


ARTICLE

‘She shouldn’t cross the line’: experiential effectivity of social guidance trajectories for socially isolated older adults with complex problems

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Abstract

Social isolation of older adults is difficult to break through, and interventions that focus on network development or enhanced social participation are hardly effective, especially when the older adults have been isolated for a long time and have problems in multiple life domains. This study aimed to investigate the needs and subjective experiences of this less-researched group and obtain a deeper understanding of their goals and priorities. The study involved a qualitative study with 25 socially isolated persons who receive assistance from a social worker in an individual guidance trajectory. Data were collected via repeated in-depth interviews with the older adults. By directing the focus towards their subjective experiences, the study gives insight into the ‘experiential effectivity’ of the intervention. It shows what their experienced problems were, and to what degree they benefited from the intervention in this respect. The experience of personal attention and involvement of the social workers represents the most relevant results for them. The participants have no need for network development or engagement in local communities. Yet, the help offered by the social workers produces other results for them, such as solved practical problems, emotional support, more self-sufficiency, a point of contact or a safety net that was not there before. This knowledge can help to improve the quality of intervention for this target group.

Keywords: social isolation; social work; relational attunement; social intervention; experiential effectivity; social network; participation; personal attention

Introduction

Western societies are confronted with a growing number of older adults who have reduced personal networks and are socially isolated (Fokkema *et al.*, 2012; Cornwell *et al.*, 2014). Older adults are particularly vulnerable to social isolation because they

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have to deal more often with major negative life events such as death of a beloved person (e.g. partner, friend, sibling), deteriorating health, limited mobility and lower income (Machielse and Hortulanus, 2013; Landeiro *et al.*, 2017). Emerging evidence shows that social isolation leads to diminished wellbeing, health and quality of life (Berkman and Glass, 2000; Owen, 2001; Cartwright and Findlay, 2002; Cacioppo and Hawkey, 2003; Tomaka *et al.*, 2006; Gale *et al.*, 2017; Leigh-Hunt *et al.*, 2017), and even an increased risk of mortality (Holt-Lunstad *et al.*, 2010; Heffner *et al.*, 2011; Steptoe *et al.*, 2012; Tilvis *et al.*, 2012; Pantell *et al.*, 2013). It is against this background that a wide range of networking interventions has been developed to stimulate social participation of socially isolated older adults. Evaluative studies nonetheless show that social networking interventions are hardly effective, and that social isolation is tough to break through (Findlay, 2003; Dickens *et al.*, 2011; Bartlett *et al.*, 2013). The individuality of the experience of social isolation is an important issue that may cause difficulties in the delivery of standardised interventions (Landeiro *et al.*, 2017; De Witte and Van Regenmortel, 2019). There is no one-size-fits-all approach to address social isolation, hence the need to tailor interventions to suit the needs of individuals, specific groups or degree of isolation (Cudjoe *et al.*, 2018; Fakoya *et al.*, 2020). It is therefore important to discern which interventions work for whom in what particular context.

Although there is no consensus on the definition of social isolation, most authors agree that social isolation is the *objective* lack or scarcity of social contacts and interactions with family members, friends or the wider community (see e.g. Nicholson, 2009; Cloutier-Fisher *et al.*, 2011; Dickens *et al.*, 2011; Dury, 2014; Zavaleta *et al.*, 2014). Defined this way, social isolation is intentionally distinguished from loneliness and perceived social isolation, both of which refer to a *subjective* and negatively experienced discrepancy between quality and number of actual relationships and a person's desires or standards about relationships (e.g. Weiss, 1973; De Jong Gierveld and Kamphuis, 1985; Cornwell and Waite, 2009; Cacioppo and Cacioppo, 2014). Feelings of loneliness may accompany social isolation, but not all socially isolated people experience such feelings (Meeuwesen, 2006). Although social isolation and loneliness are interrelated concepts that are often used interchangeably (e.g. Cattán *et al.*, 2003; Gardiner *et al.*, 2018), research suggests that both concepts may have independent impacts and should therefore be regarded as individual characteristics (Dickens *et al.*, 2011). These observations are particularly relevant when choosing interventions to combat social isolation.

In most evaluative studies, the effects of interventions for socially isolated older adults are tested against previously formulated norms or standards, especially in terms of enhanced social participation and network development (Cattán *et al.*, 2003; Greaves and Farbus, 2006; MacLeod *et al.*, 2018). Because these goals do not always correspond with the goals and priorities of clients, there is a 'coverage problem', which means that the effects of interventions are reduced to measurable goals and priorities, while results that are *not* measurable with standardised measurement scales remain invisible (Gambrill, 1999; Sheafor *et al.*, 2000; Landry *et al.*, 2001). This coverage problem applies even more to social interventions aimed at persons with problems in multiple life domains for whom different interventions are simultaneously deployed. What is effective in terms of one problem does not always work for a different problem and can sometimes be counterproductive

(Sackett *et al.*, 2000). This may be the case with interventions for socially isolated older adults.

Several studies confirm that interventions aimed at stimulating social participation do not always match the specific ambitions, motivations and abilities of socially isolated older adults, especially when they have been isolated for a long time and have problems in multiple life domains (Findlay, 2003; Dickens *et al.*, 2011; Machielse, 2015; Gardiner *et al.*, 2018). To assess the circumstances as well as the bottlenecks and success factors of interventions to alleviate the social isolation of this specific less-researched group, insight into the needs and priorities of the socially isolated older adults themselves is necessary. In this study, we focus on an intervention for this specific group, namely personal guidance trajectories for older adults who have been socially isolated for a long time and have problems in different domains. The study aims to investigate the needs and subjective experiences of the older adults in these guidance trajectories and obtain a deeper understanding of the benefits of the guidance trajectory in their eyes. Such knowledge can help improve the quality of interventions for this target group.

