Strategies of socially isolated older adults: Mechanisms of emergence and persistence

Anja Machielse*, Joachim Duyndam

University of Humanistic Studies, Department Humanism & Social Resilience, Utrecht, the Netherlands

ABSTRACT

Social isolation relates to a lack of social contacts and interactions with family members, friends or the wider community, and results in diminished health and well-being. And yet many interventions aimed at enhanced social participation are not effective because they do not match the needs of the socially isolated older adults themselves. Little is known about the experiences of socially isolated older adults and their need for help and support. In this paper, we use concepts from Giddens' structuration theory to understand the strategies they use to deal with social isolation in everyday life. We report on findings from in-depth interviews with 25 community-dwelling socially isolated older adults (aged 63–86). Most of them were interviewed two or three times with in-between periods of one to three years. The study shows that they see few possibilities for changing their situation. They consider their social skills as inadequate and choose a mode of behavior that they habitually follow and which implies a certain degree of safety. At the same time, these strategies further lower their chances of social integration and intensify their isolation. These long-term patterns of socialization make social isolation a persistent problem that in many cases takes on a structural character. This mechanism makes social isolation difficult to break through. Most socially isolated older adults have no desire to tackle their isolation but hope to solve their problems by themselves for as long as possible. Practical help may contribute to their self-reliance.

Introduction

Social isolation among older adults is an increasing social and health concern in Western societies (Cornwell, Schumm, Laumann, Kim, & Kim, 2014; Fokkema, De Jong Gierveld, & Dykstra, 2012). It is widely associated with reduced well-being and health (Berkman & Glass, 2000; Cacioppo & Cacioppo, 2014; Cacioppo & Hawkley, 2003; Cornwell & Waite, 2009; Gale, Westbury, & Cooper, 2017; Leigh-Hunt et al., 2017; Pescosolido & Levy, 2002; Tomaka, Thompson, & Palacios, 2006), and even an increased risk of mortality (Chan, Raman, Ma, & Malhotra, 2015; Heffner, Waring, Roberts, Eaton, & Gramling, 2011; Holt-Lunstad, Smith, & Layton, 2010; Steptoe, Shankar, Demakakos, & Wardle, 2013; Tilvis et al., 2012). Social isolation also has societal consequences. It often results in social exclusion, low social and civic engagement, and a lack of participation in social activities (Hortulanus, Machielse, & Meeuwesen, 2006; Brewer, 2005; 2006; Weldrick & Grenier, 2018).

The social network literature recognises a wide variety of definitions of social isolation, where social isolation and loneliness are not always clearly separated (e.g. Dury, 2014; Nicholson, 2012; Zavaleta, Samual, & Mills, 2014). In this paper, social isolation is intentionally distinguished from loneliness. The latter relates to a *subjective* and negatively experienced discrepancy between the quality and quantity of existing relationships and a person's desires or standards with regard to relationships (De Jong Gierveld & Kamphuis, 1985; Perlman & Peplau, 1981). Social isolation, however, refers to an *objective* situation, namely the actual absence of a network with persons (family, friends, acquaintances) who can give practical, emotional and "companionship" support – in short: a lack of supportive relationships (Machielse, 2015; Cornwell & Waite, 2009; Steptoe et al., 2013). Loneliness and social isolation do not always coexist. Socially isolated persons can experience intense feelings of loneliness, but not all socially isolated people experience such feelings (Meeuwesen, 2006a; Neves, Sanders & Kokanovic, 2019). Likewise, one can be lonely without being socially isolated. Yet, loneliness can be conceived as a risk factor for social isolation, because persons who deal with prolonged feelings of loneliness often see their social network shrink. (Machielse, 2006)

The focus on social isolation, defined as a lack of supportive relationships, is important in two ways. First, supportive networks that contribute substantially to a person's functioning and well-being seem to be especially significant as people age. Older adults are confronted more often with radical life changes, such as experiences of loss, illness or reduced ability, whereby their need for help and support from others may increase. Socially isolated older adults do not have a network at their disposal that can offer practical and emotional support to better cope with these situations (Findlay & Cartwright, 2002). Second, the

lack of supportive relationships people can fall back on in case of adversity is a serious threat to self-reliance in the current policy context of Western European welfare states, where access to social care services is becoming less generous (Hilton & McKay, 2011; Newman & Tonkens, 2011). Therefore, building up and maintaining supportive social relationships have become even more important now (Beck & Beck-Gernsheim, 2002; Giddens, 2003).

It is against this background that many social networking interventions have been developed to stimulate social participation of socially isolated older adults (Bartlett, Warburton, Lui, Peach, & Carroll, 2013; Cattan, White, Bond, & Learmouth, 2005; Gardiner, Geldenhuys, & Gott, 2018; Greaves & Farbus, 2006). Evaluative studies show, however, that interventions aimed at network development or at an increase in social participation are often not effective, because these interventions insufficiently fit the experiences and the needs of the socially isolated older adults themselves (Cattan et al., 2005; Dickens, Richards, Greaves, & Campbell, 2011; Findlay, 2003; Masi, Chen, Hawkley, & Cacioppo, 2011). Yet, research into the lived experiences of socially isolated older adults and their need for help and support is scant (Cloutier-Fisher, Kobayashi & Smith, 2011).

