicated between age groups. Younger adults (below 35 years) are more likely to turn to a friend for emotional support than a family member outside the household, with this – somewhat surprisingly perhaps – being even more common for respondents older than 50 years of age. This challenges the assumption that young people are in some senses more 'friends-oriented' (they spend most of their time with friends), that digital communication has become an ever more important part of young people's overall communication strategy and that they use social media to interact and talk with friends, including receiving support from members of their network (see, for example, Meier et al., 2021, p. 10). Still, the importance held by

social contact and social networking for older adults was already well documented years ago (Karavidas et al., 2005, pp. 699, 708).

Friends frequent act as sources of emotional support for young people, but do so less than their family within the household. This finding suggests that close ties with family could play an important role in providing support for young people in times of crisis like a pandemic and in creating a safe space for open communication if needed. There are also age differences in the sources of instrumental support: older adults (50+) have less family support within the household than others since they turn more to outside social sources, including neighbours. We can perhaps explain this by conjecturing that some people at this age (and older) no longer live with their children and support from this source may not be easy to access and thus they turn to 'outside family', friends and neighbours. The restrictions imposed during the COVID-19 pandemic could make immediate neighbours more important for older individuals. However, this might only be partly true because many people in this age group still live with their adult children.

The results show that gender has no association with the perception of social support available. Yet, some gender differences were found regarding support from friends: women are more likely than men to turn to friends for emotional support, while men more often than women turn to friends for instrumental support (in case of urgent shopping), which is in harmony with the way men's friendships are commonly depicted in literature as activity-based (or 'side by side' due to the focus on activity) and women's as affectively based (or 'face-to-face' due to the focus on communication); this 'talking-vs-doing' distinction appears early on in life and extends to mediated communication (Fehr, 1996; Guerrero et al., 2013, p. 252). Some research has pointed out differences in social sources of emotional support, with women being more likely than men to report receiving support from their friends and female relatives, while men are most likely to rely on their partner when in need of emotional support (see Guerrero et al., 2013, p. 253; Šadl, 2005; Šadl & Hlebec, 2007; see also Vandervoort, 2000); this is consistent with the commonly held belief that women are better providers of emotional support than men, or better providers of this type of support to men than men are to women. However, in this study such differences seem to depend more on the type of household than gender itself. The majority of women in our sample more often than men live in single-parent families, where close friends are the main source of emotional support.

Those having difficulty making ends meet on their current income ask friends for emotional support more than the family (either inside or outside the household), which is also linked to the type of household; those living alone or in single-parent families turn to close friends as the main sources of emotional support.

The results show that for people in very poor health neighbours are, apart from within-household family members, by far the most frequent provider of instrumental

support (10%), when considering other demographic characteristics of the respondents. The importance of neighbours for this type of support is probably attributable to their easy access due to spatial proximity; neighbourhood ties might grow in importance in times of crisis when access to the family and public social support services might be reduced.

The results of this study show that for the residents of Ljubljana's MABs the network of relations with family members outside the household and friends continues to play a key role in ensuring the supply of emotional and instrumental support that individuals can count on in epidemic circumstances. Although neighbourhood ties very rarely provide emotional support or do not at all, their instrumental support for older people, people living alone, or people in poor health remains important. Already prior to the COVID-19 epidemic in Slovenia, a study by Filipovič et al. (2005) established that neighbours were much more likely to provide instrumental help (e.g. household chores) – particularly for older adults generally – than emotional support (personal conversations). Our results confirm the finding of a Swedish study that "for people living alone, the proximity of relationships among neighbors might be crucial for accessing social support during a pandemic crisis" (Zetterberg, 2021, p. 5).

Neighbours are thus clearly an important source of practical support people receive where they are unable to seek help from family members outside their own household, i.e., where the mobility restrictions and lockdown measures mean there is a lack of other social sources of support. Neighbourhood ties took over, in such times of crisis, the tasks the extended family in Slovenia would perform in 'normal' circumstances. We may conclude that instrumental support was provided by neighbours in Ljubljana's MABs during the period of the COVID-19 restrictive measures.

Limitations

This study has several limitations, most being methodological. The sample is small, thus preventing multivariate exploration of the associations between demographic variables and hence the analysis remained on a bivariate level. To add to the limitations, not all age groups are represented in sufficient numbers to allow for a detailed examination of specific age groups, i.e., older respondents are clustered together in the 50+ years group. The sample is not statistically representative of the wider population of Slovenia, possibly not even of the residents of Ljubljana's MABs. Nevertheless, this study gives insights into the relationships between the social-distancing rules and provision of social support, especially instrumental support of the kind that requires physical contact between individuals in separate households or

separate municipalities. We also note that the studies with which we compared the results are generally dated to before the period of COVID-19 and are thereby limited sources for comparison.

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6 HOMELESSNESS SERVICES DURING THE COVID-19 PANDEMIC IN SLOVENIA

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Abstract

In this article we look at how the services addressed the needs of homeless people during the COVID-19 pandemic. We first present how such homelessness services were generally functioning prior to the pandemic. Then we briefly illustrate the various responses existing in Europe in homelessness services and ways in which organisations have helped the homeless people. Based on semi-structured interviews with service providers for the homeless in Slovenia, we look at the ways in which these services have adapted to the new circumstances, the challenges they detected and ways of addressing them. We identify the biggest problems such services have faced while complying with the pandemic associated regulations, where spatial issues have proven to be one of the most critical aspects.

Key words: homelessness, services, interviews, COVID-19, Slovenia

Introduction

Homelessness is an extreme form of housing exclusion and linked to several other social problems and vulnerabilities. The homeless have high mortality rates and greater health risks like mental health problems, substance abuse, personality disorders, disability, higher rates of infectious and chronic health conditions, including HIV/AIDS, hepatitis and hypertension, which are all coupled with worse access to healthcare services than for the general population (see e.g., Donley & Wright, 2018; Quilgars & Pleace, 2003; Wolf et al., 2016). The homeless are therefore one of the more vulnerable groups with regard to health risks during the COVID pandemic. It is also the group with the fewest resources and options to lower these additional health risks given that the primary message of "stay at home" simply does not apply to them, while the existing accommodation provided for the homeless typically offer little option for social and/or physical distancing, namely, the main prevention measure promoted by health professionals.

In this article, we consider how services in the area of homelessness have addressed the needs of the homeless during the COVID-19 pandemic. We first present how such homelessness services were generally functioning prior to the pandemic. Then we briefly illustrate the various responses found in Europe in homelessness services and ways in which organisations have helped homeless people. We then describe how the services have operated during the pandemic in Slovenia. Based

on semi-structured interviews with service providers for the homeless in Slovenia, we look at the ways in which these services have adapted to the new circumstances, the challenges they detected and ways of addressing them. We identify the biggest problems such services have faced while complying with the pandemic associated regulations, where spatial issues have proven to be one of the most critical aspects. These findings allow important policy lessons to be drawn with respect to not only emergency responses in a future similar health crisis, but also lessons for service development in general, where the development of longer term and better spatial solutions seems essential.

Homelessness services in Slovenia prior to the pandemic

Homelessness is the product of a complex interplay of individual, interpersonal, institutional and structural factors, whereas different welfare contexts provide an important background for understanding the extents and characteristics of homelessness in individual countries (see Benjaminsen & Bastholm Andrade, 2015; Edgar & Meert, 2005). Welfare regimes are a relevant structural determinant, with there generally being less homelessness in more developed welfare states with stronger protection instruments, such as e.g. social democratic welfare states (e.g. Norway, Sweden, Finland) where also homeless people generally have more complex needs, while welfare states with weaker social protection instruments tend to have more homelessness (e.g. in Mediterranean or Eastern European countries) (Benjaminsen & Bastholm Andrade, 2015; Stephens et al., 2010). Another important country variation concerning homelessness arises from the characteristics of the housing sector in general (see Benjaminsen & Bastholm Andrade, 2015; Stephens & Fitzpatrick, 2007; Fitzpatrick, 2005) as well as the development of homeless services. Still, it is difficult to compare countries since comparative data on homelessness are lacking.

In Slovenia, there is a lack of data on homelessness and no clear definition of the problem. This means evaluations of the extent of the problem vary significantly, with one estimate for 2016 of around 3,000 to 6,700 homeless people (Brodnik, 2017). Due to insufficient research, it is hard to detect trends in homelessness and their profile. The research indicated that the typical profile of (street) homeless in Ljubljana was a middle-aged single man with a lower education (Dekleva & Razpotnik, 2007). However, evaluations show that homelessness is rising and new groups have been identified as users of homeless services, including families with children (see Dekleva & Razpotnik, 2015; Höfler & Bojnec, 2013). The main approach to addressing

homelessness in Slovenia entails various services for homeless that offer accommodation and different support programmes, food, clothes, assorted activities and integration programmes etc. Developing over the last three decades, services for the homeless in the past decade have been based on the goals stated in the Resolution on the National Programme of Social Protection (2013–2020) whose primary goals include reducing poverty and increasing the social inclusion of vulnerable groups. The goals for homeless services as established in the Resolution were to increase the day services (from 8 centres in 2013 to 20 by 2020), make more temporary accommodation available (from 14 shelters with 260 beds in 2013 to 18 shelters with 350 beds by 2020), and developing additional housing support programmes. Although the results in 2017 showed progress toward this goal, with 15 shelters and 300 beds being available in 2017 (Smolej Jež et al., 2018), by 2019 this had dropped to 12 shelters and 267 beds available, among them 2 programmes that offered housing support in a more long-term manner (e.g., Kralji Ulice runs a programme of individualised housing support modelled on the Housing First approach, and offers 31 beds) (Kovač et al., 2020). In 2019, there were also two preventive programmes – i.e. programmes for the prevention of eviction (ibid.). Therefore, some accommodation programmes have been discontinued in the last few years, leaving certain regions in Slovenia still without any services for the homeless. Looking at the regional structure of the Centres for Social Work and the regions they cover, 6 out of 16 regions had no services for the homeless at all, while 8 regions had no accommodation available for them (see Kovač et al., 2020).

The expansion of services for the homeless in the last 20 years has mostly involved the Non-Governmental Organisation (NGO) sector (non-governmental organisations) playing a growing role in the provision of services for the homeless. This has meant a shift in the main providers of such services that a few decades ago were based on a public service network, i.e., mainly the Centres for Social Work that provided additional programmes for the homeless. Thus, in 2019 out of the 23 service providers, only 4 were a Centre for Social Work and a further 2 were public institutes (Slo. *javni zavod*), while the rest were NGOs (Kovač et al., 2020).

Regardless of a provider's status (public or NGO), various services in the sector are co-financed by the Ministry of Labour, Family, Social Affairs and Equal Opportunities. Since 2010, this has taken the form of either long-term financing under "public programmes" (financed for 7 years) or short-term financing – "developmental programmes", financed for 1 year. Among the 12 accommodation programmes, nine were public programmes with long-term financing, while of the other nine programmes five received long-term financing. In a tender for the financing of social protection programmes, the Ministry of Labour, Family, Social Affairs and Equal Opportunities (MLFSA) also specifically regulates the structure of the staff, their qualifications, evaluation and a quality control of the service must be in place,

and funding is based upon approval of the programme by the Social Chamber of Slovenia. The MLFSA is the biggest financer of these services, with an average share of co-financing of 48.8%, while the second biggest financer is local municipalities with an average share of co-financing of 26.9% (Kovač et al., 2020).

The bulk of financing is intended for the accommodation and day support programmes. Only a few programmes offer housing support and prevention, with these areas seeming to be slow to develop. Despite the progress that can be observed in the expansion and some diversification of the services and programmes, development remains slow and the innovation in these services is still low (see Filipovič Hrast, 2019). Further, services already reported facing challenges in addressing various complex user needs due to lacking qualified staff, along with understaffing for the number of users of their services, staff burnout and financial problems (i.e. because financing from the public sources does not cover the actual material costs) (Kovač et al. 2020).

The services' characteristics described above are an important background for understanding how they have functioned during the COVID-19 pandemic. Yet, before we turn to this, we give some brief examples of how homeless services having responded to the new circumstances during the COVID-19 pandemic in various European countries.

Provision of services for the homeless during the pandemic – experiences in other EU countries

Organisations and governments have taken different approaches and practices with respect to the homeless during the COVID-19 pandemic. According to a World Health Organization's report [WHO] (2020), before the outbreak, at least 700,000 people in the EU were without accommodation or in temporary accommodation. Homeless people are especially high-risk during the COVID pandemic as they usually have poorer health than the general population, live in unsatisfactory environmental conditions, face problems in accessing healthcare services, and lack medical materials like masks, hand sanitiser etc. (WHO, 2020). As at the time of publishing the report, the WHO noted that across the EU the following actions were being taken to address the needs of homeless people: informing about access to healthcare services, informing and educating on the COVID preventive measures, COVID-19 testing, and providing accommodation (WHO, 2020). Here we consider different approaches and good practices of organisations in various countries meant to help and protect the homeless in Europe. The selection of countries was not based on

a specific model, but instead seeks to capture the wide diversity in how different countries have helped homeless people during the pandemic. Homeless services are varied in Europe with significant differences apparent in the role of NGOs vs. the public sector as well as levels of funding and development, with generally North-west Europe having more developed services than in South-east Europe. Therefore, we sought to gather descriptions from both regions to give the reader a sense of the challenges faced and adaptations made in response. Both these challenges and adaptations reflect variations in the previous development of services, which however for space reasons we cannot delve into here.

At the start of the pandemic, most countries realised that action was needed to protect the most vulnerable groups of people. The first step was to work on preventive measures and remove the threats of potential exposure to the virus.

Countries like the USA, the UK, Ireland, Portugal, Denmark, France, Germany and Poland were working during the pandemic's first wave on providing access to accommodation by opening extra night shelters and facilitating access to hotels and hostels (Feantsa, 2021b). Other key themes of the actions taken by different countries are: stressing the importance of the strong role of governments and local governments in forming initiatives, increasing funding, establishing a specialised workforce, forming cooperation with different organisations, facing the pandemic and other challenges, and having the goal and priority of gradually moving people into settled accommodation.

At the start of the first wave in 2020, the UK government started the initiative "Everyone in" with which it asked local authorities to help ensure that everyone sleeping rough or in accommodation where self-isolation was difficult or impossible into safe accommodation. To this end, the authorities booked hotel rooms and other en-suite accommodation such as holiday rentals and B&Bs, and ensured they had the food, healthcare and support they needed. After the first wave ended, the government started the "rough sleeping taskforce" tasked with ensuring that as few people return to life on the streets as possible. Moreover, the government accepted the Next Steps Accommodation Programme that gives two funding streams for accommodation. Further, the UK government established substance-dependent treatment for homeless people, and the Winter provision with the goal of protecting rough sleepers over the Winter by providing safe accommodation. The government created the "Protect Programme" focussed on protecting clinically vulnerable in local areas with a large number of homeless people, and on updating the local authorities' rough-sleeping plans by carrying out a rapid assessment of the accommodated people's needs. The government confirmed additional funding for the years 2021–2022 to tackle homelessness and rough sleeping (Cromarty, 2021).

In London in the UK, close to 1,700 homeless people were being accommodated in hotels and had been supported by various charities according to London's

governing official website Greater London Authority (2021). The authorities also ensured 14 hotels for over 1,400 people and provided isolation rooms, meals, medical care, and other types of immediate support (Greater London Authority, 2021). However, as reported by both the Greater London Authority (2021) and Feantsa (2021b), the emergency accommodation is gradually being closed. It is argued that this action was not meant to be a long-term solution and that the people are moving from the hotels with the help of charities.

Poland also took action in the first period of pandemic by implementing basic sanitary regimes in shelters, informing, and applying new procedures in outreach and food distribution services (Feantsa, 2021b). As Wilczek (2020) reports, NGOs had a crucial role and reacted quickly in the initial response by helping homeless people amid the COVID outbreak. He notes the Polish government's response was mediocre. The COVID testing rate was very low, numerous measures that were meant to ensure safety within homeless shelters and other institutions, like personal protective equipment and disinfectants, were an issue. Access to non-COVID-related health services also became very challenging (Wilczek, 2020). An organisation created the "Mobile Help Desk" service, namely, a bus that frequently delivered goods such as cleaning products, food packages and other material support (Feantsa, 2021b).

Denmark's government adopted an aid package of funds for organisations to help them improve and adapt their services for homeless people during the pandemic, distribute meals, and rent out rooms in hotels. One of these organisations is Project OUTSIDE (Projekt Udenfor, n.d.) that concentrated on rough sleepers who lack access to housing and struggle with complex social and health problems. The authorities also offered COVID testing for homeless people and migrants by establishing mobile units. People who tested positive were given isolation in designated facilities with medical surveillance. During the first wave, Copenhagen quickly responded to the pandemic by opening an emergency hostel that also handed meals out (Feantsa, 2021b).

As reported by Parisotto et al. (2021) and Barbieri (2020), the Italian government introduced no measures or guidelines to safeguard rough sleepers, homeless people in shelters, or the people working in those contexts. In addition, no plan was made to boost health and social services to answer the needs of the different sections of the population (Parisotto et al., 2021). Homeless people have had to depend on the help of NGOs, charity organisations and donors. Barbieri (2020) reports the reason for the lack of national strategies on homeless people during COVID is the characteristics of Italy's health system, which is greatly decentralised. He notes that "only the Piedmont Region has issued official guidelines indicating the measures to be taken to protect homeless people during the CoViD-19 epidemic" (Barbieri, 2020). Charities and organisations, such as INTERSOS, partnered with other organisations and donors to implement the prevention measures. Mobile teams with social/health staff were moved onto the streets where they conducted health promotion, orientation

to socio-health services, and child protection activities in the homeless shelters. The INTERSOS24 centre, which has been developed to serve different project levels, adapted its activities to strengthen health support by providing medical examinations, training on personal hygiene, psychological support activities, legal referrals, accompanying people to COVID testing or COVID-isolation hotels. Further, special mobile outpatient clinics were set up, focused on prevention, medical examinations, and early screening for COVID symptoms (Parisotto et al., 2021).

In Germany too, NGOs and other donors have played an important part in helping the homeless during the COVID pandemic. Germany-based businesspersons started a pilot study with the goal of developing new ways to provide support in the fight against hypothermia-related death among rough sleepers. They installed waterproof sleep pods called Ulmer Nests for the homeless in the city of Ulm to protect them against harsh weather. These pods are intended for people who cannot access homeless shelters for various reasons (e.g. they own a pet, they feel ashamed) (Ulmer nest, n. d.).