Method

This evaluative study is part of a longitudinal qualitative study being conducted since 2006 in Rotterdam, the second-largest city in the Netherlands.¹ In that study, a large group of socially isolated community-dwelling older adults was followed over time to identify changes in their daily life situations and their need for help and support. The longitudinal study seeks to offer insight into the living conditions of socially isolated older adults and the effectiveness of a wide range of interventions for this target group (Machielse and Hortulanus, 2011). One of these interventions is a personal guidance programme aimed at a limited number of socially isolated older people for whom existing (group and one-to-one) interventions are not appropriate because the problems are too complex. The intervention is meant for older adults who have already lived in social isolation for many years and have problems in several life areas (*e.g.* social isolation, loneliness, finances, mental health, self-care, housing). These older adults are intensively supported on an individual basis by a social worker, who may devote one and a half to two hours a week to the person concerned. The main objective of the intervention is problem reduction by finding and, if necessary, developing appropriate and effective interventions that suit a specific person. Not only the social isolation but all other problems the client has to deal with are addressed, if possible. The intervention can thus be categorised as a complex one-to-one (tailor-made) intervention, aimed at health and social care provision (*see e.g.* the categorisations of Findlay, 2003; Cattan *et al.*, 2003; Dickens *et al.*, 2011; Gardiner *et al.*, 2018).

Participants

For the study reported on in this paper, 25 socially isolated older adults from the longitudinal study were selected utilising a purposeful criterion-based sampling strategy (Patton, 2015: 267). All selected older adults were included in a personal guidance programme for older adults who have already lived in social isolation

for many years and have problems in several life areas. The social workers intensively accompany the selected older adults for an extended time, often several years. The deliberate choice for this target group was motivated by previous research showing that the possibilities to expand the network and neutralise the isolation shrink as social isolation becomes increasingly structural (Machielse, 2015).

The criterion-based sampling of participants took place in close consultation with social workers from six different care-giving agencies in the city of Rotterdam, all involved in interventions for socially isolated older adults. The social workers provide different kinds of help to these older people. On the basis of intake interviews, they can determine for themselves whether a certain client belongs to the specific target group of this one-to-one intervention. A total of 19 social workers were involved in the personal support trajectories. These social workers acted as *gatekeepers* (Patton, 2015: 394) in this sub-study. They assessed which older person could be interviewed, asked the older person whether he or she was willing to participate in the research, and introduced the researchers to the selected older adults. Inclusion criteria were age 60 or older; absence of social contacts with family members, friends or acquaintances; absence of supportive relationships (no practical, emotional or companionship support) for at least five years; problems in multiple life domains (*e.g.* loneliness, finances, mental health, self-care, housing); and willingness to participate in a qualitative interview. One exclusion criterion for social workers was severe alcohol or drug addiction.

The sample of older adults consisted of 11 men and 14 women, ranging in age from 63 to 84 (Table 1), all living alone (nine divorced, two widowed, 14 were never married and had lived alone their entire adult lives; five with adult children, but the contact was broken long ago). None of the participants had a job or other activities (such as volunteering). All participants had been socially isolated for a long time, ranging from five to over ten years. They all had problems in various life domains, but most of them displayed care-avoiding behaviour and were used to solving their problems themselves. They had become a client of a social work agency after being reported by concerned neighbours or key figures such as a local police officer. Most participants accepted help because they felt like they were losing control of their lives.

Design

Identifying the subjective experiences of the users of the guidance trajectories requires a specific type of evaluation research in which the voices of the intervention's users are central (Gibbs and Gambrell, 2002; McNeece and Thyer, 2008; Christ, 2010). From this perspective, we followed a qualitative research methodology with a strong exploratory character that provides insight into the 'experiential effectivity' of the intervention – a specific form of effectivity in which the experiences of the intervention's users are central (Tavecchio and Gerrebrands, 2012). The users of the intervention are seen as 'experts' who have indispensable knowledge about their situations, which is necessary to offer adequate help (Hasenfeld, 2000; Mullen, 2004; Gordon and Cooper, 2010; Soydan and Palinkas, 2016). Hence the benefits of the intervention were not pre-defined by the researcher but assessed in terms of attunement to the needs and preferences of the client, which means that the domain of the intervention effects is seen from a broad perspective (Ritchie *et al.*, 2014). No explicit theoretical

Table 1. Details of the participants

Code	Gender	Age	Children	Number of interviews	Accompanying professional
C1	Female	83	4	3	P1
C2	Female	67	1	2	P2 and P5
C3	Female	78	1	3	P3
C4	Female	74	3	2	P4 and P1
C5	Male	74	–	3	P1
C6	Female	74	4	2	P4
C7	Female	67	5	2	P2 and P5
C8	Male	84	–	4	P1 and P6
C9	Male	70	–	2	P1
C10	Female	80	–	1	P8
C11	Female	74	–	1	P1
C12	Male	77	–	3	P10
C13	Female	78	5	2	P11
C14	Male	71	–	1	P15
C15	Male	70	–	2	P15
C16	Female	63	–	1	P26
C17	Male	63	–	1	P24
C18	Female	79	–	2	P23 and P27
C19	Male	84	–	3	P23
C20	Male	83	–	1	P30
C21	Female	79	–	1	P31
C22	Male	76	–	1	P32
C23	Female	78	–	1	P34
C24	Female	64	–	2	P35
C25	Male	82	–	1	P34

framework with expectations or assumptions was formulated before the research that would steer the data collection. The perceived benefit of the guidance trajectories was depicted by asking participants to what degree the intervention benefited them in terms of their problems and priorities.