This paper addresses the lack of knowledge on the ways socially isolated older adults experience their isolation and their need for help and support. The main research questions are: *How do socially isolated older adults explain their social isolation, how do they deal with the social isolation in everyday life, and do they have a desire to reduce social isolation?*

To answer these questions, we used Giddens' structuration theory. This theory offers insight into people's ability to shape their own lives, the habits and routines that they follow in daily life, and the ambitions they have for changing their situations. We linked the theoretical concepts of the structuration theory with the experience-based knowledge of socially isolated older adults themselves. We expected that this analysis could lead to a better understanding of the experiences of socially isolated older adults, and thereby to interventions that better suit their ambitions and needs, and improved social work practices for this vulnerable group.

Structuration theory

Giddens' structuration theory espouses an integrative vision of the enduring 'structure-agency debate' in social theory. In discussing the primacy of either the capacity of individuals to act from free choice ('agency') or of societal and cultural patterns ('structure') in shaping human behavior, Giddens argues that neither reigns supreme and instead both micro- and macro-level analyses are required (Giddens, 1979, 1995).

According to Giddens, individuals possess *agentic capacities*, which means that through their actions they can bring about changes in the course of events and are capable of making things happen (Giddens, 1979: 55). At any point in time, the individual "could have acted otherwise", either positively by interfering in the process of events in the world, or negatively in terms of forbearance or abstinence (ibid: 56).

Agentic capacities are emphatically present in the process of *becoming social*. From their earliest life experiences, individuals develop a personal identity through interactions with others (Giddens, 1996: 52). Processes of socialization, which continue throughout the life course, form the basis of the practical (experience-based) knowledge of 'normal' (conventional) and 'recognizable' (predictable) forms of interaction in day-to-day life. This knowledge is a necessary condition for relatively enduring sets of interactions and social relationships (Giddens, 1996).

In the forging of relations, *habit and routine* play a fundamental role (Giddens, 1996: 30). Internalized emotional and behavioral rules and patterns that individuals follow in the context of everyday life underlie the ontological security system that people usually develop. This

security system implies confidence in the continuity of social settings and social activity; it is the protective cocoon that protects people from potential dangers and enables them to get on with the affairs of day-to-day life (Giddens, 1996: 40).

Although habitual patterns offer a certain degree of continuity and certainty, these patterns can have unintended and unforeseen consequences that may have an adverse effect (Giddens, 1996: 127). This is the case if the practical knowledge that people have about their social environment is defective or inadequate. To accomplish a more desirable situation, people must change fixed patterns in day-to-day social life, which means that they have to abandon their safe routines and start to act otherwise (de-routinization) (Giddens, 1984).

In terms of Giddens' structuration theory, social isolation can be defined as isolation of conventional, predictable patterns whereby someone's patterns do not fit (anymore) with those of others. Although socially isolated persons may feel comfortable in their routine patterns, these routines can hamper social integration. To reduce social isolation, people must become aware of the consequences of their behavior and (want to) start acting differently. Assistance from others may be helpful or even necessary to achieve re-routinization.

Method

This study is part of a longitudinal qualitative study on socially isolated community-dwelling older adults being conducted since 2006 in Rotterdam, the second-largest city in the Netherlands. 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 aimed at this target group (Machielse & Hortulanus, 2012b). In this longitudinal study, a large group of socially isolated older adults has been followed over time to identify changes in their daily life situations and their need for help and support. Inclusion criteria in this longitudinal study are: age 60 or older; actual absence of a network with persons who can give practical, emotional or companionship support; and willingness to participate in a personal interview.

Participants

For this paper, 25 socially isolated older adults from the longitudinal study were selected, utilizing a combination of purposeful and concept-focused sampling (Patton, 2015: 268–269). A deliberate choice was made for older adults who had already lived in social isolation for many years. This choice was motivated by previous research showing that the possibilities to expand the network and to neutralize the isolation are lessening as social isolation becomes increasingly structural (Machielse, 2015).

The criterion-based sampling of the participants took place in close consultation with social workers from eight different caregiving agencies in the city of Rotterdam; the social workers acted as *gatekeepers* (Patton, 2015: 394) and introduced the researchers to the selected older adults. They asked the older adults whether they were interested in participating in our study. When they agreed to take part, the researchers made an appointment (mostly by telephone) for an interview.

The sample of older adults for this paper consisted of 11 men and 14 women, ranging in age from 63 to 86, all living alone (2 widowed; 9 divorced; 14 were never married and had lived alone their entire adult lives; 5 have adult children, but the contact was broken long ago). All participants have been socially isolated for many years, ranging from 5 years to more than 10 years. Most of them display care-avoiding behavior and refuse all kinds of help. They had become a client of a social work agency because they were reported by concerned neighbors, doctors, or other key figures such as a local police officer. The social workers visit the older adults regularly to see how they are doing, and the older adults can call them if they feel the need. In this way, they try to create a safety net to prevent deterioration of the situation. There is no formal counselling program or intervention for these older adults.

Data collection

In the present study, data were collected via in-depth interviews with socially isolated older adults. Semi-structured interviews were conducted between 2012 and 2018, aided by a list of topics. The main themes were: the living situation and daily life of the participants; their explanation for the isolated situation they live in; and the possibilities they saw for themselves to change something about the situation.

At the beginning of each interview, information about the study was given to the participant. All respondents expressly agreed to participate in the study and before the start of each interview confirmed their informed consent, which was digitally audio recorded.