In Switzerland, Belgium and France, homeless people have been assisted by Médecins sans frontières (MSF). This organisation set up bed facilities in Brussels where homeless people and migrants can isolate themselves, receive medical treatment, and be transferred to hospital. Further, two mobile teams give support to the authorised structures by educating and raising awareness. They help detect people who are infected with COVID in Paris' emergency shelters and provide consultations. They use mobile clinics to provide COVID testing and referrals. Meanwhile, in Geneva they are providing health support for homeless people and training staff to work with them (Médecins sans frontières, 2020). We have outlined the various ways in which countries have organised and responded to the pandemic and new initiatives that have addressed the needs of the homeless population, where emphasis was put on improving access to healthcare (through testing, prevention and treatment) as well as organising (additional) accommodation, with different roles in countries played by the government (local and national) and NGOs, reflecting the variations in how these services were organised also prior to the pandemic. We now turn to the services and their organisation in Slovenia.

Provision of services for the homeless during the pandemic in Slovenia

Following the above list of practices and examples concerning how homeless services have responded to the COVID-19 pandemic and often adapted with new solutions for accommodating the homelessness, we now turn to how homeless services in

Slovenia have experienced the pandemic and the ways in which they have adapted to the new reality and various restrictions and regulations imposed to protect the health of the population generally and workers and homeless people in particular.

Methodology

We conducted 12[1] interviews with people working in a service for the homeless for the purpose of gathering information within these services[2] based on a list of organisations working with the homeless (published on main website by the Ministry of Labour, Family and Social Affairs and Equal Opportunities). These included overnight shelters, shelters as well as day centres for the homeless that distribute food, clothes and offer support to homeless people. Interviews were carried out with 12 organisations (from 36 on the list)[3]. The organisations were based in eight cities in Slovenia, where such services are also mainly located for the wider region.

The interviews were performed between March and May 2021 with the restrictions on contact being still in place meaning that they were carried out via Zoom, recorded and transcribed. The interviewees had been given a written consent form containing all information about the interview, and contacts for additional information and ethical considerations as well as the possibility of withdrawing their consent at any stage.

The interviews were based on a single questionnaire covering the evaluation of work with the homeless during the pandemic, the changes, and an evaluation of the effect the measures have held for their work in particular and homelessness generally in Slovenia. The transcripts were then analysed based on a thematic analysis approach, namely, a method for identifying, analysing, organising, describing and reporting themes found within a data set (see Nowell et al., 2017; Ritchie & Lewis, 2003). We analysed the content and identified the following main themes:

- Adaptations to the new circumstances made by organisations working with the homeless
- The biggest challenges identified by the organisations
- Support received from various actors

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1 In one organisation, two people participated in the interview together, i.e. 13 people were therefore interviewed.

2 The authors thank two students Armin Salkič and Saša Lazić for helping to conduct the interviews and for transcribing them.

3 The sample is not representative and no sampling method was used. All organisations that worked with the homeless (as the main focus of the organisation's work) were contacted, initially via e-mail and in case of no response also by phone.

Results

Since this is an exploratory study, we first mapped the organisations' responses to the new situation (see Table 1). Our main finding is that all of the interviewed organisations revealed considerable innovation, flexibility and adaptation and care for maintaining those services that would continue to help the most vulnerable groups.

Main changes within the homeless services

Table 1

The organisations' responses and adaptations

Response of the organisation	Explanation
Continuation of activities	Provision of regular services and support
Increased hygiene and other preventive measures	Masks, disinfection, distancing …
Adaptation of work to the new circumstances	More work on telephone, outside, individual work
Limitation of regular services	Day centres closed, some delivery of meals limited…
Limitation of additional services	Sporting and other events, socialising …
(New) ways of caring for users' well-being	Giving information, increased individual work …
Psychological resilience and adaptation	Accepting and adapting to the new situation

Initially, the organisations tried to ensure the **continuation of their normal activities**, such as accepting new users, providing all the main services, working and supporting the users (with visits to doctors, the Employment Office, managing social assistance claims etc.). Their primary goal was to continue to support this vulnerable population most in need of the support. This was also enabled by continuous financing since no changes were seen in this respect.

However, the new conditions also saw several new measures and restrictions being introduced, with regular work being adapted in order to follow the regulations imposed and to act preventively.

Greater attention was paid to **hygiene and other preventive measures**. Therefore, following the recommendation of the National Public Health Institute (NIJZ), the staff working in the services for the homeless used masks and gloves and engaged in disinfection at the door, regular disinfection of spaces, more regular washing and cleaning of the spaces, also measuring users' temperature, wearing masks outside and other preventative measures. "And we did in both, that is, in all three waves follow the measures of the NIJZ … we followed them consistently." (2:4) They also introduced COVID testing for new users, often to protect older more vulnerable existing users, and/or a few days of isolation for new users.

> "The tempo of rotations of new users during the first and second waves was lowered, because of that we were much more conservative and much more attentive to who we would accept. Even those that we would, we would have to test them, consequently this rotation was much slower and, from this perspective, not many users changed." (2:1)

Some users also had the possibility of early vaccination when it became available.

> "We also had an option … a pro-bono clinic offered us the option of vaccination." (2:7)

Organisations were very proactive, i.e. acting preventively before any directions had been received, thinking of innovative ways to continue to support homeless people while following the various prevention rules and recommendations.

The organisations had **adapted their usual work to the new circumstances**, e.g. reducing the number of users in overnight shelters to ensure some physical distance (from 12 to 8 per unit), in one case also by reserving one sleeping unit (night shelter) for the potential quarantine of other users with COVID. Further, they changed e.g. how meals were delivered from a canteen to the provision of lunch boxes, or forming smaller groups of users while eating in the canteen. As the shelters are usually small and space is limited, in some cases the whole shelter was treated as a single household and, as such, provided the confirmation of residency and confirmation of being in the same household, to allow them to socialise also outside of the shelter.

> "Although, like I said, we treated them as members of the same household and we also gave them the temporary residence certificate so that they have the certificate with them, as they are actually temporary signed with us and we also wrote some certificates for them that they are members of the same household. If they then socialised together outside out of our area, they had no problems." (1:2)

Another adaptations entailed the discontinued or very limited use of volunteers, which also posed some problems with regard to increased workload (see the next section on challenges).

> "That is, we were left without the volunteers who previously amounted to around 20 per day, and were only left with the employees so most of the work fell on us and, as a consequence, we asked for help also the xx (name of organisation omitted for anonymity) that were cooking for us, so that we could maintain the toilets and provide all the necessary protection." (2:2)

However, the changed circumstances also meant that some **regular activities of the services have been limited**. For example, day centres have been partly closed during the pandemic (pursuant to government regulations) and therefore working with users has occurred by telephone or been transferred from inside to outside spaces. In particular periods and for some services, their fieldwork stopped and regular work could not be carried out (e.g. street newspaper sales) or regular services were changed (e.g. no hot meals). Some group work was transformed to individual user work.

> "Especially our day centre that provides for the drug users in Metelkova has restricted its work in a way that they changed to individual consultations, to individual user work. After that, they also closed a bit ... and tried a bit ... besides the individual consultations they also tried to orient themselves to helping by phone or e-mail (more by phone)." (2:1)

Moreover, **the services' additional activities have been decreased or abandoned** due to the regulations to reduce socialising. Organisations cancelled various trips, socialising, sporting or other activities for the homeless.

> "All of the other activities that were previously done with the homeless … I don´t know … from socialising, board games, news, movie nights, various celebrations, New Years, Christmas, literary nights, all of this got cancelled. All of these activities … hiking with the homeless … we had a lot of this … it all got cancelled." (2:2)

Further, within the shelters, socialising was often limited, social or physical distance was encouraged, also socialising between staff and daily users was reduced to limit contact. Users were encouraged to limit their errands outside the shelter to lower their social contacts and limit their trips only to necessary ones.

> "All of the food distribution in Nova Gorica changed to lunch packages, there was no more contact with them. And we also came, distributed the food and left. Before that, we had tried to talk with them a bit. There was no more of that." (2:2)

They were all, considering the fear and everything, respecting these preventive measures. We introduced an internal quarantine, which means that all of our residents were inside the house, and they exited only for urgent errands ... hospital or

something else. The shopping was organised by us, so they were actually very protected against the infection. (2:3)

Due to the abandoning of several activities important for the users, organisations tried to compensate with other **ways of caring for the users' well-being**. To improve users' well-being, services for the homeless connected up with other organisations like animal shelters so users could help out, participate and improve their psychological well-being, they motivated users by forming common projects within the shelters, enabled daily walks, and increasingly supplied information to the users, explaining what was happening. Many organisations mentioned that they had increased their individual work with their users.

> "In the second wave, we helped out those who wanted to cooperate with the related organisations. We have certain people who helped, for example, in the animal shelter. Gradually, we found one common solution that is good for them and for their well-being." (1:1)

> "Now of course, with the users ... for all of the time we did and still are informing them. In the first wave, when there was still a lot of uncertainty and you didn´t know exactly what to say, you told them what you had heard in the media or from others. But, amid all this uncertainty, we had to get ourselves together, explain things to the users, warn them." (1:2)

In some cases, the organisations also increased their work and added extra programmes during this time, e.g. to address current problems by establishing an additional temporary shelter for the homeless. This introduction of new programmes also enabled some new employment in these services, although it generally remained stable.

Another example is the establishing of new connections and enabling of new nursing care services on the street. In several cases, they increased the fieldwork or increased the supply of meals.

> "We usually have lunch packages once a week. During the epidemic, when access to food was disturbed, we had the centre opened twice, and each time there was the possibility to take the centre's lunch package. Tuesdays and Fridays. I provided this food by financial means and donations." (2:7)

The majority of interviewed organisations also noted they had made greater efforts with advocacy, lobbying for the groups and drawing their problems to the media's attention as well as that of policymakers. "Maybe also this, I think was our specific role, that we stressed to the public, the municipality, and the government what the needs are and what is the situation in the terrain." (1:3).

Another important internal response was **psychological resilience and adaptation**, i.e. recognition and acceptance of the new reality, as well as the use of common sense while applying various directions and measures. The most challenging was the first wave, with fewer adaptations being necessary and less insecurity being noted in

the period thereafter due to the practices and protocols in place as well as the experiences gained.

Challenges identified

We now turn to the main challenges the organisations detected in their work during the pandemic (see Table 2).

Table 2

Challenges identified

Main challenge	
Keeping the current provision of services	Confusion, lack of instructions
	Quality of services while at a distance, use of on-line and telephone communication
Financial	Increased costs and/or lower donations
Health-related	Protective equipment
	Preventative behaviour
Staff	Overburdening
Spatial challenges	Related to the organisation of work within shelters (special physically-distanced quarantine etc.)
	Related to the use of public spaces
Users' well-being	Stress, discontent, fear
	Ability to improve their conditions (employment options, housing options)
Accessibility of services	General services, water, toilets
	Homeless services
	Health services

A considerable challenges often identified concerned how to adapt and **keep the current provision of services** needed for the homeless. There was initial confusion regarding how to adjust to the new circumstances and adapt the work, with this also

leading to a feeling of helplessness for both the service providers and users. ("Fear was very present, great uncertainty amongst the employees and volunteers, as well as amongst the homeless individuals."; 1:3). Changing from provision to counselling and helping by telephone has limited use. Therefore, in later stages this was often abandoned in favour of regular in-person service provision. Often, several other activities like maintaining contact with former users had proven difficult to continue in the current circumstances. Service providers frequently found at the beginning that there were no clear instructions on how to work and which measures to adopt, and that recommendations were not adapted to how individual organisations work. Access to the provision of current services was also limited as a negative COVID test was often a new condition imposed for being accepted.

Further, certain **financial challenges** were also identified following the increase in expenses linked to the provision of disinfection, masks and similar. In addition, in cases where organisations also had an important share of their funding linked to donors (e.g., through annual donor concerts), this source of funding was unavailable during the epidemic.

Several challenges were detected **in connection to the health and preventive measures adopted**. First, several organisations initially had problems obtaining enough protective equipment, especially masks. Moreover, staff had problems explaining to the homeless what was happening, why the measures were necessary and sometimes getting them to comply with these measures ("The problem is, of course, that many users aren´t able to comprehend these kinds of things, it´s completely new. People don´t believe what is happening."; 1:2). In addition, detection of the disease was sometimes difficult given that the homeless can have various health difficulties that mask the symptoms, also they do not express their problems and can put off going to the doctor. An important prevention measure included quarantine in case of risky contacts, which was hard to enforce in the case of the homeless since they could decide to disregard it. ("Our problem was to keep our users inside so that they would not endanger the other citizens, this was the biggest issue. You are sick, you cannot go out… yes, alright, and he has taken his shoes."; 1:4).

The new circumstances also introduced several **challenges related to staff**. Most importantly, workload often increased due to the additional tasks arising from the health preventive measures, the absence of volunteers and more individual work with users.

> "After every homeless person, we had to disinfect everything, to clean. This presented a big challenge." (2:1)

The staff also encountered considerable insecurity regarding how to organise the work, they were worried about the health of both employees and volunteers as well

as that of the users and their well-being, which added to their psychological burden on staff. The organisation of work was particularly tough if staff became ill.

What the current health crisis has also brought to the surface is the spatial difficulties faced by the services. Several **challenges associated with space were identified**. First, due the spatial characteristics of the services, mainly the provision of common beds and a high number of people in a small space, it was impossible to ensure the physical distance recommended by health professionals.

> "From the point of our work and our organisation, certainly one of the most problematic measures was the keeping of social distance due to the space constraints. Our centre is made in such a way that as many people as possible can crowd together in a small space. With the epidemiological picture, this could not be done anymore. That was the biggest issue." (1:5)

Further, organising specific sections for those who had tested positive was for the large majority of interviewed services difficult or impossible. The characteristics of the population meant that several other limitations also posed significant challenges. For example, the problem of limiting movement to the municipality of one's permanent residence given that the homeless may have their permanent residence at a place different to where they currently usually are. Also being fined for not wearing masks in a public space or for socialising. Organisations reported some incidents in this respect, although it does not seem to not have been a very common occurrence.

> "I think the second wave was more problematic for the position of the homeless in Ljubljana, and probably in Slovenia too. First of all, there is a lack of accommodation, second of all, they are exposed to being given fines because of the police curfew, other offences, so they are quite exposed ... even though, let´s say, these institutions are inclined to be more tolerant and understanding of this population, I still think that on the system level this has not been resolved well." (2:1)

The limitations on the use of public space, including socialising, especially during the police curfew entailed a significant challenge for this population and may also have led to homeless hiding from the police or sometimes being brought into shelters by the police.

> "Moving around after 9 p.m. … at the beginning they were hiding a lot, but then they stopped because all the organisations that deal with this put pressure on the media to expose the lack of sense in punishing the homeless." (1:5)

> "In short, during the police hour the homeless must not be around Ajdovšččina ... it is forbidden. This is how we got 2 homeless, otherwise they might not have come here, but because they were forced to since they must not be outside during the police curfew. That was really cruel... 2 police officers and 2 from the civil protection brought them here." (2:6)

The impact of the new circumstances led to the **decreased well-being of users**. The services noted the users' stress, discontent and poorer health.

> "The users had problems especially with ... the emotional distress grew because of the great uncertainty, many things, like I said, got cancelled, changed and ... that had a bad impact on the already poor mental state (of users)." (1:2)

Their discontent with the circumstances also grew over time, which could bring about conflicts.

> "They were more scared in the first wave, they did not know what was happening, what was waiting for them, how it would continue …. In the second wave, fatigue set in and the end of the year was nearing ... people were so tired that conflicts were occurring." (2:7)

In some cases, they also noted the increasing stigmatisation of the homeless, especially during the first wave, for being outside, for socialising: "for example, during the first wave there was a huge stigma concerning our users socialising in groups on the street. People were judging them, citizens were judging them, they had problems with it." (1:5)

The circumstances and general changes also influenced the users' possibilities of improving their situation, finding work or (other) accommodation.

> "Our users who were inside, that were actually in the house, received all the services but they could not actually make progress with ... job searching or some other things ... in this time, that was discontinued ... like for others, the same for our homeless." (2:3)

The lower well-being was also linked to the **reduced availability of several services**. One of these services was day centres for the homeless, where they usually spent large parts of the day but during some periods of the epidemic were closed. Access to other services relevant for the homeless has also been limited along with the more difficult access to everyday services such as stores. Another major problem was the closed public toilets and access to public (drinking) water.

> "Now actually several ... all organisations are closed. Access to the centre is much more challenging, as well to other humanitarian organisations, to food ... the programmes with daily activities are closed ... where those who live on the street could receive lunch, take a shower." (2:3)

A further problem was **access to healthcare**. Although access to healthcare is problematic for this population generally and a few organisations did not detect any significant changes ("I think the situation was no different than before the epidemic because access to healthcare was challenging even before then"; 1:3), others also put forward the issue of more difficult access, especially to primary care, less so to emergency care.

> "Of course, all the services were more difficult to access for us employees as well for the homeless. We also had one case when a man came from Zagreb in the first wave, and we simply ... he was without clothes, without anything ... unexamined. During this time, there were far more infections in Croatia and the healthcare team simply did not want to accept or check him. So, we actually took a risk by accepting and clothing him, taking care of his hygiene situation. And we took him twice to the ER and they then had to cut his finger off because of gangrene. Thus, we noticed that accessibility to services had decreased." (2:3)

Addressing the challenges and the support received

The organisations chiefly responded themselves to the challenges outlined above by making several adaptations to their work, as described above, involving innovative ways of adopting the recommendations and psychological resilience. However, the identification of some of the additional support they have received is also noteworthy. This section presents the main actors identified during the interviews from which the organisations working with the homeless had received support (see Table 3).

The greatest support came from **within the homeless services** themselves, e.g., by organisations helping each other, cooperating, and even co-organising activities. "In the centre of the city, a house was offered in which we then … which was then taken over by organisations, our NGO, Organisation Z, we helped, and a few more organisations too." (2:1). Further, coordination within the organisations for bringing the problems to the media's attention with a view to improving the conditions for the homeless was important.

> "What you said earlier, about all the good the epidemic has brought, there is the bigger cooperation between us organisations that work with this, larger informal help. We have helped each other with the complete public infrastructure, also with schools, kindergartens, municipalities, everyone helped us. We, the organisations in the field of homelessness, have increased our advocacy role greatly." (1:5)

There was also one report of receiving help and information from **similar organisations working abroad** where Slovenian organisations had established such links. We can also see the high mobilisation of **resources within the individual organisations** themselves. Internal resources were mobilised, e.g., solidarity and help from the users, especially in cases when some users or staff had become ill other users helped. Moreover, high levels of motivation and solidarity among the staff were important.