Data collection

In the present study, data were collected via in-depth interviews with the selected participants. Unstructured interviews were conducted between 2012 and 2018, aided by a list of topics. The main themes in the interviews were: living situation

and daily life of the participants, their needs, nature of the support from the social workers, their experiences with the guidance and the relationship with the social worker. At the first interview the research was introduced as a study of the needs of people in social isolation and their experiences with social care. All participants were willing to talk very extensively about their situation and experiences.

Most interviews were held at the participant's homes. Some interviews took place at the social agency because the participant could not receive people at home (no chairs, or too messy/too dirty/not acceptable in the eyes of the participants). The interviews lasted from three to four hours. Most participants were interviewed several times (nine interviewed twice, five interviewed three times and one interviewed four times), with intervals of one to four years. The arrangements for the follow-up interviews were made by the researcher, without intervention of the social worker, although the social worker was informed (after agreement of the participant concerned). During the research period, some participants were given a new social worker because of a change in personnel due to a conflict with the client. The interviews were very open; sometimes they were used to clarify issues that emerged in the prior interview(s) to enhance mutual understanding. However, the discussions were mainly about the daily life of the participants, possible (new) life events they were confronted with and the progress of the guidance. Much attention was paid to an open, attentive attitude/approach towards the participants. The interviewer followed the flow of the conversation while preserving the orientation on the subject. Those participants who were interviewed several times became accustomed to the researcher and indicated that they appreciated the visits.

Analysis

The analysis was an iterative process that alternated data collection and analysis, using a hybrid approach of inductive and deductive thematic analyses (*see* Fereday and Muir-Cochrane, 2006). All interviews were – with the permission of the participants – digitally recorded and transcribed verbatim. MaxQDA11, a qualitative data analysis program, was used for the coding process.

The inductive analysis was conducted on two levels. First, the interview transcripts were analysed at the individual level to understand participants in context, resulting in cases that include all interviews of one participant. This analysis involved open coding – the formulation of relevant themes that were derived directly from the participant's responses. Emerging themes were constantly compared within and across the interviews to develop a proper understanding of the perspectives and experiences of the participants (Lincoln and Guba, 1986). Second, we searched thematic categories and patterns across different cases. The thematic analysis was less focused on data-driven descriptions and more on discovering patterns of meaning in the entire dataset (Ritchie *et al.*, 2014), and interpretation was central. The analysis on the two levels was a fluid one, as the researcher repeatedly moved in and out, from the parts (individuals) to the whole (all respondents) and back again (Dahlberg *et al.*, 2008). Still, in both phases codes were initially grounded in the data (inductive coding).

The inductive analysis showed that the relationship with the social workers was the most important benefit of the guidance for the participants. To understand this

relationship better, an additional, deductive phase was added. For the inductive analysis we used a conceptual framework, based on the claim of Sackett *et al.* (2000) that alignment of the professional with the client is essential to arrive at good choices in the health and welfare sector (*i.e.* good quality). To express the quality of this relational attunement, we coded all relevant fragments of the different interviews with one or more of three interrelated dimensions, derived from a study of Cossette *et al.* (2005) on the assessment of interactions between aid seekers and aid workers (nurse–patient interactions). The dimensions are: (a) perception of the client: does the client feel recognised and seen as a person by the professional?; (b) emotional closeness: does the client experience emotional support from the professional?; (c) co-ordinated decisions: is the client involved in decisions about the support being provided and does the chosen solution correspond with the direction chosen by the client? These three dimensions are not separate but build on each other. Only when the client feels acknowledged and seen can emotional closeness or support be experienced. The dimension of attuned decision-making in turn presupposes the first two dimensions.

Research quality

A variety of strategies was used to establish the trustworthiness of the study's findings. First, to achieve breadth and depth in the researched casuistry, information about most participants was collected at different moments in time. Follow-up interviews were held with 15 older adults participating in the study to check the content and interpreted meanings from prior interviews with them in order to improve the integrity of the research process. The follow-up interviews also offered the possibility of member-checking, *i.e.* confirming whether the content and interpreted meanings from prior interviews were in line with the participant's experiences (Wester and Peters, 2004). Second, continuous dialogue with the social workers who guided the participants was significant in all phases of data analysis to develop understanding further, as 'expanding horizons', to achieve intersubjective agreement between researcher and professionals (peer examination). Third, an organised record-keeping system was used that produced transparency in every aspect of the study and analysis process. Use of these strategies with the research participants helped expand and refine the analysis process, thereby increasing the credibility of findings.

Results

This section focuses on the experiences and needs of the participants. In the first part, we describe what kind of help the participants expect from the social workers and what results the assistance delivers for them. In the second part, we elaborate further on the alignment with the professional, using concepts from Cossette *et al.* (2005) that express the quality of this relationship.

Needs of the older adults

In this part, we describe the participants' needs for practical help, and their differing wishes and needs in the area of social contacts.

An acute crisis

The older adults in the personal guidance trajectories have come into contact with the social worker in various ways. For some participants, an acute crisis was the reason to seek help. They reported themselves to the social work agency because of acute problems that required the help of a professional:

The reason I called for help was that I was here for a couple of days with drug poisoning. All alone. In a weekend when no one looked on me. That was the point at which I had to contact the doctor, and he referred me to social work. (C15, man, 70)

I felt totally out of control, saw no point in anything anymore. Actually, I panicked, so I went to the Riagg [mental health-care services]. They admitted me, and after I recovered, I was transferred to elderly services. (C18, woman, age 69)

Although the situation was urgent, these older adults did not take it for granted to accept help. They are used to solving their problems themselves, and only when this is no longer possible and the situation seems to be getting out of hand, the need for help arises:

I am used to solving everything myself. I'm not going to bother other people and ask for help. I'll figure it out myself. So you keep trying for a long time, you go to extremes, but you no longer realise it won't work anymore. And then you think, 'Well, tomorrow'. And tomorrow will be next month, and next month it will be next year. That's the crazy thing. But because of the illness, at some point this had to stop. I couldn't manage on my own anymore and didn't have the energy to take care of things myself. And then you get into a downward spiral, it all starts going wrong. In one fell swoop, it was a done deal. It's like everything slips out of your hands all at once. (C17, man, age 63)

Most participants were signed up by employees of other institutions, such as housing corporations, financial institutions and local care networks, who find that there is social isolation and call in a social worker. Once the contact has been made, the participants discuss with the social worker what kind of help they need.