Nearly all the older adults were interviewed several times (9 twice, 5 three times and 1 four times), with intervals of one to three years. The researchers initiated follow-up interviews without the mediation of the social workers; all participants but one were telephoned by the researchers to make an appointment. The participant who was interviewed four times did not have a telephone; the arrangements with him were made by letter; the letter indicated date and time at which the researcher would visit him. At the announced times, he was always present and willing to be interviewed.

The interviews lasted between three and four hours. Most interviews were conducted at the participants' homes. Some interviews took place in a public place or at the social agency office because the participant could not receive people at home (no chairs, or too messy/too dirty/not acceptable in the eyes of the participants). Most respondents were willing to tell a lot about their lives and indicated that they appreciated the conversations.

Analysis

All the interviews were — with the permission of the participants — recorded on audiotape and transcribed verbatim. Before the study started, no explicit theoretical framework was formulated with expectations or assumptions that would steer the data collection. However, some way of organizing the complexity of experience is a prerequisite for the perception itself (Patton, 2015). Therefore, relevant aspects of existing theories on social isolation and loneliness (e.g. causes of social isolation, social needs, social support), and personal experiences of the researchers were used as a sensitizing framework to guide the fieldwork.

The analysis of the research material was done in two steps. First, the typed interviews were analyzed separately, using the constant comparative method, as described by Lincoln and Guba (1985). This analysis involved extracting concepts and broader themes from the interview transcripts and constant comparison between emerging themes and the raw data. Codes were derived directly from the participant's responses, and emerging themes were compared within cases and across cases to develop a valid understanding of the experiences and perspectives of the participants.

In the second phase, we sought mainly general patterns and connections by coding all relevant fragments in the different interviews with one or more concepts from Giddens' structuration theory: agentic capacities, becoming social, habits and routines, willingness to change behavior.

For the coding process, MaxQDA11, a qualitative data analysis program, was used. The process of analyzing the data was an iterative one that included extensive memo writing (Auerbach & Silverstein, 2003).

Quality of the research

Various strategies were 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 respondents

to acquire in-depth knowledge about the lives of the participants. The follow-up interviews also offered the possibility of member checking, i.e. to confirm whether the content and interpreted meanings from prior interviews were in line with the participant's experiences (Wester & Peters, 2004).

Second, the first author also discussed interim research findings with social workers who were assisting or had assisted the participants. Two focus group interviews were held. The first focus group took place in 2014 with fifteen professionals. The second focus group took place in 2018 with eight professionals. In both cases, the researchers' interpretations of the gathered materials were discussed and weighed (mental triangulation) to arrive at an intersubjective agreement between researchers and professionals (peer examination) (Patton, 2015).

Ethical considerations

The researchers adhere to the national ethical codes for research of Dutch Universities (Andriessen, Onstenk, Delnooz, Smeijsters, & Peij, 2010). An ethical committee assessed the research proposal and found the study not to be subject to the Dutch Medical Research Involving Human Subjects Act (WMO).

Results

This section focuses on the experiences of the participants, the strategies they use to deal with their isolation, and the possibilities they see for changing their situation. We discuss the following themes: agentic capacities, becoming social, habits and routines, and the need to change fixed patterns.

Agentic capacities: 'I prefer to solve it myself'

In structuration theory, people are seen as competent individuals that possess 'agentic capacities', and can adequately interpret, evaluate, influence and manage social situations (Giddens, 1979). Competent agents translate their intentions and motives into actual behavior based on their practical and discursive consciousness (Giddens, 2003). If the practical knowledge that people have about their social environment is defective or inadequate, interactions will not be successful. That is precisely the case with the older adults in this study. Most participants find it difficult to interact with other people and do not know how to build or maintain meaningful relationships.

> I could never communicate well. I was stiff, and then it is not easy… you quickly reject people. I am still a person who has difficulties in making contacts. I find myself complicated, stubborn. For myself, but also for others. (CEN09, woman, age 74).

> I don't find myself a warm human figure. I see myself as a solitary figure … because you fall short in your social contacts, in your social adaptability and benevolence towards other people. You try to correct it, of course, but you are who you are. A warm human figure, you are, or you are not. (CEN32, man, age 70).

The participants indicate they cannot estimate social situations properly. The routines and the social rules that they follow in their everyday interactions do not fit with the behavioral patterns and expectations of others. Because of this, they often end up in conflict situations or are hurt or disappointed in interactions with others. In order not to be continuously confronted with their divergency or their limited competencies, they have developed habits and routines that diminish the risk of new disappointments or rejections.

> I don't think you can trust anyone; I feel that. I was often cheated; I just feel it. And you don't want to talk about your problems with everyone. You just don't want that. Everyone has their problems, and other people have nothing to do with it. I prefer to solve it

myself. (RAD01, woman, age 79).

Social relationships also imply mutual expectations. Many participants indicated that they find it difficult to deal with expectations and social pressure.

A certain kind of pressure is put on you from your environment, from neighbors, friends and acquaintances. I find that annoying. Previously also from the family, but I don't deal with that anymore. That social pressure, how you have to live, what you have to do, that you have to work and that you have to sit neatly, that you have to earn money to buy all kinds of things, to do this and to do that. I can't handle that. (CEN34, woman, age 80).

Look, if you have friends or acquaintances … you have to go there, you have to make appointments. There are people who really claim you completely, and it is difficult for me to keep them at a distance. I cannot do that. I cannot be so clear about that. (HU40, man, age 84).