> "We are very connected in the team, we are all ready to jump in whenever necessary and we are also very collegial, so maybe it is also because of this that we don´t sense staffing problems. Now, if we here had three women with small children, we would

have a grave staffing issue. But for now, we are alone and we all almost live for this job." (1:5)

In addition, there was general cooperation within **civil society and various organisations.**

"Here we were helped by the Civil Protection … they have kept inside. One of the residents took over the coordination because all three employees had to be in isolation, and they had the food organised. The Red Cross provided food from local producers and representatives of Health centre XX and the Civil Protection came to visit them several times." (2:6)

One of the most important providers of help in organising and adapting to the new circumstances has been **municipalities**, which the organisations have reported as often showing an understanding of their problems and increasing their support for the organisations in various ways by suppling additional places, the required supplies or additional funds.

"We are partly financed by the ministry, partly by the municipality. As far as I know, the ministry also gave additional funds for the protective materials. Most of the increase in these costs was covered by municipality X. We got everything we needed without a problem." (1:4)

As an important additional resource, several organisations also mentioned **donations**, especially of food by companies (stores) that allowed them to provide a higher quality service (meals).

"When it comes to helping with food, many donors responded in the first wave. We were then also actively searching for help by collecting water bottles, also food, to lower the costs, as we had greater costs with these disinfectants." (2:2)

In addition, some cooperation within different **health institutions**, such as local health community centres, individual doctors as well as the National Institute for Public Health, were reported.

"We turned very quickly to the municipality, the Civil Protection, the health centre, that helped us by providing protective gear, protective masks, gloves, disinfectants." (2:6)

The **Ministry of Labour Family, Social Affairs and Equal Opportunities** was referred to as it supplied some instructions on work in the new conditions, but also additional funding through a tender for the financing of programmes to help vulnerable groups using EU funds. There was also some agreement on the co-financing of housing in the event of COVID infections and the need for isolation.

"The fact is, that in the second wave, the Ministry enabled that if, for example, a homeless person had become infected, that association XX could rent an apartment in which this person could spend time ... maybe this is also a part, that some options opened at least in the second wave." (1:3)

Table 3

List of internal and external actors providing support

Internal – within the homeless services	
	Cooperation among organisations working with the homeless in Slovenia
	Cooperation with organisations working with the homeless abroad
	Solidarity of users
	Solidarity and high motivations of those who work with the homeless
External – outside the homeless services	
	Help from various other NGOs
	Help from the Civil Protection
	Help from municipalities
	Donations by companies and individuals
	Ministry of Labour, Family, Social Affairs and Equal Opportunities
	Help from health professionals and health services
	Help from community services (schools, kindergartens)

Discussion and conclusion

As the analysis indicates, homeless organisations in Slovenia have done everything in their power to continue to support this very vulnerable population and shown high levels of flexibility, innovation and adaptability in order to keep providing their services. However, staff have often been overburdened by this process and revealed high internal motivation and care for the users. Therefore, further support for the staff is needed as is enabling higher staff-to-user ratios to permit more individual work and user support, especially relative to their complex needs, as has already been noted within the services (see Kovač et al., 2020).

Along with high involvement of staff, the high level of interconnectedness and cooperation among the services has been an important resource for enabling work in the new circumstances. In this health crisis as well as the linked general social and economic crisis, the services for the homeless have therefore shown their ability to cooperate and also detect problems and introduce solutions to improve the conditions for the homeless. Building on links established within the services, this cooperation is vital for enabling their growth and advancement and should be further encouraged.

In addition, strong community support was noted, especially from various municipalities. This indicates that having services firmly embedded within municipalities and receiving support and funding was also important because this was the source of additional support for many services. However, certain regions still have no services in place for the homeless (Smolej Jež et al., 2018). This is an issue that should not be left entirely up to the discretion of municipalities. Regionally-balanced coverage with services for the homeless and helping the population suffering extreme housing exclusion should thus become a national goal.

Preventive behaviour was adopted in the services and many services noted few health problems. A future preventive strategy is the possibility of vaccination which, according to one interview, has been facilitated for this vulnerable group. Vaccination is important for protecting these vulnerable people in the future. Governments and organisations such as Feantsa are campaigning to vaccinate people experiencing homelessness. They are holding webinars on how to execute campaign plans by presenting experience and good examples from praxis regarding how to deliver them to homeless people (Feantsa, 2021a). Many countries have also decided to declare homeless people as a priority group to be vaccinated. As reported by Papp and Dande (2021) for Hungary and Shah and Vandentorren (2021) for France, homeless people were one of the first groups to be vaccinated and the vaccination was performed in homeless shelters. Further, the National Board of Health decided that people experiencing homelessness are a priority group for receiving the vaccination as most homeless are not properly diagnosed (Thiesen, 2021) and have a disproportionally greater risk for COVID-19 infection (Shah & Vandentorren, 2021).

Still, this is only one thing that must be done to protect this population. The current crisis has emphasised the unsuitability of the current spatial conditions within the services. The overcrowding of shelters did not leave any room for either isolation/quarantine or distancing. This makes it one of the things in dire need of change, not only with respect to this crisis but as a general direction in the development of such services. One employee of a service stated:

> "That´s good, and it´s also good that they started to warn about the spatial issues of shelters, especially ours. It started to be talked about a lot, we have more and more

> arguments to negotiate with Municipality Z and others that we need a different space. We need a space where 2 or 3 people can use the bathroom. There cannot be 12 people in one room. It´s not humane, we have conditions like in a prison." (1:5)

Accordingly, this issue calls for change to ensure basic human dignity and human rights, as well to protect the health of the population, not simply in the context of the present epidemic, but in the wider sense of psychological and physical well-being. The Ombudsman of Slovenia attended the 11th session of the Commission on Petitions, Human Rights and Equal Opportunities of the National Assembly of the Republic of Slovenia (2021) where he spoke about the poor position of the homeless during the pandemic. He pointed out that their basic human rights have been restricted, such as freedom of movement and gathering in public places, access to clean water and use of public toilets (Varuh človekovih pravic RS, 2021). This crisis could therefore also be an opportunity to restructure the services provided that policymakers recognise this need. The services should turn to more innovative ways of addressing housing risks, while shelters should only become a first and short stop in the process of improving one's housing conditions. This is linked to what experts and professionals working in these services have long noted: that there is a need to develop the social rental sector as well as emergency housing units and housing units that are adapted to users' needs (Dekleva & Razpotnik, 2010; Hegler, 2013; Kozar, 2008; Mandič & Cirman, 2006; Mandič & Filipovič Hrast, 2015; Mandič, 2007; Razpotnik, 2008; Sendi, 2007) that would allow this population to leave the shelters as soon as possible. Moreover, it is important to recognise the value of supporting them in obtaining an apartment (e.g. organisations acting as guarantors) (Dekleva, 2013), using prevention measures like the prevention of eviction, and continued support for the most vulnerable groups leaving institutions and having housing programmes that would support their routes to independence (e.g., those leaving prison, hospitals, children in foster care etc.) as well as programmes for housing support for those who need additional help to maintain their dwelling. One way to move forward here would be a strategy on homelessness, as already adopted by many European countries (see Gosme & Anderson, 2015; Hermans, 2017; Lux, 2014; O'Sullivan, 2016), that would look at the problem and its various dimensions holistically and tackle it with ambitious aims including a clear link to housing policies (also see Filipovič Hrast, 2019).

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7 IMPACT OF THE COVID-19 PANDEMIC ON ADOLESCENT YOUNG CARERS IN SLOVENIA

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Abstract

Adolescent young carers are children and adolescents aged between 15 and 17 who provide significant and substantial care, assistance or support to a family member (or a friend/neighbour) with a disability, chronic illness, mental health problems or other conditions that require care. During the COVID-19 pandemic, the measures introduced have shifted a considerable burden of care from the care sector to individuals and families, where the adolescent young carers found among them are quite a vulnerable population. Based on a survey of adolescent young carers in Slovenia conducted within the international project Psychosocial support for promoting mental health and well-being among adolescent young carers in Europe (ME-WE), in this chapter we present analysis of the situation of adolescent young carers in Slovenia during the COVID-19 pandemic with regard to their mental and physical health and experiences in this period.

Key words: adolescent young carers, COVID-19 pandemic, informal care

Introduction

Young carers aged between 15 and 17 are adolescent young carers (AYCs) who provide significant and substantial care, assistance or support to a family member (or a friend/neighbour) with a disability, chronic illness, mental health problems or other conditions that require care. Children and adolescents become young family or informal carers for many reasons, including cultural background, a feeling of obligation, the absence of alternative solutions, affection and empathy for the care receiver, a lack of monetary and other support from family or friends/relatives. This means that AYCs regularly do things and take on responsibilities typically associated with adults, making growing up with caring responsibilities different to the growing up of adolescents without a caring situation within the families of their friends' networks. The majority of research on young carers has been done in the United Kingdom (Aldridge & Becker, 1993; Cheesborough et al., 2017), Canada and Australia, while in European countries, despite some more recent national studies (Da Roit & Naldini, 2010; Nordenfors & Melander, 2017), research is still lacking, especially in a comparative perspective. In Slovenia, young carers are an invisible population and an overlooked research topic with, to date, no study having been devoted to them.

This group of adolescents is worthy of special attention because this is a crucial period in their development and transition from childhood to adulthood. Therefore, to increase the recognition and consideration of adolescents with caring responsibilities and the issue more broadly, the support of public policies, legislation and social and healthcare sector is essential. During the COVID-19 pandemic, the various measures implemented, such as the closing of preschool institutions and schools, limited home and social care for older people, and appeals to return the occupants of nursing homes to their families, have shifted a considerable burden of care from the care sector to individuals and families (see Eurofound 2020a; 2020b; Blum & Dobrotić, 2021), among whom AYCs constitute an especially vulnerable population. Based on a survey of AYCs in Slovenia conducted within the international project Psychosocial support for promoting mental health and well-being among AYCs in Europe (abbreviated to ME-WE), in this chapter we present analysis of the situation of AYCs in Slovenia during the COVID-19 pandemic with regard to their mental and physical health and experiences of the pandemic. We are interested in whether their caring responsibilities had increased in this period and whether they had received any support. Special attention is paid to their experience of distance learning and the effect of the social-distancing measure on the life of this quite vulnerable group of children.

The structure of the chapter is as follows; we first define who AYCs are before briefly discussing the care regime's characteristics in Slovenia, also at a time of policy responses to the COVID-19 pandemic. In the empirical part, following a short presentation of the methodology, we discuss the everyday experiences during the COVID-19 pandemic in the life of AYCs, a particularly vulnerable population. We conclude by offering critical policy recommendations for policymakers and all relevant stakeholders.

Who are young carers?

The book Children Who Care: Inside the World of Young Carers (Aldridge & Becker, 1993) was the first scientific work to embrace the issue of young carers. Studies on young carers (as well as the more recently introduced category of AYC) seldom rely on varying definitions of young carers and different age categories (Aldridge, 2018). Most of the recent studies refer to the definition of young carers given in the Blackwell Encyclopaedia of Social Work (Becker, 2000), arising from the pioneering work of the Young Carers Research Group at Loughborough University.

> "Young carers are children and young people under the age of 18 who provide care, assistance or support to another family member. Young carers carry out, often on a regular basis, significant or substantial caring tasks and assume a level of responsibility, which would usually be associated with an adult. The person receiving care is often a parent, but can be a sibling, grandparent or other relative who is disabled, has some chronic illness, mental health problem or other condition connected with a need for care, support or supervision." (Becker, 2000, p. 378)

However, in more recent research this definition has been adjusted to reflect the ambiguity present in the terms "regular" or "significant" as indicators of caring, with attention moving to the concern with the impact of caring responsibilities on young carers' lives, their well-being as well as successful transition to adulthood, education and entry to the labour market (Aldridge, 2018; Cheesborough et al., 2017). Moreover, recent definitions extend the location of caring beyond the family home. The definition used in the latest UK research defines a young carer as "a child/young person under the age of 18 who provides care in, or outside of, the family home for someone who is physically or mentally ill, disabled or misusing drugs or alcohol. The care provided by children may be long or short term and, when they (and their families) have unmet needs, caring may have an adverse impact on" children's health, well-being and transitions into adulthood (Cheesborough et al., 2017, p. 9).

Further, research shows that even in countries with a high level of awareness of informal care and with support programmes developed for young carers the level of self-recognition among young carers is relatively low (Aldridge, 2018). There are very few data on young carers in European countries and this subject is comparatively new in the European space. While some studies can be found, they are incomparable because they employ different definitions of young carers, different methodological approaches, and include different age categories (Aldridge, 2018; De Roos et al., 2017; Nordenfors & Melander, 2017; Schlarmann et al., 2008).

In the ME-WE project, the source of the data presented in the chapter, we use Becker's (2000, p. 378) definition of a young carer. The ME-WE is a comprehensive and innovative project of a European consortium of established universities, research institutes and non-governmental organisations. It is financed from the EU Horizon 2020 research and innovation programme, and aims to strengthen AYCs' resilience in order to positively impact their mental health and well-being, while also alleviating the negative consequences and influences of the psychosocial and environmental factors[1].

[1] For more information on the project's rationale, results and findings, visit www.me-we.eu.

Public policies and legislation on adolescent young carers

Slovenia is a country that offers little formal support for older people ageing in the community. The country's elderly care model may be characterised as implicit familialism (Filipovič Hrast et al., 2020; Hlebec et al., 2016; Hlebec & Rakar, 2017). On one hand, Slovenia's care model is based on a long tradition of institutional care intended to support people with severe disabilities and care needs. Such institutional care provides facilities for up to 4%–5% of the population aged 65 and above. On the other hand, family care is assumed and prescribed by a legal obligation on offspring to financially support the costs of care of their parents. This deeply woven expectation that families take care of their members comes from the socialist era and before 1992 was accompanied by the grey and unregulated provision of services to fill the institutional care–family care gap. Formal services for dependent people residing in the community began to develop after 1992, chiefly in the form of social home care. Yet, their provision is limited to 4 hours a day and the financing is divided between the resident municipality (up to 50%) and the private out-of-pocket contribution of users or their family members. Social home care, which is only provided to about 1.7% of people aged 65 or older, has slowly and hesitantly developed, and is hardly cost-effective for end users (Kovač et al., 2019). The only other measure for supporting a family carer who provides care to an adult family member is up to 14 days' sick leave if the family member resides in the same household as the dependent person.

Like elsewhere, in Slovenia the familialist care model faces several challenges concerning its sustainability (Filipovič Hrast et al., 2020). The work–life balance perspective of meeting working carers' needs is becoming a critical issue in European welfare states. Still, most attention is given to working parents, while public policies have rarely considered working and holding responsibilities for caring for older relatives as a conciliation issue (Da Roit & Naldini, 2010). Moreover, gender inequalities are a salient issue in familialist regimes since both legal obligations and public support for the caring role of the family encourage support in a gender-specific way (see Schmid et al., 2012) and it is in this context that AYCs and especially girls are quite a vulnerable group.

Slovenia has no specific legislation protecting and supporting AYCs and their families. The current system offers just indirect support for young carers, arsing mainly from the following legislation:

- The Social Assistance Act (1993): provides the basis for all the services within and for the family. The Centres of Social Work must intervene when difficult family situations emerge. If it is assessed that a child is in danger, foster care placement is sought for the child.

- Long-term care legislation (still only a draft): the focus is on integrated care since the promotion of care should be a responsibility shared by the education, social and healthcare systems.
- The Domestic Violence Prevention Act (2008): includes measures to protect children.
- The Marriage and Family Relations Act (1976) (no longer in force, was replaced in 2019 by the Family Code (2017)): this law regulated marriage, relations between parents and children and among other relatives, adoption, fostering and protection of the rights of children.
- The Family Code (2017) (in force since May 2019): includes provisions on assessing whether a child is endangered and the steps to be taken to protect such a child. The best interest of the child must be pursued.
- Educational legislation: comprising several acts[2], includes regulations on how schools should communicate with the Centres of Social Work if a school notices that a child is in need of special attention.

Among the key drivers of legislative changes, the Family Code recently introduced an important novelty in the field of child protection. In the past, social workers played a double role: they worked with the family but also decided if a child should be taken out of the family. The Family Code places the decision-making in the hands of the courts. Social workers continue to work with the families and propose child protection measures to the courts, which then decide if they should be implemented or not. The high workload of social workers was a driver of these changes. As to the Long-Term Care legislation, in 2002 a special group was formed from representatives of the Ministry of Labour, the Ministry of Health, the Health Insurance Institute and certain other experts with the aim of preparing a report for the government. A draft of the Act on Long-term Care was prepared at the end of 2017 and opened for public debate. This was followed by a new draft of the Act on Long-Term Care, which was adopted in June 2021 and in December 2021 a Long-Term Care Act (2021) was passed. One of the greatest differences between the new long-term care legislation and the previous drafts is that the new legislation deals only with adults, whereas previous drafts were based on a holistic approach of whole support needed during the life span. The currently adopted Long-Term Care Act (2021) has been criticised by several stakeholders for being vague on many points (S. & Z., 2021).

[2] The most relevant are the Placement of Children with Special Needs Act (2011) and the Act on the Intervention for Children and Youth with Emotional and Behavioural Disorders in Education (2020).

Given that AYCs are not mentioned in the legislation, there are also no policy and service frameworks specifically addressing young carers. Still, there are some non-specific policy or service frameworks that can indirectly support young carers and their families:

- The National Programme for Youth (2013). It deals with different policies for young people, with the aim of empowering them. It does not include young carers as a specific target group.
- Strategic documents of the Ministry of Labour, Family, Social Affairs and Equal Opportunities. In the field of social protection and social care, the Ministry is adopting strategic documents on the national and local levels whose focus is on long-term care. However, thus far there is no mention of the protection of young carers and their families.
- Policy for young people with special needs. Slovenia provides very strong institutional care for young people with special needs (mainly referring to people who have a cognitive or physical impairment).
- Education policies. They include measures focusing on inclusion. Within higher education, students who fall in the broad 'special status' category are entitled to certain additional rights.

During the COVID-19 pandemic, despite the strong limitations on social and home care services for people in need of care, no additional measures in terms of services or financial benefits have been put in place. For an overview of the different measures adopted during the COVID-19 pandemic, see chapter 1.