Practical support

Almost all participants need practical help from the social worker, *e.g.* to solve problems, organise mail and administration, apply for benefits or facilities, or look for more suitable accommodation. Some older people want to arrange several practical end-of-life matters: making a will, arranging a funeral, drawing up a euthanasia declaration. They are aware of the fact that they do not have anyone who knows their wishes or can represent their interests:

I no longer have any family or anyone I'm in contact with. And I have several things to take care of. I have a lot of subscriptions and stuff, they all have to be cancelled, and more things like that and I want to have it all in writing. (C12, man, 77)

If I were to die, there'd be no one to take care of my affairs. Someone who can say: okay, that's this and that's that, and there's the key. No one. There is no confidant in my life who knows where my stuff is, and I don't have family or anything. And that is why I want to have a trusted person. (C10, woman, 80)

No need for social contacts

Although all participants ended up with social workers because of their social isolation, most of them have no need for network development or social activation. Some older adults – often from an early age – have deliberately cut themselves off from others and sought isolation:

Good friends I shared everything with, I never had those. Friends came and went. I have never let anyone get that deep into my life. I have always been an outsider. (C14, man, age 71)

I was isolated as a young man already. It may be a shame, but there is nothing I can do about it. I like being alone. I have always believed loneliness is the best companion. Some people are born for loneliness, others like to be alone. I just made myself fertile ground for it. (C8, man, age 84)

These participants are used to being alone and do not experience their isolation as a problem they want to work on. They have tried to enter into relationships in the past but have not succeeded in doing so. They want to avoid the risk of new disappointments or rejections and find it easier to spend their lives without interference from others. Over the years, they have become accustomed to being alone:

I don't see other people anymore. I've been alone day and night for 20, 30 years. And I no longer feel a need for it. I'm not going to force myself on others. So, I became a loner. I have tried to make contact but cannot come up with any conversation topics. And now I don't have to. I am on my own, and I watch television. (C13, woman, age 78)

I don't mind it so much these days. I find it is actually nice to be alone, to be able to go your own way. And I have learned to be alone. I don't become attached to people, and I'm really not good at keeping up contacts. I'm not cut out for it. And now as you get older, you cannot do that at all, because you're comfortable with the way things are. (C9, man, age 70)

Emotional support

Although many participants indicate that they are often lonely, most say they are used to it. They feel no need to ask for help from the social worker. Only a few participants indicated suffering from strong feelings of loneliness and have trouble getting through the days. They long for someone with whom they can make pleasant talk or do things, someone with whom they feel at home and with whom they can share life's ups and downs:

I would like someone I can talk to, just about the things that keep me busy. Someone to talk to, but also to do things with. Go into town together, go to the

movies together. Just to get out, but with someone who has a lot of patience, because I'm not that fast and stuff. Someone who can have the patience to accept me as I am. (C24, woman, 64)

I'd like someone I can say anything to. Someone who can comfort me at the end of the day, that's what I miss the most. (C16, woman, age 63)

Yet they do not want help making new contacts. Above all, they need emotional support that will help them cope:

The way I feel now, I don't want to feel like that anymore. I feel useless. And I can't get rid of that feeling. When you wake up in the morning, you have to make the best of it. And I need help with that. (C24, woman, 64)

I just don't know why I get up in the morning. It drives me crazy. I think to myself; what kind of life is this? That's why I say I want to die. And I do. That is the best solution for me because this isn't a life. This is nothing. Just misery. (C7, woman, 67)

Five participants have adult children with whom they have no contact. Although broken contact causes a lot of grief, none of the participants wants to attempt to restore the connection. They fear that this will bring back pain and grief, and prefer to leave the situation as it is:

You never get used to your children not visiting. But I don't try anymore. I won't do that anymore because I know it will backfire. Things might go well for a couple of months, and then they fall apart again. (C13, woman, 78)

It doesn't hurt anymore. Not anymore. It did at first, but it wears off. Because when I think about it, it wasn't good, it wasn't going well. So it's better to have no contact. I'm used to it. Yeah, after all these years. And you start thinking more and more: I'd rather things be like this anyway. It's too much trouble, too difficult. If they come again, it starts again, the misery. So I don't look forward to that and no longer want it. (C4, woman, 74)

One participant hopes that something will happen again. She has not seen her children since she left her husband more than 30 years ago:

For 34 years, I have had no contact with my two children, a son and a daughter. I've gone there, but they wouldn't open the door. I have sent cards but didn't get any cards back. So I quit. I don't go there anymore. I don't do it. I don't dare. Suppose they leave me again. It would be a let-down; I couldn't take it anymore. But I keep praying for there to be contact again. I pray for that every night, but I know, my prayers won't be answered. (C6, woman, 74)

Emotional support is also the most important thing for these participants. They need someone with whom they can talk about their children and share their deepest wishes.

Wish to stay healthy

Many participants are afraid of sickness and death. They do not know what the end will be like. They are scared of getting sick and becoming dependent on the help of others. Many older adults indicate that they hope not to wake up one day:

I am afraid of a long sickbed. I hope for a quick, sudden death, without a long agony. (C8, man, 84)

So I'm afraid, not of being dead, but of dying. I'm afraid of all that palliative care, so I'd actually like an alternative to pain relief, so you don't wake up again. I'd rather be euthanised. I'd like to arrange for that. (C9, man, 70)

Other participants prefer not to think about the future; they hope to stay healthy for as long as possible and maintain their independence. Most of the interviewees do not feel the need to take care of all sorts of things or think about the future.

