INTRODUCTION

In March 2020, the coronavirus disease 2019 (COVID-19) entered the Netherlands and the government was forced to take measures to prevent the spread of this disease (World Health Organization, 2019). These measures consisted of social distancing, staying at home and prohibition of gatherings. As the health consequences of infection with COVID-19 are greater in older adults. These restrictions were especially recommended for them (RIVM, 2020). The Dutch minister of Health instructed the adults above the age of 70 years to avoid...
social contact and stay at home. Furthermore, several public services were closed to prevent the spread of the disease. Most clubs and services, including those that specifically serve older adults, stopped their activities. For many older adults, these measures meant that their daily schedule changed, because they were no longer able to go grocery shopping, look after grandchildren or participate in voluntary work. As a result, there was an involuntary increase in social isolation. Before the pandemic, two million adults (31.2%) aged 45 years and older felt (somewhat) alone in the Dutch population (Data from webpages CBS, 2019). It is therefore important to understand the impact of isolation measures on older adults' perceived loneliness and well-being.

With the ageing of society, more and more senior adults are experiencing loneliness or are at risk of social isolation (Yanguas et al., 2018). Social distancing has a negative impact on loneliness and social isolation (Armitage & Nellums, 2020; Banerjee & Rai, 2020; Hwang et al., 2020). Loneliness is defined as the unpleasant experience that occurs when a person's network of social relationships is deficient in some important way, either quantitatively or qualitatively (De Jong Gierveld, 1998), whereas social isolation is the objective lack of contacts and interactions with a person, family or friends (Fakoya et al., 2020). Both social isolation and loneliness are associated with negative psychological and physical outcomes (Menec et al., 2019; Yanguas et al., 2018), so it is likely that the COVID-19 measures led to a change in older adults' social well-being (Krendl & Perry, 2020). However, it is still unclear how community-dwelling older adults have experienced this. Furthermore, the mandatory isolation affects older adults' social network (Smith et al., 2020; Williams et al., 2020). Therefore, we were also interested in people's perceptions on changing their social network post-isolation.

The aim of this qualitative study was to explore the perceptions around social and emotional well-being during self-isolation and social distancing imposed by the government measures in response to the COVID-19 outbreak among adults of 50 years and older. The key questions were: (a) 'What is the impact of the COVID-19 outbreak on the social contacts of the participants?' (b) 'What is the impact of mandatory isolation, during the COVID-19 outbreak, on the motivation of participants to enlarge their social network in the future?' and (c) 'What is the impact of mandatory isolation, during the COVID-19 outbreak, on the participants' feelings towards social isolation and social loneliness?'

2 | METHODS

2.1 | Research design

A qualitative research design with semi-structured telephone interviews was used. The Consolidated Criteria for Reporting Qualitative Research were applied to ensure methodological quality (Tong et al., 2007).

2.2 | Setting and participants

The interviews were administered from 29 April 2020 until 25 June 2020 in Nijmegen and vicinity, in the east of the Netherlands. Participants were recruited through local newspaper and website advertisement, ‘Netwerk 100’ (the regional network aimed at improving the care for and well-being of frail older adults), and the personal network of the researchers, participants and co-workers not involved in the study. Researchers who reached out to their personal network were not involved in the data collection. Inclusion criteria were Dutch-speaking and being aged 50 years or older. Exclusion criteria were a decreased mental capacity and/or problems with vision or hearing that limit participation in a phone interview (even when using hearing or visual aids). Participants were approached over the phone or through e-mail to provide information about the study and to arrange a date and time for a telephone interview. Prior to the interview, participants received further information, a questionnaire and the informed consent form by postal mail or e-mail.

2.3 | Ethics

The study was reviewed by the research ethics committee of the Radboud university medical centre and was judged as not being within the remit of the Medical Research Involving Human Subjects Act (WMO), and acquired ethics approval. The study has been reviewed by the ethics committee on the basis of the Dutch Code of conduct for health research, the Dutch Code of conduct for responsible use, the Dutch Personal Data Protection Act and the Medical Treatment Agreement Act. All participants provided voice-recorded informed consent over the phone.
2.4 | Data collection

Open-ended questions relating to the well-being and the social contacts of the participants during the corona pandemic were used (e.g. ‘How has the corona pandemic caused changes in your social contacts?’ ‘What is the impact of the corona measures on your motivation to expand your social network in the future?’ and ‘How do the COVID-19 related measures implied by the government impact on your well-being?’). See Supporting Information for the complete interview guide. Some participants found it difficult to answer the question about their motivation to expand their social network in the future, as they did not feel lonely or had large networks. In that case, an alternate question was asked: ‘Imagine if you did feel lonely or did not have a large network, what do you think would be the impact of the corona measures on your motivation to expand your social network in the future?’

The 20 interviews were independently conducted by a first-year female Master student Medicine (n = 16) and a first-year male PhD student (n = 4). The interviews were conducted over the telephone and digitally voice recorded (average duration 58 min). The audio recordings were stored in the secure, cloud-based digital environment of the Radboud university medical centre. During the interviews, field notes were taken. The recordings were transcribed verbatim and anonymously by the researchers.