The COVID-19 pandemic in the life of adolescent young carers

Methodology

In this chapter, we present answers to open-ended questions that formed part of a mixed methods evaluation designed to evaluate the effects of the psycho-educative intervention developed within the ME-WE project for empowering AYCs and strengthening their resilience and vigilance. The intervention programme was based on a psycho-educative approach and included seven sessions centred on the principles of resilience and vigilance. The programme started in autumn 2019 and was concluded in spring 2021. The participants were young people aged between 15 and

17 who were involved in caring activities as carers. The study's methodological design is reported in detail in Casu et al. (2021).

A number of AYCs were recruited for the study and assigned to intervention and control groups according to the study protocol (Casu et al., 2021). Here, we are focusing on two (T1 and T2) of the three evaluation points where a COVID-19 open-ended question was presented to the participants.

Each participant was given a code number and their responses to the open-ended questions were read in their entirety. The responses were then coded into key categories and subcategories using traditional hand mapping and the Coding tree for the open-ended questions in the Evaluation Questionnaire for participating AYCs. Finally, short summary texts with illustrative quotes were written for each key category. In the results section, the groups are labelled IG (intervention group) and CG (control group), also the different phases of evaluation process are labelled T1 and T2. Following the analysis guidelines, possible differences between the intervention and control groups are highlighted along with changes while comparing the responses in the T1 and T2 phases of the evaluation process.

The AYCs' experiences of the COVID-19 pandemic

Effects of the COVID-19 pandemic on the AYCs' lives

Surprisingly, the majority of AYCs reported the pandemic was responsible for a positive impact on their lives, especially in the CG, while in the IG the positive impact still dominated, but fewer AYCs referred to a positive impact. The positive impact of the pandemic was generally seen in the way the AYCs had more time for themselves, were more relaxed, spending more time with their families.

> "I am more relaxed and calmer, I am no longer nervous and tired, during the lockdown, I had a lot of time and I used it to get to know myself and spend more time with my family" (AYC, IG, T1[3]).

Many AYCs also found the online learning less demanding and were able to arrange their own curriculum.

[3] To ensure anonymity, quotations from AYCs are only described by the relevant group and evaluation phase.

"In a positive way. I had more time for myself, my school grades were better, because I always had time for homework, preparations for oral exams, since I was always at home" (AYC, CG, T1).

"Positive, as I finally managed to fix my schedule and had the right daily routine, like I need" (AYC, CG, T1).

In both the IG and CG, more positive effects were listed in T1 than in T2.

The AYCs also mentioned the pandemic's negative impact on their lives; in the case of the IG, more often in T2, while in the CG there were no changes.

The negative aspect most often mentioned was social distancing as that had meant not being able to meet up with their friends, which in some cases had led to depression and anxiety.

"In a negative way. I have shut myself off again; I do things that I am not proud of. I feel that I have fallen into a deep hole, for a lot of time I feel sad and anxious. I do not have many contacts with my friends and therefore I do not feel good also because I do not really talk to anyone, since I am not close to my mum" (AYC, IG, T2).

Some AYCs stated they had felt anxiety because they were afraid they would infect their vulnerable family members with COVID-19 and put their lives in danger.

"On one side, the pandemic has caused additional worries, anxiety – mainly due to the fear that I would bring the virus home and endanger my close ones. The transition to online learning was smooth for me. Actually, I understood this form of learning as something positive, as an extra safeguard, which prevents family members in the risk group from becoming infected" (AYC, IG, T2).

The AYCs also expressed the negative effects of too much digitalisation and screen time and their loss of motivation and difficulties with the distance learning.

"Because of the lockdown, my grades worsened, I was without energy and motivation, after the end of the school year things got more relaxed and I have greater energy than during the school year" (AYC, CG, T1).

Some AYCs reported both a negative and a positive impact. The positive impact was generally mentioned in relation to spending more time with the family and having more time available for themselves, while the negative aspect was largely because they missed their friends and socialising.

"Partly negative and partly positive. Positive: I had more time for myself. Negative: I have often felt lonely" (AYC, IG, T2).

A few AYCs stated that the pandemic had no impact whatsoever on their lives.

Besides what is mentioned above, there were no other differences between the IG and the CG or between T1 and T2.

The support needed and available during the COVID-19 pandemic

The changes brought by the pandemic had created a bigger need for support for the AYCs, chiefly in terms of financial or physiological support.

> "No. I was thinking to turn again for some help from a psychotherapist because of my problems and distress, for which I previously thought that I do not need, but it is becoming more obvious that I need professional help" (AYC, IG, T1).

Only one respondent in the IG in the T1 phase expressed the need for family support, while for others the changes did not lead to a stronger need for support.

> "No support. Only love and health" (AYC, CG, T2).

The majority of the AYCs also stated that they had received support, but this was mentioned more often in the CG, while in the IG in the first T1 phase very few respondents noted they had received support, whereas in T2 this was stated more often. Yet, many answers were more general, only stating that they had received support and, in some cases, the AYCs referred to financial support received from the state in terms of scholarship or social assistance. In two cases, they referred to support from the school staff and in several to the support of the family members or their friends.

> "I have received a lot of support from my friends and family. I know that we are living in tough times, but they make me happy" (AYC, CG, T2).

> "Yes, from the school counsellor and from those who I can count on" (AYC, CG, T2).

In terms of the AYCs' families' support, this was only mentioned in T1. In many cases, it was not specified who had received the support, the AYC or the whole family.

Changes in the health and well-being of the AYCs due to the COVID-19 pandemic

Although the majority of AYCs revealed the pandemic had affected their mental health, primarily in a negative way, still approximately one-third of the respondents stated that it had affected their mental health in a positive way.

In the negative way, they reported suffering increased mental health problems such as loneliness, loss of motivation, sadness, anxiety, depression, worries for their loved ones, self-injury and anorexia. Many AYCs also stressed that especially the social distancing had affected their mental health by not being able to meet up with friends.

> "I became less social. Sometimes, I feel that I do not need my friends and therefore neglect them. I disgust myself and the person I have become" (AYC, CG, T2).

The reported differences in answers between T1 and T2 are mixed, for some AYCs the experience with the pandemic was more negative in T1 than in T2, when they felt better, or vice versa, some AYCs in T2 reported that their mental health had worsened.

> "At the beginning, I was mentally distressed, but this soon disappeared. I had enough time for myself, for school and the family. Maybe I have missed social contact, but the experience was quite positive" (AYC, CG, T2).

> "My mental health worsened. There was more fear present, more stress, unpleasant feelings" (AYC, IG, T2).

In contrast, some AYCs reported that the online learning had reduced their anxiety since they were no longer worried about infecting their vulnerable family members, which had in turn influenced their well-being.

> "When we were in the lockdown, I felt that the pandemic was not affecting my mental health. On my mental health, there was a bigger influence when in September and at the beginning of October we had to go to school, and hence I was exposed to potential infection with SARS-CoV-2, which I could bring home and endanger my mother. Life during the lockdown was in every sense less stressful. Still, I do not feel that the pandemic has in any way significantly affected my physical health. If anything, I am taking better care of myself in the sense that I run more regularly than before, I also sleep more, as I am aware that to a certain extent this helps with prevention from being infected with the coronavirus" (AYC, IG, T1).

With regard to changes in well-being, the answers were again mixed, with some AYCs stressing that their well-being had improved, for example they were sleeping more, had greater time for their family, while on the other side there had been more conflicts in the family after spending more time together, and that they were missing social life.

Some of the AYCs reported the pandemic had affected their physical health, especially in the CG. However, the changes experienced were both positive and negative. Along negative lines, some reported they had been less physically active and had gained weight, while in contrast other AYCs stressed the lockdown had helped them have more time for physical activities and their health overall had thus improved.

> "My physical and mental health has worsened, I have gained weight and had a minor form of depression" (AYC, CG, T1).

> "I concentrated much more on healthy food and physical activity" (AYC, CG, T1).

In general, for some AYCs their overall well-being and health had improved between the two evaluation phases while for others it had worsened, with there being no differences between the IG and CG as well as between T1 and T2 in the changes expressed in health and general well-being due to the COVID-19 pandemic.

The AYCs' experiences of attending the intervention during the COVID-19 pandemic

The vast majority of AYCs reported positive aspects of attending the intervention with respect to the possibility of attending sessions. They largely stated that they liked them since they could express their feelings, they were relaxed and could discuss and reflect on their situation.

> "The workshops really had a positive influence on me, every week this was one of the most relaxing things. At the same time, I developed a good feeling about myself and a feeling that I am able to help others as well, when they feel down. Although the workshops were online, this did not bother me. I recognised that in such periods we should not suppress our feelings, but release them and thus become aware of them and after somehow slowly gaining control of them" (AYC, IG, T1).

Some AYCs also stated they had liked the online option.

> "I liked the workshops also on Zoom, given that we still learned a lot" (AYC, IG, T1).

> "The experience was positive. I do not know whether I could attend the workshops if they were face-to-face. Probably the biggest problem would be transport, which takes up a lot of my time as well as energy. From the same reason, it is easier for me (and less stressful) to attend school online" (AYC, IG, T1).

Only a few AYCs mentioned negative aspects, mostly in the sense they would have preferred to have all of the sessions face-to-face or that the timing was difficult for them due to their other schoolwork.

As concerns socialising, only two AYCs expressed positive aspects of the possibility of having contact with other AYCs; no participant stressed any negative aspects.

In both the T1 and T2 phases, the experiences with the intervention were very positive in both groups (IG and CG), with no major differences revealed.

> "The experience was entertaining and inspiring. Sometimes you ask yourself such things that you would otherwise never ask. I like new experiences and different things. I really liked it" (AYC, CG, T2).

Conclusion

As shown in the chapter, the AYCs' experiences of the COVID-19 pandemic were surprisingly mainly positive, with the majority of AYCs reporting the pandemic had a positive impact on their lives. This was generally seen in the way the AYCs had more time for themselves, were more relaxed and spending more time with their families. Many AYCs also found the online learning to be less demanding and were able to arrange their own curriculum. More positive effects were listed in the first period of the evaluation (T1) than in the second (T2). The AYCs also mentioned the pandemic's negative impact on their lives and, amongst those, the most frequently mentioned was social distancing from friends, which in some cases had triggered depression and anxiety. Further, the changes brought by the pandemic had led to a bigger need for support for the AYCs, primarily in terms of financial or physiological support, while the majority stated that in general they had received support.

The majority of AYCs stated the pandemic had affected their mental health, mostly in a negative way. Still, approximately one-third of the participants expressed that their mental health had been affected in a positive way. Along negative lines, they reported increased mental health problems such as loneliness, loss of motivation, sadness, anxiety, depression, worries for their loved ones, self-injury and anorexia. For some AYCs, the experience of the pandemic in T1 was more negative than in T2, when they felt better, or vice versa, some AYCs reported that their mental health in T2 had worsened. In relation to changes in well-being, the answers were again mixed, some AYCs stressed that their well-being had improved, for example they were sleeping more and had more time available for their family, while on the other side there were more conflicts in the family after spending more time together. In addition, the AYCs reported the pandemic had largely affected their physical health. The experienced changes were both positive and negative. In a negative sense, they reported having been less physically active and having gained weight, others stressed that the lockdown had helped them have more time for physical activities and their health overall had thereby improved. As regards the AYCs' involvement in the ME-WE interventions, they most often reported positive aspects of attending the intervention sessions during the COVID-19 pandemic concerning sessions, they liked them as they were able to express their feelings, they were relaxed and could discuss and reflect on their situation. Some also stated that they liked the online option.

As shown by the overview of policy measures in addressing the issue of AYCs, it must be emphasised that in Slovenia there is no specific legislation for protecting and supporting young carers and their families. The current system merely offers indirect support for young carers, mainly that arising from the social security, family policy and domestic violence legislation. Still, as evident in our research AYCs do exist in

Slovenia and therefore need to be recognised, identified and supported. As such, our findings about the AYCs' experiences during the COVID-19 pandemic can contribute to suitable policies being formed that address the needs of AYCs in familialist care regimes, whose characteristics have been exacerbated during the COVID-19 social and health crisis. The consequences of that crisis should be carefully considered while preparing the upcoming reform of long-term care in Slovenia, also in broadening the issue of informal care by paying special attention to AYCs. Accordingly, in the future such applied research, continuous education of experts on the topic of AYCs as well as the inclusion of the AYC issue in the legislation in all relevant fields must be stimulated and further developed. An integral approach is essential, involving the cooperation of different ministries (Ministry of Labour, Family, Social Affairs and Equal Opportunities, and the Ministry of Health), schools and other institutions connected with children and their well-being. The overwhelming responsibility for acknowledging young carers and their needs lies on the state. Moreover, the community approach, especially with regard to the early recognition of AYCs, is critical and schools have a key role to play here as they are the only contact point where all adolescents are present. Finally, the support needs to be designed alongside young carers to ensure it meets their needs.

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8 OLDER PEOPLE AND HEALTH DURING THE COVID-19 PANDEMIC: WHAT HAS BEEN LOST AND WHAT GAINED?

Matic Kavčič
Barbara Domajnko

Abstract

Everyday life has changed over the past two years of the COVID-19 pandemic. Apart from the COVID-19 disease itself, the fear of becoming infected, lifestyle changes and the various containment and mitigation measures have affected the health, well-being and quality of life of older people. In a mixed methods study, we examine the COVID-19 pandemic's impact on subjectively assessed health and well-being, health-related behaviour, and an assessment of the healthcare system. Analysis of representative Slovenian Public Opinion Surveys (SJM) 2020/2021 and 2020/2023 revealed no substantial immediate decrease in self-reported health, although the state of the healthcare system was assessed as worse. Older people were shown at a statistically significant level to have experienced the COVID-19 pandemic differently to others. They were also more compliant with the epidemiological recommendations. Qualitative analysis of in-depth interviews points to the depth of psychosocial risks associated with the pandemic and perceived growing social divides that have become a source of major concern. However, the analysis also hints at the emergence of new practices and coping strategies among older people.

Key words: COVID-19 pandemic, Slovenia, health, healthcare, older people

Introduction

Following the initial outbreak in December 2019 of a novel coronavirus (2019-nCoV/SARS-CoV-2, a cause of COVID-19 disease) in Wuhan, China, the virus spread around the globe and has since affected populations around the world. The first infections in Slovenia were detected in early March 2020, with an epidemic being declared in the country on 12 March 2020. After sporadic infections among the active population, nursing homes became the local infection hotspots. This was particularly concerning as the data already showed that the severity of COVID-19 is associated with increased age. Significant risk factors for mortality also include diabetes, renal disease, chronic obstructive pulmonary disease (COPD), dementia, ischaemic heart disease, stroke, solid organ tumours and obesity, meaning the residents of long-term care facilities and nursing homes were a medically and socially vulnerable group (European Centre for Disease Prevention and Control, 2021). Numerous measures were put in place by the government to prevent the virus from spreading. Most notably, on 16 March 2020 the government suspended all unnecessary services

across the country, including public transport, educational institutions, restaurants, bars etc., also non-urgent medical examinations (Legal Information System, 2021).

Everyday life in these new circumstances changed drastically. On one hand, the fear of becoming infected and its consequences and, on the other, the containment and mitigation measures like the social distancing and lockdown restrictions put a tremendous burden on people's well-being. Avsec et al. (2021), for instance, show that in Slovenia more than the fear of becoming infected itself, the perceived severity of the lockdown circumstances has shaped how individuals have psychologically functioned during the pandemic. Although the globally popular phrase "we are all in the same boat" was often used to describe the situation, research not surprisingly quickly revealed the opposite. Many studies showed how the already known social determinants of health (e.g. poverty, racial minority, homelessness, crowded housing, access to public healthcare, precarious employment etc.) had influenced health outcomes during the COVID-19 pandemic (Abedi et al., 2020; Green et al., 2021; World Health Organization [WHO], 2021). Bambra et al. (2020, p. 965) argue that, for the most disadvantaged, "COVID-19 is experienced as a syndemic – a co-occurring, synergistic pandemic that interacts with and exacerbates their existing non-communicable diseases and social conditions". Further, the virus containment measures themselves have an unequal impact on people, thereby adding to health inequalities (Bambra et al., 2020; WHO, 2021).

Apart from biological susceptibility to COVID-19, other social factors have contributed to older people's increased vulnerability during the pandemic. The change in daily routines, the social and nursing care they receive, social support, contacts with family and friends, engaging in hobbies and other activities together with the stay-at-home measures have challenged their well-being. However, Kivi et al. (2020) show that in the early stage of the pandemic older people's well-being in Sweden stayed intact. The authors conclude that in general older adults were resilient during the pandemic, albeit some heterogeneity was also observed. In contrast, Verhage et al. (2021) discovered that older adults had experienced the epidemic as disruptive and lacked meaning and that those who were living alone had struggled more than others. Older people also relied on various problem- and emotion-focused coping strategies to deal with the crisis, including rejection of being labelled as "vulnerable older adults". Other authors have pointed to the spread of ageism during the pandemic. Age-specific measures and ageist narratives in the media were observed in France where older people had experienced hostile and benevolent ageism, yet intergenerational solidarity was also observed (Barth et al., 2021). Similarly, Previtali et al. (2020) express concerns about the shaping of policies and protection measures around arbitrary chronological age, thereby overlooking differences within age groups, which supports prejudice, stereotypes and discrimination on the basis of age.

Slovenia faced its first rise in infections in the spring of 2020. The 'first wave' came following the horrible experiences of neighbouring northern Italy, leading to a fear of the Italian scenario brought about the distress among the population and the strict measures in the form of a total lockdown imposed by the government. While the first wave's impact in terms of mortality was relatively modest, in the second wave during the autumn and winter of 2020/2021 Slovenia experienced one of the highest rates of excess mortality in the world (Our World in Data, 2021). The fourth wave (autumn/winter 2021) saw the situation worsen again as the delta variant spread especially among the non-vaccinated. However, people's lives and health were not simply affected by the coronavirus or the threat of the disease, but also by the measures put in place to protect people's lives and standard of living. To fully understand people's experiences of the pandemic, it is important to consider the governmental measures and epidemiologic recommendations at a given point in time.