I don't think about that. I never think about death. I live by the day and don't think about the future. That seems the wisest to me. (C4, woman, 74)

Benefits of the guidance trajectories

In this section, we describe how the participants experience the guidance of the social workers and what the results are for them.

Acute problems solved

All of the interviewed older adults had been receiving guidance from a social worker for a long time. Only in a few cases had the personal guidance process been completed because the most important problems were solved. These participants no longer want to receive guidance but are prepared to ask for help sooner in the future:

She helped me so much that a burden fell off me. She looked through all the paperwork. Took care of the tax stuff. Put my debt together. Went with me to places where I find it hard to communicate. She gave me self-confidence, in a way. And I can always call, even if all problems are solved. She gives me comfort. Now I know that things can't go wrong anymore. (C11, woman, 74)

And if I get my finances in order again, I will be able to move on. And I'm going to organise things in such a way that this never will happen to me again. I mean, next time if I think it's going to happen, I will immediately call M. [the social worker] so that something can be done about it. I have an 'in' now, and I know she works well for me. It's as simple as that. (C17, man, 63)

Safety net

Participants who do not have acute problems like the professional to keep track of things, even after the more critical issues have been addressed. This monitoring gives them a sense of security and peace of mind for the future:

I do like the fact that she visits once in a while. She keeps an eye on me professionally, I like that. Because it sometimes happens in the neighbourhood, that older people who live alone die, and yes, then it is nice that she keeps a finger on the pulse. So there is supervision. (C8, man, 84)

I feel safer and happier now. Now I get a call every morning to see if everything is okay. If they don't get me, they take action. And I like that. It makes me feel safer. Because you sometimes hear that people lie on the floor for a long time and they only find out days later. Because no one looks after you or has time for you. (C3, woman, 78)

Most participants are happy that now there is someone they can turn to with questions or problems they cannot solve themselves:

She stops by every three weeks. This has been going on for a few years now. We make an appointment, and she comes to see how things are going. That's important because I have someone to talk to. I did not use to have that, and it worried me. It's good to be able to talk to someone now. (C12, man, 77)

Confidential counsellor

Many older people see the professional as a person with whom they can share their joys and sorrows. The emotional support provided by the social worker is the most important result for them. The contact helps them live through their situation:

I talked a lot with her, we talked for hours, and it wasn't the only time, and it went well. Now if I have a hard time, I call her, and she will come and talk to me. (C16, woman, 63)

Well, she really gives me courage. Because I'm starting to think more and more: I don't have to do this anymore. I'm thinking, I will just take pills. I don't feel like fighting anymore. I'd like some peace for once. (C13, woman, 78)

A subject that recurs in almost all conversations is the participants' confidence in the professional. Thanks to it, they can show themselves in all their vulnerability and need not hold anything back:

I trust her completely. There is not a shred of mistrust. I can ask her anything because I tend to get into trouble for no reason. I sometimes do odd things. So before I do anything, I discuss it with her. (C11, woman, 74)

Several participants indicated they would not make it without this guidance:

If she were gone, who would still stand up for me? I cannot do all that anymore. It would be terrible, and I would feel very sad. If I come to you, it's because I need you. I don't just show up. Because I'm not used to it. I'm not used to asking anyone for anything because I always did it myself. And now I'm getting tears in my eyes because I think: if that were to go away, if that happened, I think it would be awful. (C7, woman, 67)

No results

Not all participants feel that guidance delivers a positive impact. Some participants indicated that they do not get along with the professional. They have no confidence in the social worker and remain reticent about what to say or not to say:

That lady put me down in the dumps. I hit rock bottom. She never took care of anything for me. She just sat there, looking around. (C1, woman, 83)

Relational attunement

The most crucial result identified by the older adults is that now there is someone they can go to with questions or problems they cannot solve themselves. They appreciate the time and attention the professional has for them, someone who has an eye for their situation and understands their fears and reluctance. The involvement of the social worker forms the basis upon which adequate help is possible. In this section, we elaborate further on this involvement using concepts from Cossette *et al.* (2005) that can express the quality of the relationship with the social worker: the extent to which the older adults feel acknowledged, the emotional closeness with the social worker and how decisions about the content of the intervention are made. To gain more insight into the relationship between professionals and older adults in the personal guidance trajectories, we will discuss these three dimensions below.

Feeling acknowledged

The first dimension that impacts the quality of the relationship with the professional is the extent to which the participant feels acknowledged. Most participants in this study have noticed that the social workers look into their situation and take their impediments and fears into account. They have the opportunity to talk about matters that are on their mind, without immediately setting expectations and goals for themselves. Most of them are very satisfied with the guiding professional because they feel the professional has a sincere interest in them and is able to sense what they need. Mainly because their problems are not easily solvable, they definitely get to notice whether the professional is not in a rush, shows respect for them and tries to empathise:

She is someone who can listen very well and can really tell who she has in front of her. And can also react well to someone. That is very important to me. (C7, woman, 67)

The contact with her is pleasant. She worries about me. She feels my social needs. (C15, man, 70)

Most participants feel that the professionals care for them and are compassionate. They take the situation seriously and work without being judgemental:

She is someone who doesn't give me a feeling of being incapable. And that is very important. For me, at least. And probably for other people too. (C22, man, 76)

The professional must see them as a person, with specific characteristics and peculiarities. Participants do not want to feel like a number or 'yet another customer':

I just don't want certain things, because they don't suit me. They need to see what kind of life you've led. Indeed, you cannot say: everyone should do A, B or C. (C25, man, 82)

Emotional closeness

The second dimension relevant to the quality of the relationship is the emotional closeness the participant experiences in contact with the social worker. The connection with the professional is often the only contact they have:

I have known her for a few years. She has become almost like family. And I think that's a really good thing. You can talk about your problems or anything else. I can discuss everything with her, what I'm feeling and everything. Even when things aren't going well, I can discuss that with her. (C21, woman, 79)

Most participants do not expose themselves easily, and their willingness to let anyone in and accept help depends on the quality of the contact with the professional:

She is precisely the type that suits me. We clicked instantly. If she were a type that did not suit me, it wouldn't have worked out. That is not my expectation. It would have been a one-time thing and nothing more. I am very selective when it comes to that. I don't want to be cringing at someone I expect help from. (C17, man, 63)

If they notice the professional has a sincere interest in them, they are more likely to show their vulnerability and help think about ways to improve the situation. A good relationship in which they experience social support is a condition for the participants to open up to receive help:

The contact is really good. That is why it's not a problem for me to share that openness with her so that she can get a picture. If you don't do that, you will never get results. That is my idea of all those conversations. I have nothing to hide, why shouldn't I just tell everything? If that contact isn't good, then you have to ask for someone else, or stop the project, because it will amount to nothing. (C15, man, 70)

I'm a loner – been one all my life. And I've learned never to talk about my things. Then why with her? Because it's so comfortable. It's like a warm blanket. It is good, it feels good. Otherwise you wouldn't tell her anything. From the day she sat at my table, it was like having a fireplace at home. That warmth, how should I put it. With her, I can just show myself as I am. And I don't need to protect myself in a shell. (C7, woman, 67)

Because of that relationship, they are also willing to accept critical remarks from the professional:

It's not like she agrees with everything. You have arguments too, and that's a good thing. (C7, woman, 67)

Co-ordinated decision-making

A final dimension of the relationship covers how decisions about the guidance are made and the extent to which the social worker fine-tunes choices with the participant. Older adults expect a professional not to bring up solutions for things that they themselves do not feel constitute problems:

I don't need someone who checks every Monday afternoon if I'm doing okay. I don't like that. I am a loner. I just am. I can get along fine with people, but whenever possible: close the door, close the curtains, and stay out. (C19, man, 84)

The most important aspect of the guidance trajectory is that nothing happens if the older adults do not want it. They do not wish to be belittled by the social worker, are wary of meddling, and want to decide what does and does not happen themselves. The help has to be dosed well and suit their needs. Only what they themselves find important can be dealt with, in their tempo:

It isn't like she should bring up all kinds of things, as in 'it has to be done now'. That doesn't help me. I know what's wrong too. Just the approach, that's a different thing. And she shouldn't patronise me either. (C17, man, 63)

She shouldn't cross the line. She has to let me fret until it becomes a problem for me until I'm ready to deal with it. And then she can take care of it. She should not patronise me. And I enjoy it, mainly because she doesn't do anything. She doesn't patronise me. I think that would turn me away from her. (C5, man, 74)

Some participants find a good relationship with the professional so crucial that there is a certain degree of reciprocity. They want to keep the social worker as a friend:

I don't want to disappoint her. So if she thinks I should go outside, I do it to meet her expectations. Because I also know that I have to go outside and that I have to exercise and that it's just better for my health, but without her, I just don't do it. (C24, woman, 64)

For example, if she wanted someone to call me every Wednesday morning at 11, well, okay, if it makes her happy, I would do it for her. She does a lot for me, so why shouldn't I do something in return? (C22, man, 76)

Even in the absence of concrete results, the older adults draw strength from the relationship with the professional. It gives them the courage to continue because they feel they are not alone. Yet they also think that the relationship has limitations and that the social worker keeps a certain distance:

She is everything to me. She's very sweet. I even started to love her. I cannot tell her that, though. But I do understand that she keeps me at a bit of a distance. (C7, woman, 67)

Negative experiences

A few of the interviewed older adults are not satisfied with the social worker who assists them. They feel that the professional goes too much by the book and pays too little attention to their real needs and desires:

She isn't accessible to me at all. She's deaf to my reasoning. She projects it back on me, those things, and has no consideration for me. I have to make that clear to her when she comes back. That there is no point in going on with her because she fights me on everything. (C10, woman, 80)

She has been here about six times. And every time I say: I am not in isolation. That's what I keep telling her. What I'm looking for is just one person I can trust and who can be my friend, but well, she wouldn't even listen to that. I mean, why do you keep coming? What do you want? She says she cannot help me. Well, what's the point, then? (C20, man, 83)

They do not always agree with the professional's view that certain solutions are necessary or desirable. Sometimes they feel they are not taken seriously because the professional who guides them comes up with solutions that do not meet their needs:

She wanted to make contact with an old people's home for me. Listen, I'm not the type to do that, I have to be able to live my own life. I have to be able to do what I feel like doing and not feel forced. (C5, man, 74)

Another participant has the feeling that the professional refuses to accept what he is like:

I am apprehensive about her meddling, her professional meddling. She finds it difficult to reconcile herself with the fact that I fall outside the norm and that it's best to leave me alone. She wants to take over, constrict me. Force me into a sort of corset, a mould. She keeps trying to do that. And I don't want that at all. (C8, man, 84)

Some older people feel no real affection for the social worker, although they do appreciate their help:

No, these aren't in-depth conversations. It's a bit about the day-to-day business. And of course, you can discuss the difficulties with her, but that's not how things are. I mean, there's no deep connection. (C24, woman, 64)

Discussion

The objective of this study was to investigate the needs and subjective experiences of a less-researched group – older adults who have been socially isolated for a long time and have problems in multiple life domains – in one-to-one guidance trajectories and to provide a deeper understanding of the personal benefits of the guidance. The guidance trajectories aim to reduce problems by offering appropriate and

effective help that fits an individual situation. To identify the subjective experiences of the users of the guidance trajectories, we followed a qualitative research methodology in which the users of this intervention are seen as ‘experts’ who have indispensable knowledge about their situations.