Information on the sample characteristics was obtained with questionnaires. The Older Persons and Informal Caregiver Survey-Short Form includes questions on age, gender, education, morbidity, emotional well-being, social functioning and health (Lutomski et al., 2013). The responses on the TOPIC-SF can be used to calculate the frailty index. Scores range from 0 to 1 with scores 0.2 and below indicating ‘not frail’, 0.2–0.6 indicating ‘moderate frail’, 0.6–0.8 indicating ‘frail’ and with a score of 0.8 and above indicating ‘very frail’. On average, the sample score showed low levels of frailty (M = 0.07) (Table 1).

3 | FINDINGS

3.1 | Participant characteristics

In total, 20 participants were recruited (n = 5 through advertisement, n = 4 through ‘Netwerk 100’, n = 5 through the network of researchers, n = 2 through the network of participants, n = 3 through the network of co-workers uninvolved in the study and for n = 1, it is unknown how this participant was recruited). The mean age of the study sample was 72 years (range 56–87) and 11 participants were female. Sixteen participants were classified as not lonely and 40.0% had a social network of more than 20 persons. Additionally, 55.0% of the participants lived independently and with a partner. Two participants (10.0%) were classified as frail. Nearly all participants indicated that everybody was in the same situation (quote 5). They adapted to the situation by finding ways

3.2 | Qualitative findings

The qualitative data analysis revealed three themes: (a) ‘Social behaviour during the COVID-19 outbreak’, (b) ‘Emotional behaviour during the COVID-19 outbreak’ and (c) ‘Motivation to expand the social network’. Table 2 shows the themes, categories, codes and quotes. In the next section, the categories will be evaluated per theme.

3.3 | Social behaviour during the COVID-19 outbreak

3.3.1 | Category 1: Maintenance of contact

Participants tried to keep in contact with their relatives in different ways, for example, by phone calls, postcards or e-mail. They also expressed that there was more digital contact (e.g. WhatsApp Messenger and video calls) during the social isolation (quote 1). Some participants experienced little change in social contacts (quote 2). But, one participant was explicitly called by a relative who said that they must look after each other (quote 3).

3.3.2 | Category 2: Adaptation

Nearly all participants indicated that everybody was in the same situation (quote 5). They adapted to the situation by finding ways

2.5 | Data analysis

Sample characteristics were described with descriptive statistics. The program Atlas.ti (version 8.4.24) was used to analyse the interview data. The analysis of the transcripts was performed according to the grounded theory approach of open, axial and selective coding (Glaser et al., 1968; Williams, 2019) and consisted of three steps. First, the open coding process of the first three transcripts was conducted by two coders separately, and discussed face to face to reach agreement on the codes. Second, to improve validity, the two coders each independently coded half of the transcripts and checked the coding for the remaining transcripts. Third, a codebook was written containing all the codes and definitions. The final codes were categorised on paper. These categories were grouped to form themes.
to maintain their social contacts within the boundaries of the social distancing measures, for example, by receiving guests in their garden so there was more space to keep distance (quote 7) and by avoiding crowded places (quote 6). On the one hand, participants were hindered in daily activities which felt as if the naturalness of their usual lives was gone (quote 8). On the other hand, participants filled their time with other activities, such as house chores (quote 9).

3.3.3 | Category 3: Less contact

Participants saw their family and friends less, and spontaneous contact was gone (quote 10), but this was generally not perceived as a problem (quote 11). Others said that this situation was difficult for everyone as they missed physical contact with relatives and they were looking forward to cessation of the social isolation and distancing measures (quote 13).

3.4 | Emotional behaviour during the COVID-19 outbreak

Participants described their emotional state during the COVID-19 lockdown as either calm, unchanged or unpleasant. Most participants indicated that the lockdown did not change their emotional well-being (quotes 15 and 16).

These participants described this period as calm (quote 14). However, some participants experienced negative feelings during the lockdown. They said that they felt more dreary and more emotional, or were affected by the stories of lonely people living in nursing homes (quotes 17–20). Interestingly, some participants noted a change in the mood of other people. While some participants noted a short temper in other people, other participants commented that people were generally more supportive and friendly (quotes 21).

3.5 | Motivation to expand social network due to COVID-19

None of the participants felt a need to expand their social network after the isolation measures are lifted. The main reason was that they felt that their current networks were sufficiently large and strong. Moreover, they felt that expansion of their network would make it difficult to maintain contact with everyone or that the experience of the lockdown made participants appreciate social contact more. Rather than expanding their networks, they felt it was more important to strengthen the bond with existing contacts (quotes 22 and 23).

Participants pointed out, however, that they could imagine that in older adults who do feel lonely, the strict government-imposed isolation measures could potentially lead to either an increase in motivation to expand their networks (quote 24) or a decrease in interest to expand their networks (quote 25).

4 | DISCUSSION

This study aimed to explore the impact of the government-imposed measures in response to the COVID-19 outbreak on fit older adults’ emotional and social well-being, and their motivation to expand their social network. This group of relatively vital and well-educated community-dwelling older adults, generally felt minimally emotionally affected by the measures despite the substantial impact on their daily and social lives. However, they did note changes in the socio-emotional well-being of others.