In this paragraph, we briefly present some of the key measures (as published at Legal Information System, 2021) imposed to prevent the virus' spread in order to understand how the situation was different between the waves. Measures were declared gradually and according to the changing epidemiological situation. Many were later adjusted or optimised with hindsight, expert opinions or public criticism. It is hard to compare directly the measures implemented with regard to their possible effect on people's perceptions and experiences. However, e.g. during the first wave, visitors to nursing homes were completely prohibited and in the second wave the preventive testing of employees and contact tracing of infections was implemented. All elective and non-urgent medical treatments were stopped for a period during the first wave, yet only some were postponed during the second. Notably, the government suspended all unnecessary services across the country in the first wave. Schools were closed, public transport was halted, bars and restaurants were closed and offering and selling goods and services to consumers was prohibited, with some exceptions for essential services like grocery stores etc. To mitigate the negative effects, some (mainly financial) measures were also introduced (see Rakar et al., ibid- chapter 1), e.g. pensioners on the lowest pensions were given a one-off solidarity supplement. In addition, grocery shops were exclusively opened to older people between 8 and 10 a.m. (the last hour of opening times was later added). This was accepted with mixed feelings while the Advocate of the Principle of Equality (2020) later declared this measure to be partly discriminatory. The second lockdown (entailing the suspension of unnecessary services) during the second wave was implemented on 24 December 2020, albeit certain restrictions on the movement of people were lifted for the holidays. Educational institutions were only partially closed and/or continued to operate online in the second wave. Taxi services were excluded from the limitations on public transport. Outside the period of the second lockdown, bars and restaurants could operate with certain restrictions. In the first wave, the gathering and

movement limitations banned gatherings of people in public places, and movement outside of one's municipality of residence. During the second wave an additional curfew was implemented that restricted the movement of people between 9 p.m. and 6 a.m. (with some exceptions). Moreover, the use of a protective mask in public spaces and even outside became obligatory (for a more detailed overview of the measures implemented, see Legal Information System, 2021; Ulčnik, 2021). While some measures in the second wave might be considered to be stricter, we believe they also changed more often and were less consistent. In general, despite various restrictions, a large part of the economy remained open for most of the time. This means an important and not to be overlooked characteristic for understanding the infection rates and people's experiences across the waves may lie in the more uniformly applied lockdown during the first wave. Ulčnik (2021), for instance, shows that mobility and thus contacts were reduced far more by the measures implemented in the first wave compared to the second. Still, the reason might also be due to greater compliance with the measures at the start of the pandemic.

These briefly outlined characteristics of the course of the pandemic lead us to question the effects that the experience of these circumstances might have had on the health and well-being of people. Concretely, we are not concerned with the impact of the infection or COVID-19 disease on people itself, but instead explore the pandemic's role as a psychosocial phenomenon – an event that is influenced by interpersonal interactions and relations of power and solidarity. The focus of this chapter is to examine the COVID-19 pandemic's impact on subjectively evaluated health and well-being, health-related behaviour, and an assessment of healthcare system, specifically the changes it has brought to the everyday life of older people and older people with chronic health conditions. We aim to analyse the experiences, attitudes, opinions and practices that have emerged during the pandemic in Slovenia, particularly those related to the experience of health and healthcare among older people, and thus to help understand how the pandemic has impacted older people's lives and health.

Methods

This study uses a mixed methods approach. Quantitative analysis is focused on the first and second waves, while qualitative analysis explores the situation during the fourth wave. First, a general description is based mainly on two Slovenian Public Opinion Surveys [SJM] 2020/2021 and 2020/2023 (Hafner Fink et al., 2020, 2021), using basic descriptive and bivariate analysis. These data were collected from

representative samples (N = 853 and N = 1102, respectively) between 1 April 2020 and 31 May 2020 as well as between 10 November 2020 and 31 January 2021, roughly corresponding to the pandemic's first and second waves in Slovenia. Some data from past SJM from 2002 to 2018 (Hafner Fink et al., 2011; Hafner Fink et al., 2012; Hafner Fink et al., 2013; Hafner Fink et al., 2018; Kurdija & Malnar, 2014; Kurdija & Malnar, 2016; Kurdija & Malnar, 2018; Kurdija et al., 2006; Kurdija et al., 2008; Kurdija et al., 2011; Kurdija et al., 2012; Kurdija et al., 2016; Malnar & Hafner Fink, 2006; Malnar et al., 2008; Malnar et al., 2011; Toš & Malnar, 2004; Toš, 2002a, 2002b; Toš, 2004) were also used to demonstrate changes through time. Second, in the qualitative phase we gathered data from a purposeful sample of nine in-depth interviews with older people conducted to acquire a deeper insight into the experiences of older people during the pandemic. The interviewees were aged 70 to 90 years, four being women and five men. Their education ranged from upper secondary (technical) to tertiary level. They all lived in an urban or suburban environment, at home, except for one woman who was in a nursing home. Their participation was voluntary and the confidentiality of the personal data encountered was assured. The interviews were carried out between 24 November and 13 December 2021, i.e. during the fourth wave of coronavirus infections in Slovenia. The interviews were held by telephone and lasted from 18 to 49 minutes. They were fully audio recorded and transcribed. The qualitative analysis of the gathered data was initially performed inductively through the coding and categorising of data (Graneheim & Lundman, 2004). Categories were further organised into themes following the 4-S model of coping with life events (situation, self, support, strategies) by Goodman et al. (2006). For better illustration, the interviewees' views are presented by way of interview excerpts and coded by the participant's assigned number, followed by the consecutive number of the turn of speakers during a respective interview. Text in brackets was added where additional information seemed necessary for clarifying meaning.

Results

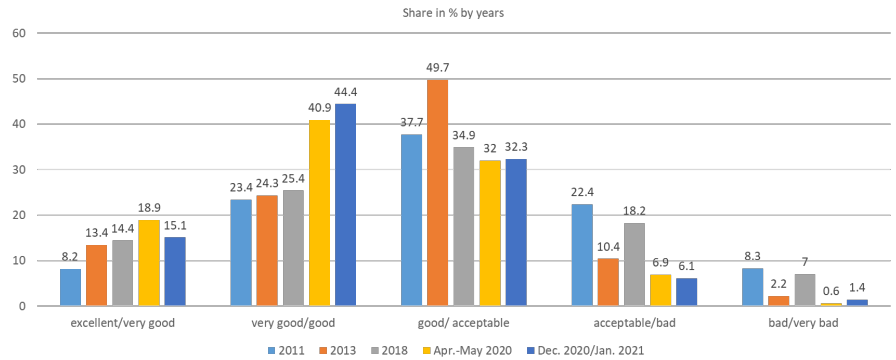
We begin with a brief descriptive overlook of quantitative representative data on people's experiences, opinions and attitudes during the first and second waves of the pandemic in Slovenia.

First, we wanted to reveal the pandemic's general influence on people's health. Subjective or self-rated health is an important and valid indicator of objective health (Idler & Benyamini, 1997; Malnar & Kurdija, 2012; Wu et al., 2013). SJM regularly measure subjective health, yet unfortunately with slightly different wording of

the responses provided on a 1 to 5 scale. One would assume generally the pandemic to have negatively impacted subjective health assessments, however the data do not show any decline in health. If we neglect the change in wording, we may attribute this to the relatively low mortality and infection rates in the first wave and the fact that subjective health might not be affected immediately when people are faced with adversity (Palmer et al., 2020). This notion can be supported by the later drop in the share of people who rate their health as very good and the slight increase in those who rate it as very bad in the second-wave measurement (see Figure 1).

Figure 1

Self-rated health between 2011 and 2021



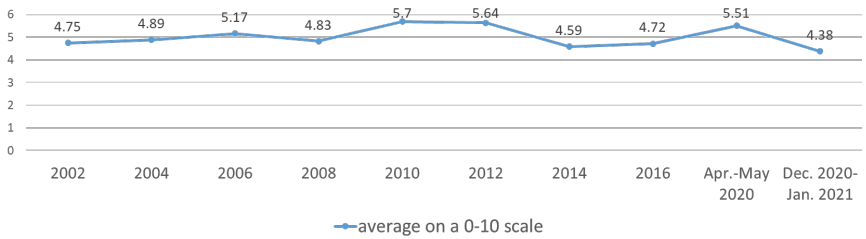
Note. Sources: Fink et al., 2011; Hafner Fink et al., 2013; Hafner Fink et al., 2018; Hafner Fink et al., 2020; Hafner Fink et al., 2021; Kurdija et al., 2018; Malnar et al., 2011.

Next, we wished to examine how the pandemic had impacted the assessment of healthcare. In the past 10 years, it seems that the general state of healthcare has been assessed as in decline, possibly mainly due to the longer waiting lists (OECD/European Observatory on Health Systems and Policies, 2021). Yet, at the beginning of the pandemic people seemed to recognise and value the extraordinary efforts of healthcare professionals, and thus the healthcare assessment average improved during the first wave. However, the average assessment of health facilities' functioning during the epidemic was lower (4.04 on a 1 to 5 scale). Those younger than 61 years on average assessed their functioning statistically significantly slightly more critically (3.97) than those aged 61 and above (4.20) (t = –2.64, p = .008). Nevertheless, it is important to also note the assessment decreased to its lowest point in the last 20 years during the second wave (see Figure 2). We may attribute this to the system having

been overwhelmed by rising numbers of casualties, the extremely limited access to healthcare services, possibly also to some contradictory public statements and opinions expressed by health professionals in the public and in mass media. For instance, a specific issue with regard to older people was alleged irregularities in triage, that according to some NGOs (Fajfar, 2022) had led to discriminatory access to hospital treatment among nursing home residents. Although these were dismissed by the authorities, the fact remains that the majority of infections and deaths during the first two waves were among nursing home residents.

Figure 2

Healthcare assessment



Note. Sources: Hafner Fink et al, 2012; Hafner Fink et al., 2020; Hafner Fink et al., 2021; Kurdija & Malnar, 2016; Kurdija et al., 2006; Kurdija et al., 2008; Kurdija et al., 2010; Kurdija et al., 2012; Kurdija et al., 2014; Kurdija et al., 2016; Malnar et al., 2006; Malnar et al., 2008; Toš & Malnar, 2004; Toš, 2002a, 2002b; Toš, 2004.

Table 1 presents the average responses between those aged younger than 61 years and those 61 years and above to questions or statements posed in both the first and second waves. An independent samples t-test was conducted to show the differences in means that were statistically significant. There is a statistically significant difference between those older and younger than 61 years for the majority of items, except the questions "how hard is it for you to personally follow the measures preventing the spread of coronavirus", "to what extent are people in Slovenia following the measures to stop the spread of coronavirus" and "how likely is it that you will become ill due to coronavirus" in the first wave. This may be explained by the strict and uniform measures (lockdown) put in place during the first wave. With the changed circumstances and measures in the second wave, the differences between those younger and those older than 61 years become more prominent and statistically significant even for these items.

We conclude that in general and on average older people were more compliant and cooperative with the proposed measures. Specifically, they followed the epidemiological recommendations more and/or it was easier for them to follow them, at the same time they were more critical of other people not respecting the measures enough, but conversely expressed greater trust in key stakeholders like the government, the mass media and healthcare professionals. The changes in the mean answers between waves are not surprising and can be explained by the nature of the epidemic or measures employed. For example, more infections and a higher death rate during the second wave led to a bigger sense of endangerment and probability of being infected. Similarly, over time and following the measures being adjusted the proposed epidemiological recommendations and practices were also followed somewhat less. Perhaps another interesting change can be observed with respect to trust in the key stakeholders. Trust in the government, in the media but also in health professionals fell during the second wave, probably indicating general dissatisfaction with the way the epidemic was being managed.

During the stay-at-home measures, i.e. the 'lockdown of the first wave', people reported having been engaged in certain activities more than before. For example, among respondents aged younger than 61 years spending more time with the family was the most common first answer (13.4%), followed by work around the house and gardening (8.0%), and reading (7.9%). Comparatively, for respondents aged 61 years and above the most common first answer was work around the house and gardening (24.3%), followed by reading (14.8%) and watching TV (9.1%). Not surprisingly, e.g. sport and recreation was mentioned as the first-choice answer by 6.4% of those younger than 61 years, but only by 1.2% of respondents aged 61 years and above. For 4.1% of the latter, taking walks more than before was more common compared with 2.3% of those younger than 61 years.

With regard to changes in the relationships among household members at that time, interestingly for more 61+ year olds the relationships did not change (70.8%) compared to those younger than 61 years (55.9%). However, for more of them (35.1% compared with 23.6% for those older than 61 years) relationships became even closer while at the same time for 9.0% of them tensions had occurred in the relationships (compared to 5.7% among those aged 61 and above). These differences are also statistically significant, although the association is weak ($\chi^2 = 14.37$, $p = .001$, Cramer's $V = .13$, $p = .001$).

With regard to vaccination preference at the time of the second survey, the analysis shows that statistically significantly more older people were willing to be vaccinated than those younger than 61 years, with the association being moderate ($\chi^2 = 62.17$, $p < .001$, $\Phi = .28$, $p < .001$).

Table 1

Comparison of opinions on the coronavirus epidemic between those aged younger than 61 years and those aged 61 years and above during the pandemic's 1st and 2nd waves Slovenia

Item	Age	Average		Std. dev.		t		p	
		1st wave	2nd wave	1st wave	2nd wave	1st wave	2nd wave	1st wave	2nd wave
To what degree do the statements below apply to your behaviour? (1 – not at all to 5 - completely) I do not socialize with people outside of my household.	< 61	4.28	3.87	1.03	1.18	-3.98	-6.73	< 0.001	< 0.001
	≥ 61	4.56	4.33	0.85	0.94				
To what degree do the statements below apply to your behaviour? (1 – not at all to 5 - completely) I wash my hands more regularly and thoroughly than I did before.	< 61	4.55	4.36	0.83	1.04	-2.64	-6.85	< 0.001	< 0.001
	≥ 61	4.70	4.73	0.73	0.68				
To what degree do the statements below apply to your behaviour? (1 – not at all to 5 - completely) I go to the store only for necessary purchases.	< 61	4.76	4.35	0.67	0.99	-2.18	-7.53	< 0.001	< 0.001
	≥ 61	4.85	4.74	0.51	0.67				
To what degree do the statements below apply to your behaviour? (1 – not at all to 5 - completely) During necessary personal contact, I maintain a physical distance of at least two meters.	< 61	4.46	4.10	0.89	1.09	-4.18	-10.32	< 0.001	< 0.001
	≥ 61	4.70	4.65	0.67	0.64				
How difficult is it for you to strictly follow all the measures that are supposed to curb the spread of coronavirus? (1 - very difficult to 5 - very easy)	< 61	3.92	3.43	1.06	1.31	-0.01	-7.29	0.992	< 0.001
	≥ 61	3.93	3.99	1.03	1.08				
To what extent do people in Slovenia adhere to measures that are supposed to help stop the spread of coronavirus? (1 - far too little to 5 - in full)	< 61	3.25	2.61	1.02	1.12	0.48	4.18	0.631	< 0.001
	≥ 61	3.21	2.28	1.07	1.14				
What do you think about the effectiveness of measures to prevent the transmission of coronavirus infection? (1 - not effective at all up to 5 - very effective) - restriction of socializing (physical distance)	< 61	4.35	3.77	0.92	1.24	-3.10	-7.89	0.002	< 0.001
	≥ 61	4.55	4.35	0.80	1.01				
What do you think about the effectiveness of measures to prevent the transmission of coronavirus infection? (1 - not effective at all up to 5 - very effective) - washing or disinfecting hands	< 61	4.67	4.45	0.69	0.90	-2.67	-4.53	0.008	< 0.001
	≥ 61	4.80	4.69	0.64	0.74				
To what extent do you trust these actors in relation to the coronavirus epidemic? (1 - not at all to 5 - I trust very much) - Government of the Republic of Slovenia	< 61	2.85	2.49	1.19	1.30	-3.10	-7.10	0.002	< 0.001
	≥ 61	3.16	3.11	1.32	1.31				
To what extent do you trust these actors in relation to the coronavirus epidemic? (1 - not at all to 5 - I trust very much) - mass media	< 61	2.41	2.37	1.08	1.08	-6.33	-10.06	< 0.001	< 0.001
	≥ 61	2.96	3.10	1.19	1.08				
To what extent do you trust these actors in relation to the coronavirus epidemic? (1 - not at all to 5 - I trust very much) - physicians, pharmacists	< 61	3.98	3.75	0.96	1.20	-6.04	-8.77	< 0.001	< 0.001
	≥ 61	4.41	4.35	0.83	0.93				
How much do you feel threatened by coronavirus? (1- not at all to 5 - very)	< 61	2.66	2.85	1.02	1.15	-4.06	-12.74	< 0.001	< 0.001
	≥ 61	3.00	3.81	1.11	1.02				
How likely do you think you are to get coronavirus (covid-19)? (1 - not likely at all to 5 - very likely)	< 61	2.66	3.62	0.88	1.51	0.36	2.20	0.715	0.028
	≥ 61	2.63	3.41	0.94	1.14				

Note. Source: Hafner Fink et al., 2020; Hafner Fink et al., 2021.

As the quantitative data reveal, the epidemics led to changes in people's attitudes and behaviours in relation to the length of the epidemics and the differences between the waves. Older respondents reported significantly different responses to the epidemics in many ways. The quantitative data can be further complemented by their broader experiential context. The interpretation presented in the continuation builds on the narratives of our interviewees. Although not representative due to the small

sample of relatively healthy and socially well-positioned older people, the attitudes and opinions they expressed can provide an important glimpse at deeper insights into the situation.

The overall theme – coping with the great social divide – was generated from three main themes that were also used to structure further interpretation of the qualitative data: conceptualising the pandemic, experiencing adverse life changes and being resilient. Each theme consisted of categories and subcategories. Conceptualising the pandemic combined views on the decline in the quality of life, the unexpected duration of the pandemic, the perceived characteristics of the mass communication, and identification of the gains and losses. Experiencing adverse life changes consisted of three categories: health and well-being, psychological effects and social relations. Being resilient consisted of four categories: acceptance, resources, strategies and vulnerability. Most categories also comprised subcategories; the category strategies, for example, included hobbies, facilitating social contact, care of body/health, and proactivity. All (sub)categories were induced directly from the codes, which were sometimes corresponding to the interviewee's exact words.