Becoming social: 'I am not fully grown up'

Giddens posits that the individual is an agent that has an influence on his social environment from his earliest life experiences (Giddens, 2003). Through interactions with others, the individual internalizes emotional and behavioral rules and patterns he can use in the social settings of adult lives (Giddens, 1991: 38–40). The older adults in this study indicate that they are insecure about the conventions and social rules that are common in the social contexts in which they interact. Some participants state they had never learned this. They had few options to establish contacts or make friends because of the circumstances in which they grew up:

I grew up with few contacts. Because no one came to visit, you don't learn how to interact with people properly. And when you start living on your own later on, you clash against things. […] Only when I started seeing a psychiatrist at a certain point, did I find out how that came about. Then I was able to see it. (F05, man, age 63).

Other participants have had difficulty making and/or sustaining contacts since they were young because of their character or inadequate social competencies. They are unsure about their social skills and never felt at ease with others:

I was a loner as a young man already. I never led a "normal" life. I am a bit of a misfit. I'm not that complete. Socially and emotionally, mentally, I am not fully grown up. I'm not ready. (CEN12, man, age 83).

Some older adults in the study ended up in social isolation after a major life event that caused a dramatic change in their social environment, such as the breaking off with their (adult) children, the death of a partner or a divorce. This life event disrupted the habitual, taken-for-granted character of their day-to-day activities, and they were never able to resume their social life again. One woman got socially isolated after her divorce, almost twenty years ago:

I didn't have many friends, but after my divorce, I lost everyone… I ended up alone. It's still that way now, after all that time. My life has remained socially very limited. The light has somewhat dimmed. And it has stayed that way. (CEN11, woman, age 67).

This intense experience not only violated her trust in others; she also lost her self-confidence. Because of this, she never tried to make new contacts again:

You start getting a bit of a grim picture of yourself when you've been alone for so long. At some point, you start thinking "there's something wrong with me. I am not fine at all. I am not a success as a person because no one wants me." That's what you get. It sneaks up on you slowly. (CEN11, woman, age 67).

Habits and routines: 'I'm pulling back a little'

The internalized habits and daily rituals that individuals follow in the context of everyday life offer them a certain degree of continuity and certainty (Giddens, 1996: 127). This is also the case with the participants in this study. Since their practical knowledge about social rules and conventions is inadequate or defective, they have developed habits and routines that provide a feeling of safety and comfort.

The strategy that most participants follow to manage their social isolation is a routine of avoidance behavior, in which they shun social interactions with others as much as possible. They feel comfortable with this behavior and have no need for contact with others. Some participants do not attach importance to social contacts or have set requirements that others cannot meet.

I do not fit with this society, and I'm pulling back a little… and I think that's fine. I'm not so greedy, not so scratchy, not so superficial as most people are… Things that I find interesting, I cannot discuss with other people. About culture, history, art or music, I cannot talk with others about that. (CEN08, man, age 74).

I don't feel the need. Because that is called social contacts, but that means nothing at all. It is a bit of bridging or something, or a drink … that's what it's all about. Most social contacts are very superficial. Well and I'm not superficial. (RAD02, man, age 76).

Some other participants, by contrast, have a strong need to interact with people. To meet this need, they have developed habits and rituals that compensate for their lack of personal relationships.

Yes, I have a social instinct, all people have, but I am social when I take a walk through the city. There are people. I like to ride the tram, watching people get on and off. (CEN12, man, age 83).

I am at home all day, but sometimes I don't feel like being at home all day. Then I want to meet people. I leave, for example, for a walk in the city and then I come back immediately. I'm not going to stand, just walk around, just see people. (CH89, man, age 70).

One woman fills this need for company by approaching strangers and talking to them, in the street or in stores:

If I'm outside and people walk by … They don't have to approach me. I approach them myself. I talk, I talk with a lot of people. I talk a lot and hold people up. I do that with strangers, even if I never saw them before. Complete strangers, I have no problem with it. (TH02, woman, age 64).

The patterns these participants use deviate strongly from conventional and recognizable types of interaction. They often result in unintended consequences, such as feelings of misjudgment, insult and offence. Although the routines followed by them work out negatively, they are repeatedly confirmed in their actions. The result is a vicious cycle they are hardly ever able to get out of. As the routines become more ingrained, it becomes more difficult for them to disrupt the behavioral patterns and decide to act differently.

Changing fixed patterns: 'It's very difficult to change things'

Some participants have deliberately chosen to avoid others. They have no need to break their social isolation and feel comfortable with the chosen strategy. Yet, other participants have a strong need for social contacts and are looking for ways to meet that need. According to structuration theory, people can adapt their behavioral patterns, so that their results better meet their needs (Giddens, 2003). To accomplish a more desirable situation, they have to abandon their fixed habits in day-to-day social life and start to act otherwise (de-routinization) (Goffman, 1980). Presumably, a change in behavior breaks through self-evident and safe routines, though, which entails social risks. The internalized routines, even if they are not adequate, provide a feeling of security and

control. Letting go of these routines means taking a step into the unknown. Furthermore, there is never certainty as to whether a different behavior will be more successful.

For all participants in the study, the idea of changing their fixed patterns of behavior is threatening and feels daunting. Five participants have adult children, but none have had contact with them for many years. Although they are very sad about the lost contacts, none want to make an attempt to restore the relationships as most have made prior attempts in vain. One woman who has not seen her children for 34 years, says:

> No, I don't do that anymore. I don't try anymore. I don't dare. Because I know it doesn't work. Maybe it goes well for a few months, and then they say "black" and I "white" and then it is wrong again. (CEN09, woman, age 74).