The study shows that problems in the social sphere are not a priority for the interviewed older adults, although feelings of loneliness came to the fore in almost all interviews – either because the older adults themselves brought it up or because the researcher explicitly asked whether the older adults felt lonely. Although the older adults themselves indicate that they are regularly dealing with feelings of loneliness (social, emotional or existential), this is not the problem they are asking help for or want to work on. Over the years, they have become more or less accustomed to their isolated lives and feel no need whatsoever to spend more time with other people. They do need other kinds of support, especially practical, so that they can maintain their independence. This is in line with findings from earlier studies, which show that older people who have lived in isolation for many years have found ways to deal with their isolation and try to resign themselves to the situation (*see e.g.* Machielse and Duyndam, 2020). Some older adults in this study experience strong feelings of loneliness and find it difficult to get through the day, yet at the same time do not want help in making new contacts or restoring broken contacts. They are afraid of disappointments and especially need emotional support in order to cope. This corresponds with findings from earlier studies indicating that interventions aimed at network development or social participation are not realistic for older adults who have been living in isolation for a long time (Wenger and Burholt, 2004; Machielse, 2015; Jagosh, 2019).

The help offered by the social workers nonetheless yields a variety of significant results for the participants, such as solved practical problems, emotional support, more self-sufficiency, a point of contact they can go to with their problems or a safety net that was not there before. The experience of personal attention and involvement of the social worker represents the most important results for the participants. They are better equipped to deal with their problems and feel they are being understood and supported when going through difficult circumstances. It is also a condition for maintaining their independence. These findings support the previous research of Sackett *et al.* (2000), which concludes that the quality of the relationship between the professional and the client is the core working element of help for vulnerable target groups. It confirms that adequate support is only possible through compassionate use of individual preferences, needs and values in making decisions about their guidance. The quality of the relationship between the social workers and the older adults is expressed in the degree to which they feel seen and recognised and experience emotional support from the professional, and decisions about future interventions are made after a thorough consultation. When the participants trust the professional and the relationship is emotionally supportive, they are willing to open up and show themselves to the professional in all their vulnerability.

Key insights

The final aim of this study was to improve the quality of interventions for older adults who have been socially isolated for a long time and have problems in different domains. This study provides several important insights in this respect.

First, intervention strategies for older adults who have lived in social isolation for many years must be person-centred and tailored around the specific situation of the individual. A study by Fakoya *et al.* (2020) shows that many interventions lack clear definition and a theoretical understanding of how the intervention causes change. For example, most interventions are aimed at both loneliness and social isolation, while various studies have made it obvious that loneliness and social isolation represent different concepts and require distinct approaches and interventions (see e.g. Perissinotto *et al.*, 2019; Burholt *et al.*, 2020). Furthermore, the individuality of the experience of social isolation is an important issue in determining adequate interventions (Landeiro *et al.*, 2017). Hence a prerequisite for effective interventions is that the assessment of individual needs should be conducted during the early phases of intervention, with subsequent tailoring of programmes to meet the needs of the person involved (Mann *et al.*, 2017).

Second, support for this target group requires what is known as complex interventions (Craig *et al.*, 2008), which contain several interacting components and permit a high degree of flexibility or tailoring. Interventions aimed primarily at strengthening the network do not meet the needs of these older people, because they have become accustomed to their situation and experience working on loneliness and social isolation as threatening. As Fakoya *et al.* (2020) concluded in their review on interventions to combat social isolation, many interventions for lonely and socially isolated older adults (both group and one-to-one) have as the main objective to improve the social participation or the social skills of the individuals concerned. Gardiner *et al.* (2018) too conclude that the most prominent category of interventions has as the primary purpose facilitating social interaction with peers or others who may be lonely. Our study shows that the domain in which help is provided for socially isolated older persons with structural, complex problems must be much broader, and that help in other life areas is often a priority. This is consistent with the conclusion of De Witte and Van Regenmortel (2019), who state that intervention strategies should take on a holistic perspective in which not only the specific characteristics of the loneliness and/or social isolation problem (duration, causes, severity) are taken into account, but also the personal characteristics of the older adults (subjective perceptions and needs, coping strategies, motivation, psychological and physical health) and their context.

Third, these findings place demands on the professional who provides support to socially isolated older persons with complex problems. Professionals can only make good choices if they understand the perspective and logic of their clients, and from there see what can be achieved and through which route (Sackett *et al.*, 2000). This requires from the professional expertise to empathise with the other and build a relationship, and the ability to think outside one's own mental box (Van Dijke *et al.*, 2020). This can prevent mismatches where interventions are applied incompletely or to the wrong problem, adding suffering because critical emotional experiences are not recognised or the worlds of the professional and the participant never intersect. Professional empathy is also a prerequisite for timely detection of accumulation of problems and the need for other types of help, e.g. because a client's independence is threatened by mounting health issues (Machielse and Duyndam, [forthcoming](#)).

Fourth, accepting help is not self-evident for older adults who have lived in social isolation for many years. They have become accustomed to their situation and have developed their own strategies to cope with their situation. Accepting help requires breaking through their familiar routines and brings along new uncertainties (*see also Machielse and Duyndam, 2020*). The professionals must be constantly aware of this. Crucial is that the help offered by the social worker corresponds with the request for help of the client and that the professional does not use interventions for which clients are not ready. What does not work are goals and plans that do not fit with their ambitions or possibilities. A relationship in which help is possible requires that professionals do not cross the boundaries of the older adults – in the words of one participant: ‘She shouldn’t cross the line.’