Conceptualising the pandemic: A bio-psycho-social hazard

The pandemic abruptly changed everyday lives and is considered to have caused "the decline in the overall quality of life" (2:25). The change was interpreted as profound. From the physically existential viewpoint, for example, as "an attack on humanity ... defending itself according to its best knowledge" (5:20). The interpretation of the new situation of uncertainty was recognised by our interviewees as being strongly influenced by the media of mass communication, especially political public speakers and experts. It was also highly criticised. The political discourse was resented to for its lack of empathy, spreading distrust, fear, forcing feelings of guilt, and communicating in an offensive, aggressive and deceptive manner:

> "Politics is sowing mistrust and I can't stand it ... I find it hard to face this incredible lack of empathy. As they bombard us with some feelings of guilt and resultantly also those of us who got vaccinated or wear masques, show certificates, we find ourselves constantly in a situation when someone, let me say, reminds us, pokes at us, and on the other hand there are others who are insulting, aggressive." (3:24)

> "It has been already proven that (the politicians) were deceiving us. And that they have triggered a psychosis within the state." (9:54)

Expert discourse on the other hand was distrusted for being inconsistent and unable to form a solid uniform strategy for controlling the health hazard and for sometimes spreading contradictory messages:

> "Things started to get extremely complicated. Agreement could not be reached, either people were against (or for) and then there were various contradictory messages coming also from the experts as well as politicians." (3:22)

Consequently, people were observed by our interviewees to react in two extreme ways: to 'unplug', to refrain from watching the TV news and reading newspapers or become uncritically attached to and absorbed by the news. To the great surprise and disappointment of our interviewees, the lack of trust in expert opinion, establishing itself as a kind of lay Internet resourced counterpropaganda, was quite significant:

> "I am disappointed by the attitude of so many people, such a percentage, that somehow negates or belittles, so to say ... well, I know those intensive care units, and it hurts that people who have never seen them judge this illness in this way. I don't like this. I think, you know, let the cobbler stick to his last, right? I mean, people make too much fuss with this counterpropaganda without having expert knowledge. This is not right. It seems a bit weird. But these are the times of the Internet and Google and the like, we can't change it." (6:50)

The more socially committed interviewees sought alternative information and broader horizons abroad. Some of the basic human values (such as freedom) were brought to the surface as misunderstood and in need of readdressing/reconsidering. Finally, in the midst of the adverse life challenges and imposed restrictions some opportunities were also detected, including the redundancy of shopping, becoming aware of consumerism's excessive power in general, strengthening satisfaction with what one already has, finding natural and cultural beauty in local destinations, developing IT skills, having more time for hiking:

> "Even before (COVID) I liked to go around a bit, I lived healthily, walks, hikes and the like and then I made use of it actually a bit more, because I had more time, I definitely spent more time in nature than in previous years. In this respect, this turned out beneficially, right?" (6:24)

Despite also being able to see the good sides, there was still a shared surprise over the long duration of the epidemic, the uniform tiredness of it dragging on, with the concern being related to fear for one's health much less than to being socially constrained and manipulated:

> "Of course, at that time we all expected it to be very short-lived ... at that time I understood them as temporary measures that were in certain respect a bit exaggerated, for example restrictions of movement within a municipality, that seemed so forced, so to say ... I would say people were scared too much in a way ... for example, if I met someone in the woods, there were some people who would point out with their hand to me the distance I should maintain as I walk by. In short, people are different, some ignored such measures, others took them way too seriously ... Still, I personally thought it would be over in 2 or 3 months, which unfortunately did not happen." (6:14)

Such concerns were moderately allayed by the belief that all things fade away at some point, even though the actual end was not yet in sight.

Lived experiences of adverse life changes: Life becoming black-and-white

Our interviewees evaluated their current health status as relatively good. None had experienced a serious decline in their physical health due to COVID-19; one faced and is now proactively addressing an issue concerning mental well-being.

According to our interviewees, the first psychological response to the epidemic's onset and especially its representation in the mass media related to the primal existential fear of losing good health, even dying. People reported and were observed as feeling nervous, agitated, afraid, anxious, stressed by the immediate threat and unpredictability of the situation. The alternative first reaction was expressed in a more self-composed and settled attitude, taking the situation in cautiously and slowly, step by step, without reckless reactions:

> "I explained it to each of them, since I kept contact with people by phone and Zoom, come on, dear people, let's take it sloooowly, slowly, slowly. Don't get deceived by those who are buying all sorts of stuff on the spur of the moment. Don't give in." (9:12)

As the pandemic continued and measures became available and well established, the perceived drawbacks in overall well-being were gradually attributed to the unfavourable socio-political context of the epidemics. A chronic fear of infection emerged:

> "Maybe they don't show it explicitly, but everyone takes a step backwards, and you can feel it … they are happy to meet you, but are afraid." (4:141)

Yet this fear was then accompanied by anger, irritation, powerlessness, exhaustion, anxiety, mistrust, confusion, loneliness, bitterness, melancholy, pessimism and depression:

> "There are people who bite. Bite. People bite. When you walk along the street, they bite, in buses, they bite, in shops, in cars, you drive and that feeling, you know, that people are angry ... I know from previous professional experience, what it means to be angry, when someone cannot control the feelings and reactions and, if there is anything explosive in our state right now, it is this huge anger that has accumulated." (3:30)

These are just some of the perceived psychological issues related to the experience of adverse changes in social relations. There were multiple social barriers to well-being. Although the measures were initially met with favourably and with understanding,

the feelings of unease due to the limitations gradually grew and reached a peak when certain of them, e.g. the restriction requiring that individuals may only move within their own municipality, became seen as quite exaggerated:

> "Such nonsense. Municipalities that don't have a shop, we have 212 municipalities and no one gave it a thought in this state of what it means to the people who live in those hills and those villages. Not everyone lives in Ljubljana, not everyone has a shop around the corner. It is not like that." (9:40)

Social contacts were drastically reduced, also virtually. Our interviewees suffered greatly from the lack of cultural events and other kinds of group activities, e.g. physical training:

> "It has affected me greatly because I was strongly engaged in such recreation. Among other things, I attended Pilates but that was cancelled in that time. It has affected me because then it depended solely on me and it was very hard to maintain discipline. It has affected my fitness." (8:22)

According to our interviewees, more and more people confined themselves within the four walls of their home. The quality of both public and private relations was affected quite detrimentally. There was less joy, kindness became superficial and formal, impatience and agitation culminating in aggression was seen as being on the rise, conflicts were appearing among people that previously got along well:

> "It seems that we are becoming, that we slide into conflicts with people, with whom previously there was no reason to quarrel. It seems to me that these reasons for discord are somewhat piling up." (3:28)

The political approach to navigating the pandemic had evidently started to impose hostile attitudes among people:

> "I notice that it is forcing us against each other, I sometimes simply cannot, I couldn't imagine that someone from political circles, or anyone actually, could say something like that or so, how to say, low, so ugly, so to say, even falsely devised ... it seems to me that we are pushing everything towards, how to say, somehow difficult situation; either we blame ourselves or blame others, there is no neutral position any more that would enable some sort of relaxed conversation, how to say, without judgment, judgment in brackets or genuine judgment. And this actually hurts." (3:30-34)

In the experience of our interviewees, opposing attitudes to COVID-19 had led to splits among acquaintances, friends or within the family, mainly on the subject of vaccination. This disassociating manner in which the pandemic was interpreted on the political level has been quite intimately reflected in deep and long-lasting social divisions:

> "Of course, I am afraid that this will set people against each other. The attitude to this disease, and especially to vaccination, of course. Sadly, this also, in my understanding,

> conflicts are appearing among relatives, friends and so on. On top of all the divisions in Slovenia, there is now yet a new division, attitudes to this disease ... in my opinion, this is the damage of this disease." (6:44-46)

Resources and strategies for a resilient disposition: Well-being despite adversity

Our interviewees becoming aware and reflecting on the tough life challenges had strengthened important coping mechanisms in them that had helped restore a quality-of-life balance. The threat of losing had sometimes stimulated appreciation of the situation as it was. Being able to accept the situation, which still does not mean approving of it, had led to various life modifications:

> "Everyone needs to adapt, and the sooner the better ... it's no use crying over bad things, it's important to also see what is good." (1:14)

The ability to cope materialised in multiple strategies, depending on personal values, socio-economic status and previous experience. Some interviewees had been able to retreat to their holiday houses in the countryside. Others had spent more time at home, giving them opportunities to engage more with hobbies (reading, playing an instrument, writing), develop new ones or even learn from scratch. Proactivity proved to be vitally important, be it in the form of establishing a new daily routine for oneself, retaining a sense of autonomy or contributing to the common welfare:

> "If I am to cook something, they (the family) prepare things for me, for example, they wash the vegetables so that I only get to cut them into smaller pieces, enough for me to be able to say I am cooking, right?" (1:124)

> "My husband and I said, you know, when it was time to pay for the season (theatre) ticket and our colleagues said forget it, they shift dates all the time, but we said, let's take it, let's fund them a little... we need to ensure that culture survives." (3:146)

Although group workouts were mainly cancelled, health and body fitness was maintained in other ways. Care for oneself was also observed in complying with the measures, and vaccination was gladly endorsed:

> "It was a great relief for us ... early, as soon as it was announced, we signed up to be vaccinated ... We are very pleased to have this opportunity quite soon." (5:12)

Taking account of the awareness of the importance yet also the frail nature of interpersonal connectedness, our interviewees' core challenge therefore became maintaining it within the given limitations of the situation. On the most basic level, this meant avoiding conflict. Further on, the significance of facilitating social contact was

highly acknowledged. Various well-established and available technologies enabling virtual contact were applied. The Slovenian Third Age University had adopted its activities in a simultaneous response to the changing epidemic situation:

> "I started a (name of the course) course, but there were many participants who wanted to keep it as physical contact, not over Zoom. I came there and had an anxious feeling. I did not feel good. We were so close to each other so I said if there is a chance for my husband and myself to attend on-line and they arranged a hybrid option ... and now some other people will join on-line. Around 5 people there, the rest on computers." (5:28)

Virtual communication was seen by some interviewees as entailing many limitations that can only be transcended by maintaining physical contact:

> "I am not pleased at all. I am happy to remain in contact ... I am not pleased with the virtual contact. That is why I don't make use of this opportunity as often as I could, although I have Skype and Zoom. It doesn't seem the right thing." (2:17)

> "I attend the weekly readings of Cankar's works and we also have some kind of socialising there ... about 10, 12 people, mainly outside in the nature or we find a place, a cottage or something to take refuge from the rain ... we have maintained it for 5 years now, regularly, every Wednesday ... we are outside, we keep a distance ... nature has enough space ... and we keep it going ... before reading, we talk to each other for a little while waiting for people to gather and, at the end, the same." (4:21)

Our interviewees relied on various sources of empowerment to face the adversities in a resilient and proactive way, with some being related to personal characteristics, others to social support networks, communities, organisations and the state. On the most intimate level, informal social support was reported to be reciprocally exchanged between partners, family members, friends, colleagues and neighbours in the form of providing practical help, information and emotional support:

> "My son used to take care of me a lot, paid a lot of attention, but is now in Brussels already for 4 years. But he calls me every evening, we talk, what is happening, and it means a lot to me. Both his sons are here and, in my opinion, he encourages them to pay visits to me. And they are real jewels in my present life." (7:39)

Not surprisingly, physical contact was retained throughout the pandemic despite the strict measures precisely among members of one's most intimate social support network. On the contrary, sometimes well-connected neighbours and even friends or family members became estranged:

> "I couldn't really praise that (neighbours) ... although I have not quarrelled with anyone, not now not ever before, but, what do I know, everybody is staying inside ... we don't exactly yell from the windows, but if we meet, we say hello politely, keep a little distance, how are you?" (4:133)

Support was exchanged reciprocally or at least potentially available:

> "Nearby, down the street, lives my husband's sister and we were in frequent contact. When the need arose, we brought things for each other and left them in front of the door. Or her children went to the shop and bought goods for us as well … Can we help? Our family, also our neighbours, yes, for sure, if there was a need to bring anything and we could, absolutely, we would make the effort. And also, so to say, we would seek help ourselves. I would not hesitate to call." (5:68-78)

The lack of social support was regarded as a serious drawback, also related to general well-being:

> "She is terribly afraid (of getting infected) ... also because she lives alone, she knows she would not get much help." (1:156)

Besides informal support, certain forms of formal support by different organisations or within some institutions were identified: local inns and shops, help with basic daily living activities, escort and transport for medical purposes, payable therapeutic services:

> "Every now and then it is beneficial to take care of the spine ... there is not enough physical activity, walking ... too much sitting and it (the pain) piles up ... I have it well arranged, I can't complain, we set the date over the phone, I get the therapy right on time, there are no complaints on my side ... it is important to maintain it a bit, to take care of oneself, if there is this possibility ... I pay out of my pocket, my condition is not serious enough to get a referral ... " (4:161-175)

Formal healthcare services appeared to be well accessible on the surface or in particular cases, but serious concerns arose if health issues became more prominent and services were needed urgently:

> "I would like to thank all of them for being so good and understanding ... at the clinic, at the surgical unit, I was also at the emergency department once, everywhere physicians, as if nothing has happened, no anxiety, they answered my questions, I have the best of impressions." (1:86)

> "My husband is a diabetic and couldn't see his diabetologist for nearly a year. They said, our orders are 'nothing'. Well, hello!! It is not all the same ... what if there are complications: well, there is no bed available, COVID patients are occupying them. I mean, we know what the priorities are, but all the other health issues ... you can postpone them for some time, but 2 years is a bit too long." (5:42)

Experiences also varied with respect to access to a general practitioner. Disappointment was somewhat eased by the opportunity to manage health services virtually:

> "The general practitioner couldn't be reached … panic about becoming overloaded with COVID patients, but we could not reach the general practitioner … and it is still going on and this is not good." (3:24)

> "It turned out very well that we could arrange prescriptions electronically." (2:99)

Paying for health services out of one's own pocket was a very different experience, but at the same time our interviewees were well aware it was not affordable to everyone to the same extent, if at all:

> "Luckily, we have that much money to be able to afford it … saying that, to be able to afford it, a friend of mine, she fights, she is on the phone for 3 hours ... but I pay it without any problems out of my pocket. So long as I can." (3:110)

Before retiring, some interviewees had worked in the healthcare system and knew a lot about its potential and how it can be run. It was particularly disappointing for them that the policymakers had not made better use of the existing resources.

Our interviewees were clear in acknowledging that they were among the privileged ones. None had suffered seriously directly from COVID in terms of physical health, nor been materially deprived. Far more they had been affected psychologically and especially socially. Despite the mentioned adversities, they all expressed high levels of resilience, proactivity, social inclusion and empowerment. They were aware of being in control of their own situation. Congruently, they could identify people or groups unable to manage so well: the oldest old, people outside of the system, the materially deprived, frail and lonely. Being grandparents, some interviewees expressed an extra concern for the impacts of the pandemic on children, particularly families with young children in small apartments:

> "Their children have problems, social and health issues. Mainly social ones, because children need socialising and this has gone now. It is being restored somewhat now, but it was lacking for such a long time that it led to considerable troubles, they became aggressive." (8:38)

Discussion

The COVID-19 pandemic has struck societies unexpectedly and globally. However, not every population group within society has been impacted equally by either the virus itself or the containment and mitigation measures put in place. We have focused on older people. Regrettably, life expectancy fell by a year in 2020 and COVID-19 accounted for the biggest share among causes of death (OECD/European Observatory on Health Systems and Policies, 2021). Despite this grim outlook, people initially

did not assess their subjective health as worse, yet as the epidemic continued the data indicate a turn for the worse. This is in line with the findings of Avsec et al. (2021) who stress the importance of the psychosocial burden of the implemented measures that may have detrimental effects for individuals' basic psychological needs and thus their mental health. Similarly, Palmer et al. (2020) warn of the pandemic's indirect long-term impact on healthy ageing. As expected, statistical analysis showed that older people felt more at risk and this feeling of endangerment only grew in the second wave. Older people also followed the epidemiological recommendations more than others did. Similarly, to Smrke and Vovk (2021), we can say that older people were significantly more cooperative than the rest, yet, as they also point out, this is not necessarily for altruistic reasons. The quantitative data already indicated 'pandemic fatigue' (weariness in having to abide by the restrictions and epidemiological recommendations) but also suggested that new practices and coping strategies are emerging. These were however uncovered in much more detail in the qualitative part.

The interviewees described their quality of life as having declined but still assessed it as relatively good. They revealed high levels of resilience and demonstrated that they were well empowered. What can we learn from them? Drawing from their experience, what can we learn about others? What are the needs of older people who declare themselves to be among the privileged and what do they tell us about the needs of the socially deprived? On the scale from micro to macro social structure, we can summarise the quality of life barriers and facilitators that were identified to help us further design salutogenic strategies that support older people in staying in good condition, active, confident and in control.

The COVID-19 pandemic has brought many unexpected social issues to the surface. The whole conceptualisation and thus management of the epidemic turned out to create a state of emergency. According to social determinants people were affected by it to different degrees. On the macro societal level, the communication with the public was strongly criticised, the political and partly also the expert discourse for inconsistency, certain containment and mitigation measures for being exaggerated, the general political attitude to the people was seen as unsympathetic, humiliating, misleading and quite autocratic but, above all, destructive of the vital social tissue by exposing and further widening the existing social divisions and imposing new ones, most notoriously between the vaccinated and the non-vaccinated. The healthcare system was on the verge of collapse. On the mezzo level, there were huge differences in the provision of healthcare services depending on the institutional or regional context. On one hand, health professionals in COVID units were working to the edge of burnout while, on the other, people were experiencing limited access to general practitioners, and many non-urgent procedures were postponed, even cancelled. There were also noticeable contrasts in how the measures (e.g. the lockdown) had affected

differently privileged groups of people. On the micro level, it all exerted a heavy toll on the quality of life. After the initial existential shock, social barriers and feelings of being (excessively) restricted have become gradually prominent. The quality of most intimate relations was seen as being compromised. The detrimental psychological reactions persisted and inwardly culminated as an obsessive fear for oneself or alternatively burst outwardly into quite an aggressive and destructive attitude towards others. Social gaps and divides were widened and implanted into the most intimate relationships, damaging the frail social tissue at its weakest point. What started as a direct threat to physical health was transformed into profound social disorder and economic and social crisis (Marmot, 2020). It is important to note here that in the long run such social disruptions (fewer social contacts, isolation, social divides, inequalities) combined with simultaneous harmful psychological reactions (fear, anger, aggression, mental health issues) clearly represent a serious health hazard also in a physical sense in its own right. It is even more important not to overlook the fact that the hazard varies across the population – what the COVID-19 pandemic has brought to the fore extremely well is that increased social inequalities are and will continue to be reflected in increased health inequalities (Marmot, 2020).