None of the participants see options for improving the situation; they just hope that it does not get worse.

> It's very difficult to change things. I always had to figure things out myself, so I'm used to it. I am not inclined to ask anything, also because I feel that people have no patience for it. And I have something like … yes, let me sort things out for myself. I don't need all those advises; I don't like it at all. (F02, woman, age 63).

> If there is anything, then I try to solve it myself. I don't talk about it that fast. I don't see the point in that. I do it myself. That works reasonably well. It may take a little longer, but I'll take care of it myself. (CH17, man, age 71).

Their wish to solve their own problems and have control extends to the guidance offered by the social workers. The participants are afraid of meddling and want to decide what happens themselves. They do not want to be belittled and expect the social worker not to bring up solutions for things that they do not see as problems.

> She shouldn't cross my line… She has to let me think, until I see it as a problem myself, until I'm ready to deal with it. And then she can take care of that. She shouldn't patronise me. Look, obviously, I have a problem. I know what's wrong. Just dealing with it, that's different. And she shouldn't patronise me. Then I would turn away from her. (F05, man, age 63).

One participant waits passively for the end to come:

> Unfortunately, I'm getting really old. I'd like to die. I am now in my 83rd year of life and have had enough. I can no longer change my life. I've done it alone, and I probably shouldn't have done that. But yes, that's how I did it. What can one do about it at this point? (CEN12, man, age 83).

Discussion

The aim of this study was to learn how socially isolated older adults experience their isolation and to discover their needs for help and support. The main research questions were: *How do socially isolated older adults explain their social isolation, how do they deal with the social isolation in everyday life, and do they have a desire to reduce social isolation?* To answer these questions, we used four concepts of Giddens' structuration theory: the agentic capacities of the participants, their becoming social, the habits and routines they follow in daily life, and their need to change fixed patterns.

Agentic capacities

The study makes clear that the participants experience a lack of personal capacities to act adequately and successful in social settings, due to poor social competences or social awkwardness, as illustrated by one of the participants who takes himself to be "a misfit, as socially and emotionally not complete" (CH17, man, age 71).

Becoming social

For most participants, the problems started early in life. They grew up in problematic family circumstances, in which they could not develop feelings of trust in others or lacked the social competences to establish and maintain social relationships since they were young. In some cases, a radical event was a turning point, after which problems just kept piling up (e.g. divorce, death of a close person, loss of work, the breakup with their adult children). After these life-events, they lacked the skills to deal with the new social situation.

Habits and routines

To deal with their inadequate or defective social competencies the participants have developed safe habits and routines to fall back on. The conversant character of these habits and routines makes them feel (relatively) comfortable in a social environment that routinely excludes them. At the same time, these strategies lower their chances of social integration even more because the patterns that they follow do not correspond with the conventions or social rules that people usually follow: for instance, they avoid or reject people and, therefore, they are often seen as strange or abnormal. Because they do not deal with others very much, their practical knowledge about social situations keeps declining, thus further reducing the possibilities to turn the situation around.

Changing fixed patterns

The participants themselves see few options to improve their situation. Most of them consciously do not want to change the situation, even those who are dissatisfied with it. To change something about their situation, they have to abandon their trusted routines and take risks whose consequences they cannot completely foresee. These risks are too high for them, and they opt for their habitual behavioral pattern, which implies a certain degree of security. They hold back, afraid to lose what they have and are hesitant to interfere in the process of increasing isolation. They try to keep going and solve their problems as much as possible on their own, in the hope that the situation "as it is" remains stable.

To address the research questions, we can conclude that the participants explain their social isolation by referring to problematic family circumstances while growing up, to a lack of social competences, or to a radical life-event that has shattered their lives and disrupted existing relationships. All participants have found ways to deal with their isolation. Some have consciously withdrawn from social life to avoid disappointment and rejection, and they report feeling comfortable with it. Others have a great need for social contacts and have developed strategies to meet that need. To them, the fact that the chosen strategies do not lead to social integration is no reason to accept help and adapt their behavior. They find the risk too high and too threatening and try to resign themselves to the situation.

The findings in this study are consistent with previous studies reporting that the points of action for interventions for socially isolated older adults can be strongly divergent and that interventions can hardly be effective if they do not fit with the ambitions and strategies of the clients involved (Dickens et al., 2011; Fakoya, McCorry, & Donnelly, 2020; Findlay, 2003; Landeiro, Barrows, Musson, Gray, & Leal, 2017; Masi et al., 2011). It also confirms findings from earlier studies indicating that interventions aimed at social participation are not realistic for older adults who have been living in isolation for a long time (Machielse, 2015; Machielse & Hortulanus, 2012a; Jagosh, 2019; Wenger & Burholt, 2004). While much prior research indicates that guidance to social activities can alleviate social isolation (Greaves & Farbus, 2006; Windle, Francis, & Coomber, 2011), there is no universal

solution to helping socially isolated older people.