Evaluation of the experiential effectivity provides information that enhances prioritisation and steering of the professional input for this complex target group, in the process of achieving practical innovation and quality improvement. Based on these insights, professionals are better equipped to formulate realistic and feasible goals. This is also consistent with the findings of Fakoya *et al.* (2020), who recognise that the evaluation of complex interventions should transcend the question of effectiveness to identify ‘mechanisms’ of action that can be described as the resources offered through an intervention and the way people respond to these resources (*see also Jagosh, 2019*).

Strengths and limitations

In this study, the preferences, needs and values of the participants were central. Participants are seen as ‘experts’ who have knowledge about their situation, which is necessary to offer adequate help. Insight into the experiences, goals and priorities of the assisted older adults is essential to assess their circumstances and identify the possibilities and limitations of the guidance trajectory. In this way, the present study supplements the more objective measurements that the involved organisations themselves traditionally keep score of, like number of completed trajectories, number of participants activated towards social activities and average time investment per participant.

The study also produces knowledge about the target group of the guidance trajectories. It offers insight into the complexity of their problems, which can be used to improve the adaptation of interventions to socially isolated older adults. The study made it clear that increasing self-sufficiency is a more realistic option for the involved participants than network development or social activation, additionally providing useful knowledge about the type of professionals that are needed to be effective in the eyes of participants. It becomes clear what professionals can expect from the guidance trajectories for this target group, as well as the characteristics and skills expected of them.

Some limitations of this study should be considered when interpreting results. First, the contribution of the social workers who acted as gatekeepers and determined which clients they asked to participate in the research. Some social workers were reluctant because they did not want to jeopardise the contact with their clients. Other social workers wanted the researcher to get to know their clients. Also, it is not always clear how the social workers judged whether or not a specific client

would be eligible to participate in the research. Second, there is no statistical generalisation in this study. The external validity of the conclusions depends on the plausibility that the research results can also apply to socially isolated older adults who were not involved in this study. Third, research transferability in the sense of usefulness or practical value (Lincoln and Guba, 1986) is to be determined by social workers, who from their professional background can assess whether there are sufficient relevant similarities to make it plausible for the research conclusions to apply to non-researched situations too. The social workers can decide if there are analogies between the researched and the non-researched persons, *e.g.* whether sufficient relevant similarities exist to make it plausible for the research conclusions to also apply to the non-researched socially isolated older adults. For these reasons, during the study we regularly spoke to people involved in the practical side, also from organisations that were not involved in the research. From these talks it became clear that the experiences from the study are widely recognised.

At the same time, it is improbable that the participants represent the entire target group of older adults who live in structural social isolation. All participants in this study had contact with a social worker. They were also prepared to have one or more personal interviews with the researcher. For this reason, the results are not generalisable to socially isolated older adults who are not being reached by caregiving agencies. Follow-up studies should also explore the experiences of older adults who are marginalised even further and who are not being reached through any supportive services in the community.

Conclusion

Social isolation among older adults is an increasingly social and health concern in Western societies and is associated with diminished well-being and health. It is against this background that many social networking interventions have been developed to stimulate social participation of socially isolated older adults. Evaluative studies show, however, that interventions aimed at network development or increased social participation are not effective, as such interventions insufficiently fit individual experiences and needs. In this study, the experiences and needs of a specific less-researched group are central. The study focuses on older adults who have been socially isolated for a long time and have problems in different domains. These older adults get guidance from a social worker in a one-to-one trajectory. The results of these guidance trajectories are not listed in terms of network development or social activation but in terms of perceived benefit for the users. By directing the focus towards the preferences, needs and values of the participants, the domain on which the results of the intervention are measured is expanded. The older adults themselves indicated what their experienced problems and questions were, and to what degree they benefited from the guidance in this respect. Following their norms, they could assess the degree to which the intervention had adequate effects. Insight into their experience is vital to assess the circumstances of the individuals in the target group as well as the bottlenecks and success factors of interventions, and to identify the possibilities and limitations of the assistance for this target group. The study brings forth results that are not visible when the effectiveness of the intervention is measured in terms of enhanced social

participation and network expansion. It makes clear that interventions which produce no such outcomes may still have positive effects on older adults. Improvements like solved practical problems, assistance with debt or addiction, increased self-sufficiency, a point of contact they can go to with their problems, or emotional support can be conceived as important outcomes of interventions to combat social isolation in older adults.

This study was conducted in the Netherlands, where the situation of older people is more or less comparable to that in other European countries. However, their social isolation is also a growing issue outside Europe (e.g. United States of America, Canada, Australia, Japan). As the backgrounds of social isolation are linked not only to personal factors but also to the social and societal context in which people live their lives, the possibilities for combating social isolation can vary widely. The social circumstances, the value systems in place and, in particular, the perception of older people can play a role in both the emergence of social isolation and its resolution, in terms of adequate assistance. This study shows that interventions must be person-centred and tailored around the specific situation and needs of the individual. These findings seem universal, but the experiences and needs of older adults in non-Western societies may differ to such an extent that other focuses of assistance are necessary.

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Conflict of interest. The author declares no conflicts of interest.

Ethical standards. We followed standard procedures for the Netherlands, including the Dutch Code of Conduct for Applied Research for Higher Professional Education (Andriessen *et al.*, 2010). An ethics committee assessed the research proposal following Dutch guidelines. The research was found not to be subject to the Dutch Medical Research Involving Human Subjects Act (WMO). Permission of participants was requested in advance by the social workers and repeated at the start of every interview. All respondents expressly agreed to participate in the study and before the start of each interview confirmed their informed consent, which was audio recorded digitally. Researchers behaved respectfully towards participants. Special attention was paid to anonymity in all notes and observation descriptions, and in the article, we used codes for the participants.

Notes

1 The 2012 National Health Monitor in the Netherlands shows that 24 per cent of older adults in Rotterdam (age 64 and older) have no one in their network for practical, emotional or companionship support (Rotterdam, 2014: 6).

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