To successfully meet these challenges, our interviewees revealed many facilitating sources and strategies helping them to preserve or restore a good quality of life. A high degree of resilience was observed among them, ranging from contentment and the ability to recognise opportunities as something good even in the most adverse situations, to readiness to make affordable lifestyle modifications. They displayed various coping strategies (e.g. turning to their hobbies, adopting new ways of maintaining social contact, a proactive attitude in care for oneself and the community). They were aware of their own good social status, which enabled them to afford certain modifications. They themselves exposed that some of them, in contrast to many others, possessed the resources to obtain easier access to information and even health services, had the funds to buy and stock food or afford out-of-pocket expenses for maintaining health, were able to leave their urban homes and stay in their countryside houses for a few months, were capable of supporting their children and grandchildren in their work and education from home etc. Enthusiasm for education and lifelong learning provided them with faith in, knowledge and understanding of scientific interpretations, enabling them to distinguish evidence-based facts from political rhetoric. Last but not least, older age (in terms of rich life experiences) was interpreted as beneficial for developing a resilient disposition. On the mezzo societal level, social support networks proved to be a highly important facilitator of facing adversities successfully; the lack of reliable supportive informal relations, on the other hand, left some more exposed to the detrimental effects. Due to being financially secure, our interviewees could make use of various generally available as well as payable formal support services. Some institutions adapted to the changed situation quickly and

well, e.g. the Slovenian Third Age University was reported as being able to maintain most of its activities in an altered yet still accessible way. They had made good use of the already existing and quickly responding solutions in widely available IT technology and virtual networks. Reaching already the macro societal level, the available resources facilitating health were public measures that at least to some extent were seen as being protective and well complied with, while also the availability of vaccine brought substantial relief from the fear of becoming infected, especially among the older people. Finally, the healthcare system did not collapse; health professionals themselves faced the challenge professionally and, even more importantly, their selfless and devoted attitude was recognised and praised by patients many times. It was the healthcare policy that came into question and was also increasingly distrusted as the epidemic continued in terms of providing uniform, stable and equally accessible support to all people as well as health professionals in practice.

All in all, the results of this qualitative study allow us to reveal some of the deeper aspects of the pandemic that give grounds for us to interpret it as a true turning point in the course of life. As Wethington et al. (1997) define it, a turning point is characterised by a personal major transformation in views about oneself, one's commitments to important relationships and involvement in significant life roles. It is associated with a fundamental shift in the meaning, purpose or direction of a person's life. As such, it affects life courses both negatively and positively. Within our study, the social aspect of the epidemic became quite prominent – the perceived growing social divides were becoming a source of major concern. To apply another concept, the pandemic shook our social lives and commitments to such an extent that it could be described as a critical social transition (Marmot & Wilkinson, 2006), a life-course change in social status whose outcome might hold long-term effects for future life chances. Our evidence is congruent with the view that previous levels of accumulated social advantage or disadvantage (e.g. social capital, social inclusion, financial security, education) have influenced the level at which an individual has been affected by the disadvantages of the pandemic, as well as whether a critical transition would lead to a favourable or unfavourable outcome. It is further important to stress once again that these critical social transitions are not distributed randomly or approximately equally among the population, but tend to cluster and accumulate on top of past disadvantages. It is therefore crucial to strengthen both sides of the same coin – to identify the barriers and strengthen the salutogenic coping competencies of different social groups while developing various formal means for supporting them respectively to contribute to resilient individuals, communities and states, where the population faces narrower social and health inequalities (Marmot, 2020). The question for us as a society and for further research is not whether the social gaps are widening, but whether there is the interest to narrow them and, moreover, who has the means and the power to do so?

Like all research, this study unavoidably has some limitations. The results and findings of this study should be considered in light of the dynamic nature of the COVID-19 pandemic. Infections and consequent hospitalisations come in waves, as do the measures put in place by the government or other institutions to prevent infections. All these together importantly shape people's perceptions and experiences at any given point in time. Thus, quantitative or qualitative cross-sectional data gathering strategies necessarily bring important limitations with them. The authors ask the reader to keep in mind the specific circumstances at the two points of quantitative data gathering roughly corresponding to the first wave with more uniform measures, fewer casualties but also a more optimistic outlook of the upcoming summer, and to the second wave of the pandemic with adjusted measures but high numbers of infections and deaths. Moreover, the third point in time at which we gathered qualitative data was in November and December 2021 during the situation's repeated worsening and the proposed measures. While the secondary quantitative data analysis is based on representative samples, it is limited by the number of specific questions on pandemic experiences with regard to well-being, health and healthcare. On the other hand, the quite small qualitative sample biased towards more active and highly educated older people does not support further transferability or generalisations. The question of how has health and the quality of life been affected among the most vulnerable older people during the coronavirus pandemic in Slovenia thus remains.

Conclusion

This chapter has focused on the social aspects of health, well-being and certain practices and coping strategies that have emerged during the pandemic among older people in Slovenia. When reflecting on the past two years of coping with the pandemic and considering the quantitative analysis of data gathered during the first and second waves, as well as the qualitative analysis of in-depth interviews conducted during the fourth wave – it seems that the physical threats to health posed by the virus were more easily managed than the psychological and social risks. The older people were found to be more cooperative, with greater trust in the key stakeholders of the epidemic and were following the epidemiologic recommendations more than others. The disruptions to everyday routines, socio-political media representations, social life changes affecting socialising, relationships, together with the deepening of the political divide and new addition of a social divide between the proponents of vaccination and those opposed to it were pressing and had a deeper and long-lasting effect on the well-being of older people. Our interviewees reveal some of the barriers

and coping strategies with respect to maintaining a good quality of life among older people, more precisely among empowered, resilient and well-situated older people. They refuted many if not all of the widespread myths about older people (Ritsatakis, 2008): they were in good mental and physical condition; demonstrated high levels of creativity and readiness to learn new things and skills; proved that their experience as well as voice mattered; expressed sympathy for younger generations and a readiness to actively contribute to the common welfare in collaboration with the young. As agreeable as it seems, this is far from capturing the overall picture of the pandemic experience; neither for older people themselves nor the population at large. Future research should therefore focus on specific subgroups of older people, e.g. those living in nursing homes, living alone in the community, or with a specific chronic illness, yet also other underprivileged groups in society. Still, this study provides an important insight into the mechanisms of exposing and widening social divides and raises awareness of the various forms and strength of social salutogenic principles and coping strategies for ensuring a decent quality of life for all.

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ABSTRACTS IN SLOVENE

Izzivi v skrbstvenem režimu v Sloveniji med pandemijo covida-19

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V poglavju avtorice analizirajo spremembe v skrbstvenem režimu v Sloveniji med pandemijo covida-19 na področju skrbi za otroke in skrbi za stare. Sprejeti ukrepi, kot so: zaprtje vrtcev in šol, omejena socialna oskrba starih na domu, pozivi za začasno vračanje oskrbovancev domov za starejše v domačo oskrbo, so pomenili velik prenos bremena in skrbstvene vloge na posameznika in družino. Vsesplošno sprejetje fleksibilnih oblik dela je na eni strani lahko prispevalo k lažjemu usklajevanju dela in družine, na drugi strani pa so ti ukrepi s sočasnimi ukrepi zaprtja vrtcev in šol ter omejene oskrbe na domu še posebej za t. i. »sendvič generacijo« predstavljali zelo velik izziv. V poglavju je sprva predstavljen skrbstveni režim v Sloveniji, za katerega je značilen defamilializem na področju skrbi za otroke in familializem pri skrbi za stare ljudi. V nadaljevanju so analizirani sprejeti ukrepi med pandemijo covida-19 in analiza pokaže, da skrbstveni režim v Sloveniji sledi zanj značilnemu dualizmu, saj je bilo na področju skrbi za otroke sprejetih znatno več ukrepov pomoči družinam za usklajevanje delovnega in družinskega življenja kot pa na področju skrbi za starejše, predvsem kar zadeva oskrbo na domu. Ta dualizem v skrbstvenih politikah je razviden tudi iz Eurofoundove analize ukrepov držav v EU med pandemijo covida-19 (Eurofound, 2020b). Ta je pokazala, da je večina evropskih držav uvedla ukrepe za pomoč staršem in družinam (npr. nadomestilo plače za varstvo otrok med zaprtjem vrtcev in šol, povečan otroški dodatek, vavčerji za varuške, starševski dopust itn.), kar bi lahko definirali kot podprti familializem. Zapostavljeno pa je ostalo področje skrbi za starejše, saj kljub omejitvam storitev pomoči na domu in socialne oskrbe med pandemijo covida-19 evropske države niso zagotovile dodatne pomoči za tovrstno razbremenitev družin. Vpliv sprejetih ukrepov na usklajevanje dela in družine avtorice analizirajo na podlagi podatkov raziskave o medsosedskih odnosih na vzorcu prebivalcev večstanovanjskih stavb v Ljubljani, izvedene aprila in maja 2020 v okviru Centra za proučevanje družbene blaginje, FDV, ki pokažejo, da se je med pandemijo covida-19 povečala obremenjenost družin predvsem glede skrbi za otroke. V primerjalni perspektivi z drugimi evropskimi državami so na deskriptivni ravni predstavljeni tudi podatki mednarodne raziskave Eurofounda o učinkih sprejetih ukrepov na usklajevanje delovnega in družinskega življenja med pandemijo covida-19 v

Sloveniji (Eurofound, 2020c, 2020d). V splošnem primerjalni podatki pokažejo, da se Slovenija umešča nad evropsko povprečje, in sicer med države, v katerih je bilo spoprijemanje z izzivi usklajevanja delovnega in družinskega življenja ocenjeno kot lažje, tj. blizu skandinavskim državam, kot so: Danska, Švedska in Finska, ter nekaterim zahodnoevropskim državam, kot so: Avstrija, Nemčija in Nizozemska. Rezultati tako pokažejo, da so se družine v evropskih državah različno uspešno spoprijemale z izzivi usklajevanja dela in družine, ki jih je povzročila pandemija covida-19. Vsem pa je skupno, da se zaznane razlike odmikajo od nekih ustaljenih vzorcev in značilnosti skrbstvenih režimov v evropskih državah na kontinuumu (de)famililizma in da so predvsem ženske tiste, ki so prevzele večino skrbstvenih obremenitev.

Ključne besede: skrbstveni režim, usklajevanje dela in družine, covid-19, Slovenija

Nadzor nad lastnim življenjem med epidemijo covida-19: študija primera večstanovanjskih stavb v Ljubljani

Srna Mandič i
Valentina Hlebec

Članek obravnava vpliv epidemičnega zaprtja na vsakdanje življenje ljudi in njihov občutek, da svoje življenje nadzirajo. Naša študija primera izhaja iz podatkov izvorne ankete, opravljene maja 2020, in se nanaša na ljubljanske večstanovanjske stavbe, ki zaradi fizične bližine stanovalcev ter uporabe skupnih prostorov in naprav predstavljajo specifičen primer posebnega tveganja (za prenos okužbe) pa tudi potencialnih virov (medsosedska podpora) za shajanje s težavami, ki so povezane z epidemijo. Cilj je bil opazovati, kako stanovalci večstanovanjskih stavb zaznavajo, ali imajo nadzor nad svojim življenjem, in kako se ta zaznava spreminja glede na več z epidemijo povezanih pojavov v stavbi ter med stanovalci, in to v času prvega popolnega zaprtja v Ljubljani na začetku leta 2020. Naši podatki kažejo na dramatičen upad občutka nadzora nad svojim življenjem, natančneje s 75 % (običajno) na 35 % (med epidemijo). Drugače od pričakovanega je bilo najvišji nadzor nad življenjem najti med anketiranci z nižjo izobrazbo, slabšega zdravja in med samohranitelji. Glede na druge dejavnike, ki so vplivali na zaznavo nadzora nad življenjem, je naša regresijska analiza izpostavila zelo velik vpliv celokupnega medsosedskega dogajanja

v stavbi, ki je močno preseglo tudi vpliv običajnih kazalnikov kakovosti življenja in osnovnih sociodemografskih značilnosti. Čeprav naša analiza dokazuje, kako velik je vpliv medsosedskega dogajanja v večstanovanjski stavbi in kako pomembno raven človeškega delovanja ta predstavlja v kriznih časih, pa so pred posploševanjem potrebne nadaljnje študije.

Ključne besede: pandemija, zaznava nadzora nad lastnim življenjem, ontološka varnost, večstanovanjska stavba, blaginja, nadzor nad življenjem

Biti ali ne biti … cepljen? Pogledi tistih, ki so nenaklonjeni cepljenju proti covidu-19 v Sloveniji

Srna Mandič

Cilj prispevka je osvetliti poglede posameznikov, ki niso naklonjeni cepljenju proti covidu-19, upoštevaje pri tem značilnosti slovenskega okolja. To so zaznamovali nasprotovanj polna politična situacija, močno hierarhična oblastna komunikacija, nestrinjanje z vodilnimi epidemiologi ter nenehno spreminjajoči se ukrepi in prepovedi. V primerjavi z EU je država zaznavala zelo nizko raven zaupanja v vlado in nizko stopnjo precepljenosti proti covidu-19.

Pri analizi intervjujev smo uporabili pristop interakcijskega uokvirjanja, ki omogoča razkriti širok spekter problemov, skrbi in razlogov za nezaupanje do cepljenja, kar v javnosti prej še ni bilo znano. Pristop ugotavlja tudi prisotnost različnih tipov uokvirjanja odnosa do cepljenja, kar kaže na kognitivni in diskurzivni potencial za konvergenco ali – nasprotno – nadaljnjo polarizacijo pogledov. Naši rezultati so pokazali na močno polariziranost in čustveno nabitost glavnine javne razprave o cepljenju. Močna prisotnost identitetnega in procesnega uokvirjanja v naših intervjujih ja pokazala, kako različni, nasprotujoči si in celo konfliktni so pogledi dveh strani – na eni strani oblasti z grobim in nespoštljivim nagovarjanjem ljudi in na drugi strani tistih, ki so nenaklonjeni cepljenju. In nadalje, glede na napovedno moč pristopa interakcijskega uokvirjanja sklepamo, da značilnosti zdajšnje diskusije vodijo k nadaljnjemu poglabljanju polarizacije in večanju nezaupanja v vlado.

Ključne besede: cepljenje, nenaklonjeni cepljenju, polarizacija, uokvirjanje, pristop interakcijskega uokvirjanja

Drugi val epidemije covida-19 v Sloveniji: stresorji in spoprijemanje s stisko, povezano s covidom-19

Metka Kuhar
Valentina Hlebec

Pandemija covida-19 ima značilnosti množične krize s številnimi in (dolgo)trajnimi stresorji: s potencialno boleznijo in celo z izgubo življenja (svojega in bližnjih), gospodarsko destabilizacijo, s socialno izolacijo in z osamljenostjo, s spremembo življenjskega sloga (npr. usklajevanja dela in varstva otrok ter prostega časa, omejeno gibanje), z omejenim dostopom do različnih vrst podpore (zdravljenje, verska podpora, različne storitve itn.), nepredvidljivostjo, negotovostjo, izgubo nadzora in z ambivalentnostjo informacij. V tem poglavju smo se osredotočili na dojemanje stiske in spopadanja z njo v prvi polovici drugega vala epidemije v Sloveniji (ta je trajal med 19. 10. 2020 in 15. 6. 2021), ko je potekalo zbiranje podatkov (v okviru raziskave Ocena potreb po psihosocialni podpori v drugem valu epidemije covida-19). Ugotavljali smo, kako so z epidemijo povezani stresorji (povezani z zdravjem, delovno sfero, s socialnimi odnosi, z državnimi ukrepi, s splošno situacijo) vplivali na zaznano stisko (tudi stisko v drugem valu v primerjavi z obdobjem pred pandemijo in prvim valom) ter spopadanje z izzivi covida-19. Udeleženci raziskave so v povprečju doživljali zmerno močno stisko. V drugem valu so občutili večjo stisko v primerjavi s časom pred pandemijo (72,6 % jih poroča o večji stiski kot v obdobju pred pandemijo) in večjo stisko kot v prvem valu epidemije (55,8 % jih poroča o večji stiski v drugem valu). S stisko so se spopadali zmerno uspešno. Med zaznanimi stresorji so udeleženci kot najbolj obremenjujoče ocenili tiste, ki so povezani s socialnimi odnosi in z družbeno situacijo, sledijo stresorji v povezavi z zdravjem in delovne spremembe, izguba dela/dohodka je na zadnjem mestu. Posamezniki, ki so bolj zaskrbljeni zaradi različnih dejavnikov, povezanih z epidemijo, so doživeli višje stopnje stiske. Stresorji pojasnjujejo večino variance vseh odvisnih spremenljivk (vseh treh vrst zaznave stiske in spoprijemanja z njo), medtem ko imajo kontrolne spremenljivke, ki vključujejo demografske spremenljivke in bolezen covid-19 (zbolel sam ali kdo izmed bližnjih), zelo majhen vpliv. Psihološka fleksibilnost in socialna opora prav tako malo prispevata k zaznani stiski in spoprijemanju.