Our study also supports research on social competencies and coping strategies of lonely and socially isolated persons (e.g. (Meeuwesen, 2006b; Schoenmakers, 2013), which concludes that many socially isolated persons use passive coping strategies when dealing with major life events and keep withdrawing even further from society due to a lack of social competences. Adequate social competencies would make it possible to confront problems and adversity in life *actively,* whereas inadequate social competencies tend to lead to *passive* coping strategies, manifested as emotional denial, avoidance or withdrawal behavior (Lazarus & Folkman, 1987; Rokach & Brock, 1998). To break through this downward spiral, professional help or assistance may be necessary (Duyndam, 2010; Van Dijke, Van Nistelrooij, Bos, & Duyndam, 2020). Future research should be aimed at discerning what forms of guidance and help are appropriate for older adults who have been isolated for a long time.

Follow up studies should also explore the experiences of even further marginalized older adults who are not being reached through any supportive services in the community.

Conclusion

The concepts of Giddens' structuration theory help us understand the strategies that older adults who have been isolated for a long time use to manage their situation, and how they perpetuate or even exacerbate their isolation through their strategies and behavior. Structuration theory helps to clarify why some older adults remain chronically socially isolated despite the best-intended inteventions. If they feel that things "happen" to them without having an influence over it, then the lack of self-efficacy makes it nearly impossible to proactively confront problems and adversity. Hence, they use passive strategies, manifested as emotional denial, avoidance or withdrawal behavior, and keep withdrawing even further from society. In doing so, they avert having problems with others, but simultaneously enhance their isolation. Besides, the strategies they use may cause problems in other areas of life, such as addiction, depression, debts or neglected personal hygiene (Åkerlind & Hörnquist, 1992; Day, McCarthy, & Leahy-Warren, 2011; McNeilly & Burke, 2002).

According to this study, an improvement of the situation of the socially isolated older adults is only possible when they dare to give up on safe routines and the certainty which is connected to it. Social workers and other carers should be aware of this. Excessive expectations about behavioral change threaten the safety system of these older adults and are counterproductive. Hence, solving practical problems appears to be the best starting point: it helps stabilize the existing situation. It is less risky for them than tackling the social isolation directly. Interventions may also contribute to the self-reliance of older adults, even if social isolation cannot be resolved.

Funding

Declaration of Competing Interest

None.

References

Åkerlind, I., & Hörnquist, J. O. (1992). Loneliness and alcohol abuse: A review of evidences of an interplay. *Social Science & Medicine, 34*(4), 405–414. https://doi.org/10.1016/0277-9536(92)90300-F.

Andriessen, D., Onstenk, J., Delnooz, P., Smeijsters, H., & Peij, S. (2010). Code of conduct applied research for higher professional education. Retrieved from https://www.verenigginghogescholen.nl/system/knowledge_base/attachments/files/000/000/121/original/Code_of_Conduct_Applied_Research_for_Higher_Professional_Education.

pdf?1438782215.

Auerbach, C., & Silverstein, L. B. (2003). *Qualitative data: An introduction to coding and analysis.* NYU press.

Bartlett, H., Warburton, J., Lui, C. W., Peach, L., & Carroll, M. (2013). Preventing social isolation in later life: Findings and insights from a pilot Queensland intervention study. *Ageing and Society, 33*(7), 1167–1189. https://doi.org/10.1017/S0144686X12000463.

Beck, U., & Beck-Gernsheim, E. (Eds.). (2002). *Individualization: Institutionalized individualism and its social and political consequences.* London: Sage.

Berkman, L. F., & Glass, T. (2000). Social integration, social networks, social support, and health. *Social Epidemiology, 1,* 137–173.

Brewer, M. B. (2005). The psychological impact of social isolation: Discussion and commentary. In K. D. Williams, J. P. Fogas, & W. Hippell (Eds.). *The social outcast: Ostracism, social exclusion, rejection and bullying.* New York/London: Taylor and Francis.

Cacioppo, J. T., & Cacioppo, S. (2014). Social relationships and health: The toxic effects of perceived social isolation. *Social and Personality Psychology Compass, 8,* 58–72. https://doi.org/10.1111/spc3.12087.

Cacioppo, C. T., & Hawkley, L. C. (2003). Social isolation and health, with an emphasis on underlying mechanisms. *Perspectives in Biology and Medicine, 47,* S39–S52. https://doi.org/10.1353/pbm.2003.0049.

Cattan, M., White, M., Bond, J., & Learmouth, A. (2005). Preventing social isolation and loneliness among older people: A systematic review of health promotion interventions. *Ageing and Society, 25*(1), 41–67. https://doi.org/10.1017/S0144686X04002594.

Cornwell, E. Y., & Waite, L. J. (2009). Social disconnectedness, perceived isolation, and health among older adults. *Journal of Health and Social Behavior, 50*(1), 31–48. https://doi.org/10.1177/002214650905000103.

Chan, A., Raman, P., Ma, S., & Malhotra, R. (2015). Loneliness and all-cause mortality in community-dwelling elderly Singaporeans. *Demographic Research, 32,* 1361–1382.

Cornwell, B., Schumm, L. P., Laumann, E. O., Kim, J., & Kim, Y. J. (2014). Assessment of social network change in a national longitudinal survey. *Journals of Gerontology. Series B, Psychological Sciences and Social Sciences, 69*(Suppl_2), S75–S82.

Cloutier-Fisher, D., Kobayashi, K., & Smith, A. (2011). The subjective dimension of social isolation: A qualitative investigation of older adults' experiences in small social support networks. *Journal of Aging Studies, 25*(4), 407–414.

Day, M. R., McCarthy, G., & Leahy-Warren, P. (2011). Professional social workers' views on self-neglect: An exploratory study. *British Journal of Social Work, 42*(4), 725–743. https://doi.org/10.1093/bjsw/bcr082.

De Jong Gierveld, J., & Kamphuis, F. H. (1985). The development of a Rasch-type loneliness scale. *Applied Psychological Measurement, 9,* 289–299. https://doi.org/10.1177/014662168500900307.

Dickens, A., Richards, S., Greaves, C., & Campbell, J. (2011). Interventions targeting social isolation in older people: A systematic review. *BMC Public Health, 11,* 647. https://doi.org/10.1186/1471-2458-11-647 PMid:21843337 PMCid:PMC3170621.

Dury, R. (2014). Social isolation and loneliness in the elderly: An exploration of some of the issues. *British Journal of Community Nursing.* https://doi.org/10.12968/bjcn.2014.19.3.125.

Duyndam, J. (2010). Empathy and the potential body of imagination. In G. Bottà, & M. Härmänmaa (Eds.). *Language and the scientific imagination.* Helsinki: University of Helsinki, Language Centre.

Fakoya, O. A., McCorry, N. K., & Donnelly, M. (2020). Loneliness and social isolation interventions for older adults: a scoping review of reviews. *BMC Public Health, 20*(1), 129. https://doi.org/10.1186/s12889-020-8251-6.

Findlay, R., & Cartwright, C. (2002). *Social isolation & older people: A literature review.* Brisbane QLD Australia: Ministerial Advisory Council on Older People.

Findlay, R. A. (2003). Interventions to reduce social isolation amongst older people: Where is the evidence? *Ageing and Society, 23*(5), 647–658. https://doi.org/10.1017/S0144686X03001296.

Fokkema, T., De Jong Gierveld, J., & Dykstra, P. A. (2012). Cross-national differences in older adults loneliness. *Journal of Psychology, 146*(1/2), 201–229. https://doi.org/10.1080/00223980.2011.631612 PMid:22303621.

Gale, C. R., Westbury, L., & Cooper, C. (2017). Social isolation and loneliness as risk factors for the progression of frailty: The English longitudinal study of ageing. *Age and Ageing, 47*(3), 392–397.

Gardiner, C., Geldenhuys, G., & Gott, M. (2018). Interventions to reduce social isolation and loneliness among older people: An integrative review. *Health & Social Care in the Community, 26*(2), 147–157. https://doi.org/10.1111/hsc.12367 PMid:27413007.

Giddens, A. (1979). *Central problems in social theory. Action, structure and contradiction in social analysis.* London: MacMillan Press https://doi.org/10.1007/978-1-349-16161-4.

Giddens, A. (1991). *Modernity and self-identity: Self and society in the late modern age.* Cambridge: Polity Press.

Giddens, A. (1995). Politics, sociology and social theory. *Encounters with classical and contemporary social thought.* Cambridge: Polity Press.

Giddens, A. (1996). *Modernity and self-identity: Self and society in the late modern age.* Cambridge: Polity Press.

Giddens, A. (2003). *The constitution of society: Outline of the theory of structuration.* Cambridge: Polity Press.

Goffman, E. (1980). *The presentation of self in everyday life.* Harmondsworth: Penguin.

Greaves, C. J., & Farbus, L. (2006). Effects of creative and social activity on the health and well-being of socially isolated older people: Outcomes from a multi-method observational study. *The Journal of the Royal Society for the Promotion of Health, 126*(3), 134–142. https://doi.org/10.1177/1466424006064303.

Heffner, K. L., Waring, M. E., Roberts, M. B., Eaton, C. B., & Gramling, R. (2011). Social isolation, C-reactive protein, and coronary heart disease mortality among

community-dwelling adults. *Social Science & Medicine, 72*(9), 1482–1488. https://doi.org/10.1016/j.socscimed.2011.03.016.

Hilton, M., & McKay, J. (Eds.). (2011). *The ages of voluntarism: How we got to the big society*Oxford: Oxford University Press. https://doi.org/10.5871/bacad/9780197264829.001.0001.

Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social relationships and mortality risk: A meta-analytic review. *PLoS Medicine, 7*(7), e1000316. https://doi.org/10.1371/journal.pmed.1000316 PMid:20668659 PMCid:PMC2910600.

Hortulanus, R., Machielse, A., & Meeuwesen, L. (2006). *Social isolation in modern society.*. London/New York: Routledgehttps://doi.org/10.4324/9780203020142.

Jagosh, J. (2019). Realist synthesis for public health: Building an ontologically deep understanding of how programs work, for whom, and in which contexts. *Annual Review of Public Health, 40*, 127–146. https://doi.org/10.1146/annurev-publhealth-031816-044451.

Landeiro, F., Barrows, P., Musson, E. N., Gray, A. M., & Leal, J. (2017). Reducing social isolation and loneliness in older people: a systematic review protocol. *BMJ Open, 7*(5), e013778. https://doi.org/10.1136/bmjopen-2016-013778.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal and coping.* New York: Springer.

Leigh-Hunt, N., Bagguley, D., Bash, K., Turner, V., Turnbull, S., Valtorta, N., & Caan, W. (2017). An overview of systematic reviews on the public health consequences of social isolation and loneliness. *Public Health, 152*, 157–171. https://doi.org/10.1016/j.puhe.2017.07.035 PMid:28915435.

Lincoln, Y. S., & Guba, E. G. (1985). Establishing trustworthiness. *Naturalistic Inquiry, 289*, 331.