Ključne besede: stresorji, stiska, spoprijemanje s stisko, psihološka fleksibilnost, socialna opora, anketa

Socialni viri emocionalne in instrumentalne opore med epidemijo covida-19 v Sloveniji

Zdenka Šadl
Valentina Hlebec

Pandemija covida-19 in posledični preventivni ukrepi, zlasti omejitve neposrednih stikov med ljudmi, so močno vplivali na običajne načine družbenega povezovanja in nudenja socialne opore. Ukrep socialnega oz. fizičnega distanciranja je povezan z negativnimi učinki na emocionalno počutje, vodi v izolacijo in osamljenost ter otežuje nudenje instrumentalne opore. Na podlagi podatkov, zbranih s pomočjo ankete prebivalcev ljubljanskih večstanovanjskih stavb, ki jo je izvedel Center za proučevanje družbene blaginje Fakultete za družbene vede maja leta 2020, smo identificirati socialne vire emocionalne in instrumentalne opore med epidemijo covida-19 v Sloveniji. Emocionalna opora se osredinja na emocije in je tipično komunikacijska aktivnost, ki prek pogovora olajšuje spopadanje s stresnimi dejavniki, pomaga pri obvladovanju vsakodnevnih problemov in težkih življenjskih situacij, preprečuje občutke osamljenosti in spodbuja psihološko dobro počutje. Po drugi strani se instrumentalna opora nanaša na pomoč pri opravljanju vsakodnevnih praktičnih nalog. Anketirancem smo postavili tri vprašanja: 1) Koga bi v času omejitev, povezanih z epidemijo, najprej zaprosili za pomoč pri nujnih hišnih opravilih, če bi bili vi bolni in bi obležali za nekaj dni v postelji? (instrumentalna opora); 2) Koga bi v času omejitev, povezanih z epidemijo, najprej zaprosili za pomoč, da bi se, če bi bili osamljeni, pogovorili z njim? (emocionalna opora); 3) Koga bi v času omejitev, povezanih z epidemijo, najprej zaprosili za pomoč, da bi šel za vas po nujnih nakupih? (instrumentalna opora). Obenem nas je zanimalo, kakšen vpliv imajo demografski dejavniki (starost, tip gospodinjstva, spol, izobrazba, zdravje in dohodek) na anketirančevo izbiro socialnih virov emocionalne in instrumentalne opore. Pričakovali smo, da so ob izbruhu epidemije covida-19, ko so bili v Sloveniji prvič uvedeni ukrepi fizičnega distanciranja, viri emocionalne opore (npr. družinski člani zunaj posameznikovega gospodinjstva, prijatelji) ostali nespremenjeni, saj neposredna, fizična bližina ni nujno potrebna za izražanje emocij ter ohranjanje tesnih družbenih odnosov in občutkov družbene povezanosti. Po drugi strani smo – zaradi ukrepov omejevanja združevanja oz. fizičnih stikov ter gibanja na občine – pričakovali bolj omejeno zagotavljanje instrumentalne opore, predvsem za ljudi, katerih sorodniki živijo v drugih občinah; pričakovali smo tudi, da bodo običajne ponudnike praktične pomoči nadomestili tisti, ki živijo v geografski bližini, torej sosedje v večstanovanjskih stavbah. Rezultati

študije so potrdili pričakovanje, da imajo ukrepi fizičnega distanciranja večji vpliv na vire instrumentalne opore v primerjavi z viri emocionalne opore, saj večji delež praktične pomoči nudijo sosedje. Učinek omejevanja stikov zunaj gospodinjstva pa se kaže tudi v instrumentalni opori, saj bi se večina anketirancev po pomoč pri nujnih gospodinjskih opravilih in nakupovanju obrnila na družinskega člana v gospodinjstvu. Glede na opazovane spremenljivke ni značilnih razlik, razen pri tipu gospodinjstva, ki vpliva na različne vire emocionalne opore. Tisti, ki živijo s partnerjem ali s partnerjem in z otroki, se ob osamljenosti obrnejo za pogovor na partnerja, tisti, ki živijo sami ali pa sami z otroki, pa se obračajo po pomoč na prijatelje. Ugotovitev je skladna s teoretičnim razumevanjem, po katerem emocionalno oporo nudijo tesne osebne vezi – pri kakovostnem partnerstvu je to partner, pri samskosti pa prijatelj. Prijatelji nudijo malo praktične pomoči, a več kot tretjina anketiranih jih zaznava kot primarni vir opore, ko se počutijo osamljene. Glavni vir emocionalne opore pa so še vedno družinski člani znotraj in zunaj gospodinjstva, kar kaže, da je družina najdostopnejši vir za pomenljive, neposredne interakcije in vezi, ki prispevajo k izboljšanju posameznikovih sposobnosti obvladovanja kriznih in stresnih situacij med epidemijo. Pri ohranjanju tesnih vezi zunaj gospodinjstva med pandemijo je postala ključna digitalna/telefonska komunikacija, ki gotovo prinaša nekaj psihološkega olajšanja oz. občutka družbene povezanosti. Zaradi izgube dotika, gibanja telesa, vonja itn., ki podpirajo komunikacijo, pa primanjkujejo prisotnost v pogovoru, toplina, vtisi ter s tem poglobljena in bogatejša družbena izkušnja. Mladi do 35 let se pogosteje kot na družinskega člana zunaj gospodinjstva obračajo na prijatelja, pri starih nad 50 let pa je to še pogosteje, kar odstopa od predstave, da so mladi v nekem smislu bolj orientirani k prijateljem, da je digitalna komunikacija postala vse pomembnejši del celotne komunikacijske strategije mladih in da spletna družbena omrežja uporabljajo za interakcijo oz. pogovor s prijatelji, vključno s prejemanjem opore. Starostne razlike so se pokazale tudi pri virih instrumentalne opore: stari nad 50 let imajo manj družinske opore znotraj gospodinjstva kot drugi, saj se bolj obračajo na zunanje vire, vključno s sosedi. Verjetno nekateri pri tej starosti (in starejši) ne živijo več s svojimi odraslimi otroki, njihova opora pa ni lahko dostopna, zato se obrnejo na »zunanjo družino«, prijatelje in sosede. Neposredni sosedje lahko zaradi epidemičnih omejitev postanejo pomembnejši za starejše posameznike. Glede na spol se anketiranci obnašajo enako; čeprav se na prijatelja obrača več žensk kot moških, ocenjujemo, da je bolj kot spol v ozadju pomemben tip gospodinjstva (ženske pogosteje kot moški živijo v enostarševskih družinah, v katerih so prijatelji glavni vir emocionalne opore). Rezultati študije primera so pokazali, da ima socialno omrežje, ki ga sestavljajo družinski člani zunaj gospodinjstva in prijatelji, za prebivalce ljubljanskih večstanovanjskih stavb še naprej ključno vlogo pri zagotavljanju emocionalne in instrumentalne opore, na katero lahko posameznik računa v »normalnih« in epidemičnih okoliščinah. Sosedske vezi so zelo redko vir emocionalne opore ali pa sploh ne, ne glede na specifično bivalno

okolje te študije primera; še vedno pa je pomembna instrumentalna opora, ki jo te vezi nudijo starejšim ljudem, ljudem, ki živijo sami, ali ljudem s slabim zdravjem.

Ključne besede: emocionalna opora, instrumentalna opora, socialna opora, covid-19, družina

Storitve za brezdomce v Sloveniji med pandemijo covida-19

Maša Filipovič Hrast
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Brezdomstvo je rezultat kompleksnih dejavnikov in strukturnih determinant, ki nudijo pomembno podlago za razumevanje obsega in značilnosti brezdomstva v posameznih državah. Predstavlja ekstremno stanovanjsko izključenost in je povezana z različnimi socialnimi problemi, kot so: visoka stopnja smrtnosti, večje tveganje za zdravje, zloraba raznih substanc, osebnostne motnje in drugo. Poleg tega je za populacijo značilen otežen dostop do zdravstvenih in drugih storitev. Brezdomci so tako v smislu zdravstvenega tveganja ena izmed najranljivejših skupin med pandemijo covida-19. So tudi skupina, ki ima najmanj resursov in možnosti, da bi to tveganje zmanjšali. V poglavju predstavljamo pregled storitev, ki naslavljajo potrebe brezdomcev ter njihovih sprememb in adaptacij med pandemijo covida-19. Najprej predstavljamo delovanje storitev za brezdomce pred nastopom pandemije, ki jih umestimo v delovanje slovenske državne blaginje na splošno, in specifike, ki se vežejo na področje brezdomstva. Pri tem opozorimo na izrazito pomanjkanje podatkov o brezdomstvu, kar ne omogoča dobrega spremljanja trendov, onemogoča pa tudi opazovanje učinka pandemije. Vendarle pa velja, da naj bi se stopnja brezdomstva zviševala, identificirane naj bi tudi bile nove skupine uporabnikov storitev, tj. družine z otroki. Glavno vlogo pri naslavljanju brezdomstva v Sloveniji imajo javne in nevladne organizacije, ki nudijo nastanitev, širok razpon podpornih programov, hrane, oblačil in drugih aktivnosti.

V poglavju nato sledi ilustrativen pregled različnih odzivov in ukrepov, s katerimi so organizacije za brezdomce v Evropi pomagale brezdomcem med pandemijo. Storitve za brezdomce se po Evropi razlikujejo, kot se razlikujejo tudi vloge nevladnih organizacij in javnega sektorja ter stopnja njihovega financiranja in razvoja. V

severni in zahodni Evropi so na splošno storitve razvitejše kot v južni in vzhodni Evropi, zato tudi ne presenečata velika pestrost in različnost odzivov. Ob prvem valu pandemije so vlade začele iniciative ukrepanja za rešitev stiske brezdomnih ljudi tako, da so rekrutirale lokalne oblasti in nevladne organizacije ter jih opremile za delo med pandemijo (z opremo, izobraževanjem, z delovno silo itn.) ter z odpiranjem dodatnih namestitev v hotelih in hostlih. Na podlagi polstrukturiranih intervjujev s ponudniki storitev za brezdomce v Sloveniji pregledamo načine, na katere so se organizacije pri nas prilagodile na nove okoliščine, pa tudi, katere izzive so prepoznali in kako so jih naslovili. Identificiramo glavne težave, s katerimi so se spopadali, med katerimi so prostorske težave, težave, povezane s finančnim stanjem, težave z zagotavljanjem delovne sile, z uporabniki, dostopnostjo storitev in z ohranjanjem obstoječe ravni storitev. Na podlagi teh ugotovitev v sklepu poudarimo pomembno sporočilo v povezavi s splošnim razvojem politik na tem področju, pri katerih je ključen razvoj dolgoročnih in boljših prostorskih rešitev in standardov na področju zagotavljanja namestitev za brezdomce.

Ključne besede: pandemija, storitve za brezdomce, brezdomstvo, Slovenija, Evropa, prilagoditvene strategije, država blaginje

Vpliv pandemije covida-19 na mlade oskrbovalce adolescente v Sloveniji

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Mladi oskrbovalci adolescenti so otroci in mladostniki v starosti 15–17 let, ki opravljajo pomembne ali precejšnje naloge nege, pomoči ali podpore članu družine (ali prijatelju/sosedu), ki je hendikepiran, ima eno izmed kroničnih bolezni, težave z duševnim zdravjem ali drugo stanje, ki je povezano s potrebo po negi. Mladi oskrbovalci prevzemajo stopnjo odgovornosti, ki jo običajno pripisujemo odraslim, zato je potek odraščanja mladih z oskrbovalno odgovornostjo drugačen od odraščanja njihovih vrstnikov. Ta skupina mladih terja posebno pozornost, saj so v ključnem obdobju razvoja in prehoda od otroštva k odraslosti. V obdobju pandemije covida-19 sprejeti ukrepi, kot so: zaprtje vrtcev in šol, omejena socialna oskrba na domu, pozivi

za začasno vračanje oskrbovancev domov za stare v domačo oskrbo, so povzročili prenos bremena in skrbstvene vloge na posameznika in družino, pri tem pa posebej ranljivo populacijo predstavljajo mladi oskrbovalci. V poglavju na podlagi raziskave med mladimi oskrbovalci v Sloveniji, ki je bila izvedena v okviru mednarodnega projekta ME-WE – Psihološka podpora za spodbujanje duševnega zdravja in dobrega počutja med mladimi oskrbovalci v Evropi, preučimo položaj mladih oskrbovalcev v obdobju pandemije covida-19 z vidika njihovega duševnega in telesnega zdravja ter njihove izkušnje ter doživljanje tega obdobja. Posebno pozornost namenjamo izkušnji šolanja na daljavo in vplivu ukrepa socialnega distanciranja na življenje te posebej ranljive skupine otrok. Ugotovitve kažejo, da je imela po mnenju mladih oskrbovalcev epidemija covida-19 na njih poziven in negativen vpliv. Pri pozitivnem vplivu so poudarili, da so imeli več časa zase in za družino, bili so bolj sproščeni, učenje na daljavo je bilo manj zahtevno in sami so si ustvarili urnik. Prožnost šolanja in prebivanje doma sta mladim oskrbovalcem omogočila prožnejše usklajevanje vseh odgovornosti. Med najpogosteje omenjenimi negativnimi vplivi je bilo izpostavljeno socialno distanciranje, predvsem zaradi prepovedi druženja s prijatelji, kar je v nekaterih primerih pripeljalo do občutkov depresije in tesnobnosti. Spremembe med pandemijo so vodile tudi k povečani potrebi po podpori mladim oskrbovalcem, in sicer predvsem finančni in psihološki. Pri telesnem zdravju so nekateri poročali, da so bili manj telesno aktivni in da so pridobili na teži, drugi pa so navajali, da jim je karantena omogočila, da so imeli več časa za telesne aktivnosti in zdravo prehrano ter da se je njihovo zdravje v splošnem izboljšalo. V okviru projekta so v obdobju pandemije potekale tudi spletne delavnice in srečanja za pomoč in podporo mladim oskrbovalcem; večina mladih oskrbovalcev je navedla, da so jim bile tovrstne aktivnosti v pomoč pri spoprijemanju s stresnimi mislimi in čustvi, spoznavanju samih sebe, postali so bolj prijazni do sebe, našli so smisel, energijo in moč, počutili so se dobro in sproščeno ter se zaradi deljenja izkušnje niso počutili same. Ugotovitve tako kažejo, da bi bilo treba v prihodnje spodbujati tovrstno aplikativno raziskovanje, kontinuirano izobraževanje strokovnjakov in vključevanje problematike mladih oskrbovalcev v zakonodajo ter oblikovati ustrezne politike, saj v Sloveniji zaščita in podpora mladim oskrbovalcem nista sistemsko urejeni. Država mora ostati primarno odgovorna za prepoznavanje in reševanje problematike mladih oskrbovalcev, podpora mladim oskrbovalcem pa mora biti oblikovana skupaj z njimi, da ustreza njihovim potrebam, saj jih le tako tudi uspešno naslavlja.

Ključne besede: mladi oskrbovalci adolescenti, pandemija covida-19, neformalna oskrba

Starejši ljudje in zdravje med pandemijo covida-19: Kaj je bilo izgubljeno in kaj pridobljeno?

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Vsakdanje življenje se je v zadnjih dveh letih pandemije covida-19 spremenilo. Poleg bolezni covid-19 so na zdravje, dobro počutje in na kakovost življenja starejših vplivali tudi strah pred okužbo, spremembe življenjskega sloga ter različni ukrepi za zajezitev epidemije in omilitev njenih posledic. Prve okužbe so se v Sloveniji pojavile v začetku marca 2020, epidemija pa je bila razglašena 12. marca 2020. Po posameznih okužbah med aktivnim prebivalstvom so domovi za starejše postali lokalna žarišča okužb, kar je bilo še posebej skrb vzbujajoče, saj so že takrat podatki pokazali, da je hujši potek bolezni covida-19 povezan s povečano starostjo in z drugimi pridruženimi kroničnimi boleznimi. Medtem ko je bil vpliv prvega vala epidemije na umrljivost razmeroma majhen, je v drugem valu jeseni in pozimi 2020/2021 Slovenija doživela eno najvišjih stopenj presežne umrljivosti na svetu. Poleg biološke dovzetnosti za covid-19 so k večji ranljivosti starejših med pandemijo prispevali tudi nekateri družbeni dejavniki. Obstoječe raziskave so pokazale na rezilientnost pa tudi na povečano ranljivost in težave starejših pri spopadanju z epidemijo. V študiji z integracijo metod smo želeli preučiti vpliv pandemije covida-19 na subjektivno oceno zdravja in dobro počutje, z zdravjem povezano vedenje in na oceno zdravstvenega sistema. Pri tem se ne ukvarjamo z neposrednim vplivom okužbe ali bolezni covid-19 na zdravje ljudi, ampak raziskujemo vlogo pandemije kot psihosocialnega pojava – dogodka, ki ga zaznamujejo medosebne interakcije ter odnosi moči in solidarnosti. Analiza podatkov, zbranih na reprezentativnih vzorcih raziskav Slovensko javno mnenje 2020/2021 in 2020/2023, ni pokazala bistvenega takojšnjega zmanjšanja samoocene zdravja, medtem ko je bilo stanje zdravstvenega sistema ocenjeno kot slabše. Pokazalo se je, da so starejši ljudje pandemijo covida-19 doživeli statistično pomembno drugače kot drugi. Bolj so tudi sledili epidemiološkim priporočilom in/ali jim jih je bilo lažje slediti, hkrati pa so bili bolj kritični do drugih ljudi, ki ukrepov ne spoštujejo dovolj, nasprotno pa so izražali večje zaupanje v ključne deležnike, kot so: vlada, množični mediji in zdravstveni delavci. V primerjavi s prvim valom so v drugem valu ljudje ocenili, da je verjetnost, da se bodo okužili, višja. Podobno so višje ocenili tudi ogroženost zaradi okužbe. Opaziti pa je mogoče tudi nekoliko

manj dosledno sledenje epidemiološkim priporočilom ob hkrati bolj kritični oceni sledenja ukrepom drugih. Med veljavo najstrožjih ukrepov so se ljudje več kot prej ukvarjali z določenimi dejavnostmi. Starejši so npr. več urejali okolico in vrtnarili, brali in gledali televizijo, medtem ko so mlajši na prvem mestu več časa preživeli z ožjo družino, nato urejali okolico in vrtnarili ter brali. Zanimive so tudi razlike v odnosih med člani gospodinjstva, pri katerih so odnosi za večji delež mlajših postali tesnejši ali pa so se pojavile napetosti, medtem ko za večino starejših ni prišlo do sprememb. Kvalitativna analiza poglobljenih intervjujev, izvedenih med četrtim valom, kaže na globino psihosocialnih tveganj, povezanih s pandemijo, ter na zaznani naraščajoči in skrb vzbujajoči družbeni razkorak. Odkloni od vsakodnevnih rutin, družbenopolitičnih medijskih reprezentacij, spremembe družbenega življenja, ki vplivajo na druženje, odnose, skupaj s poglabljanjem političnega razkola ter z novim razkorakom med zagovorniki cepljenja in tistimi, ki temu nasprotujejo, so bili pereči; imeli so globlji in dolgotrajnejši učinek na počutje starejših. Kar se je sprva kazalo kot neposredna grožnja zdravju v fiziološkem smislu, se je med valovanjem epidemije vedno bolj odražalo v poglabljanju obstoječih in nastajanju novih družbenih vrzeli. Iz številnih mednarodnih raziskav vemo, da prav zadnje na dolgi rok predstavljajo močen dejavnik tveganja za zdravje in se povečevanje družbenih neenakosti odraža v povečevanju neenakosti v zdravju. Analiza pa namiguje tudi na pojav novih praks in spoprijemalnih strategij pri starejših. Naši intervjuvanci so svojo kakovost življenja opisali kot upadlo, vendar so jo še vedno ocenili kot sorazmerno dobro. Razkrili so visoko stopnjo rezilientnosti in dokazali, da so dobro opolnomočeni. Pri tej skupini pa gre za pretežno bolje situirane starejše, zato bi morali prihodnje raziskave usmeriti v tiste bolj prikrajšane. Kljub temu ta študija daje pomemben vpogled v mehanizme širjenja družbenih razkorakov ter ozaveščа o različnih oblikah in moči družbenih salutogenih načel in spoprijemalnih strategij za zagotavljanje dostojne kakovosti življenja za vse.

Ključne besede: pandemija covid-19, Slovenija, zdravje, zdravstveno varstvo, starejši ljudje

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