Machielse, A. (2006). *Theories on social contacts and social isolation. Social isolation in modern society.*. London/New York: Routledge13–36.

Machielse, A. (2015). The heterogeneity of socially isolated older adults: A social isolation typology. *Journal of Gerontological Social Work, 58*(4), 338–356. https://doi.org/10.1080/01634372.2015.1007258.

Machielse, A., & Hortulanus, R. (2012a). *Social ability or social frailty? The balance between autonomy and connectedness in the lives of older people. Ageing, meaning and social structure: Connecting critical and humanistic gerontology.*. Bristol: Policy Press119–138. https://doi.org/10.1332/policypress/9781447300908.003.0007.

Machielse, A, & Hortulanus, R (2012b). *Sociaal isolement bij ouderen (Social isolation in older adults.* Amsterdam: SWP.

Masi, C. M., Chen, H., Hawkley, L. C., & Cacioppo, J. T. (2011). A meta-analysis of interventions to reduce loneliness. *Personality and Social Psychology Review, 15*, 219–266. https://doi.org/10.1177/1088868310377394 PMid:20716644 PMCid:PMC3865701.

McNeilly, D. P., & Burke, W. J. (2002). Disposable time and disposable income: Problem casino gambling behavior in older adults. *Journal of Clinical Geropsychology, 8*(2), 75–85. https://doi.org/10.1023/A:1014679507988.

Meeuwesen, L. (2006a). *A typology of social contacts. Social isolation in modern society.* London/New York: Routledge37–59.

Meeuwesen, L. (2006b). *Personal competences and social isolation. Social isolation in modern society.*. London/New York: Routledge81–99.

Neves, B. B., Sanders, A., & Kokanović, R. (2019). It's the worst bloody feeling in the world": Experiences of loneliness and social isolation among older people living in care homes. *Journal of Aging Studies, 49*, 74–84.

Newman, J., & Tonkens, E. (Eds.). (2011). *Participation, responsibility and choice: Summoning the active citizen in Western European welfare states*Amsterdam: Amsterdam University Press.

Nicholson, N. R. (2012). A review of social isolation: An important but underassessed condition in older adults. *The Journal of Primary Prevention, 33*(2-3), 137–152. https://doi.org/10.1007/s10935-012-0271-2.

Patton, M. Q. (2015). *Qualitative research & evaluation methods.* Los Angeles: Sage.

Perlman, D., & Peplau, L. A. (1981). Toward a social psychology of loneliness. *Personal Relationships, 3*, 31–56.

Pescosolido, B. A., & Levy, J. A. (2002). The role of social networks in health, illness, disease and healing: The accepting present, the forgotten past, and the dangerous potential for a complacent future. In J. A. Levy, & B. A. Pescosolido (Eds.). *Social networks and health* (pp. 3–25). Amsterdam: JAI/Elsevier Science. https://doi.org/10.1016/S1057-6290(02)80019-5.

Rokach, A., & Brock, H. (1998). Coping with loneliness. *The Journal of Psychology, 132*(1), 107–127.

Schoenmakers, E. (2013). *Coping with loneliness.* Amsterdam: Vrije Universiteit.

Steptoe, A., Shankar, A., Demakakos, P., & Wardle, J. (2013). Social isolation, loneliness, and all-cause mortality in older men and women. *Proceedings of the National Academy of Sciences, 110*(15), 5797–5801. https://doi.org/10.1073/pnas.1219686110 PMid:23530191 PMCid:PMC3625264.

Tilvis, R. S., Routasalo, P., Karppinen, H., Strandberg, T. E., Kautiainen, H., & Pitkala, K. H. (2012). Social isolation, social activity and loneliness as survival indicators in old age; a nationwide survey with a 7-year follow-up. *European Geriatric Medicine, 3*(1), 18–22. https://doi.org/10.1016/j.eurger.2011.08.004.

Tomaka, J., Thompson, S., & Palacios, R. (2006). The relation of social isolation, loneliness, and social support to disease outcomes among the elderly. *Journal of Ageing and Health, 18*(3), 359–384. https://doi.org/10.1177/0898264305280993 PMid:16648391.

Van Dijke, J., Van Nistelrooij, I., Bos, P., & Duyndam, J. (2020). Towards a relational conceptualization of empathy. *Nursing Philosophy*. https://doi.org/10.1111/nup.12297.

Weldrick, R., & Grenier, A. (2018). Social isolation in later life: Extending the conversation. *Canadian Journal on Aging/La Revue canadienne du vieillissement, 37*(1), 76–83. https://doi.org/10.1017/s071498081700054x.

Wenger, G. C., & Burholt, V. (2004). Changes in levels of social isolation and loneliness among older people in a rural area: A twenty–year longitudinal study. *Canadian Journal on Aging/la revue canadienne du vieillissement, 23*(2), 115–127. https://doi.org/10.1353/cja.2004.0028.

Wester, F., & Peters, V. (2004). *Kwalitatieve analyse. Uitgangspunten en procedures.* Bussum: Uitgeverij Coutinho.

Windle, K., Francis, J., & Coomber, C. (2011). *Preventing loneliness and social isolation: Interventions and outcomes.* London: Social Care Institute for Excellence1–16.

Zavaleta, D., Samual, K., & Mills, C. (2014). Social isolation: A conceptual and measurement proposal. *OPHI working paper no. 67. Oxford Poverty & Human Development Initiative (OPHI)*. Oxford: University of Oxford/Department of International Development.