Despite the substantial impact of social isolation and social distancing on participants’ daily lives and social activities, most participants felt minimally emotionally impacted. This was partly due to their creativity in finding ways to maintain social contact and fill their day, for example, through the use of digital technology and welcoming visitors to their garden where they were able to maintain distance. The use of internet is associated with reduced

| Variable | Total (N = 20) |
|----------|---------------|
| Age – years, M (SD) | 72 (7.5) |
| Female sex – n (%) | 11 (55.0) |
| Education – n (%) | |
| Primary school | 1 (5.0) |
| Elementary technical school | 3 (15.0) |
| Secondary school | 8 (40.0) |
| University/higher professional education | 8 (40.0) |
| Degree of loneliness – n (%) | |
| Not lonely | 16 (80.0) |
| Moderately lonely | 3 (15.0) |
| Severely lonely | 1 (5.0) |
| Employment situation – n (%) | |
| No work history | 1 (5.0) |
| Performing a job <20 hr a week | 3 (15.0) |
| Performing a job >20 hr a week | 1 (5.0) |
| Retired | 15 (75.0) |
| Living situation – n (%) | |
| Independent, alone | 9 (45.0) |
| Independent, with partner | 11 (55.0) |
| Social network size – n (%) | |
| 2–5 persons | 2 (10.0) |
| 6–10 persons | 5 (25.0) |
| 11–15 persons | 1 (5.0) |
| 16–20 persons | 4 (20.0) |
| >20 persons | 8 (40.0) |
| Frailty index – M (SD) | 0.07 (0.07) |

*Including pre-university education, Senior General Secondary Education and Pre-vocational General Secondary Education.
TABLE 2 List of themes, categories and quotes of interviews on COVID-19-related changes in social contacts with older adults aged 50+

| Category | Participant | Quotes |
|----------|-------------|--------|
| **Theme 1: Social behaviour during the COVID-19 outbreak** | | |
| Maintenance of contact | I14 (F) | (1) Physical and personal contact have decreased, but of course we can use Skype and Facetime. In fact the phone never stopped ringing. |
| | I7 (M) | (2) Well, almost nothing changed, I must say. People who came by spontaneously, still come by. I also visit other people, I think not much has changed. |
| Maintenance of contact | I7 (M) | (3) The great thing is, actually in our family we rarely have contact, but during the corona outbreak suddenly my youngest brother called [...] and he said: 'yes, the prime minister said we should take care of each other more, so I called you'. I extremely appreciated that. |
| Adaptation | I8 (F) | (4) We are very realistic about the situation and we all have to go through it. Better days will come. |
| | I5 (F) | (5) It was the same for everyone. Everyone had to deal with the situation. So you were not the only one. |
| | I13 (M) | (6) The spontaneous contact disappeared, it is blocked. |
| | I17 (F) | (7) Well, I think it is not that bad. Look, ideally, you have more freedom of course, but no, it did not bother me. |
| | I18 (F) | (8) You see your friends less, but there is still a phone, so I don't have any problems with it at this moment and I have not had problems with it for the past few months. |
| | I1 (F) | (9) What I miss the most is contact with my children and grandchildren. I can call them, and I can see them, but I can't touch them. |
| **Theme 2: Emotional behaviour during the COVID-19 outbreak** | | |
| Perception during COVID-19 outbreak | I5 (F) | (14) I actually experienced it as very calm. |
| | I13 (M) | (15) I tried to live my life as before. |
| | I18 (F) | (16) ‘And how did you feel during the corona outbreak?’ ‘Well, same as usual. Just good!’ |
| | I15 (F) | (17) Well, it is very tough. I also noticed that this week I said to someone: ‘it is very stupid, because I actually have nothing to complain about as I live here, I can go outside, I can go to my garden, whatever, but I am more emotional’. Yes, apparently it does have an impact on me. I am more emotional. |
| | I14 (F) | (18) Sense of something lacking, that you are actually forced to be inside, that you can’t go your own way anymore. |
| | I15 (F) | (19) It is just awful, because you hear miserable stories about loneliness and people who say: ‘I don’t want to live anymore’, ‘I don’t want to take a pill, but I can’t live like this’, you know. Yes, so it is intense, yes, it is intense. |
| | I20 (M) | (20) Yes, in the beginning you think it is not that bad, it will be over soon, but in the long term it does make you feel more dreary. |
| | I6 (M) | (21) We cycle a lot and then you see that there are people who have a short temper. We have the impression that this has increased, that more people are having a low tolerance. |
| **Theme 3: Motivation to expand social network due to COVID-19** | | |
| Motivation | I9 (M) | (22) No, I would not expand it. What I do is appreciate it even more. It is already very extensive. I will see what comes along, but I do not think due to the corona crisis: ‘I should pay more attention to my social network’. |
| | I7 (M) | (23) I'm not like: ‘I need more contacts’, but I should tighten up my existing contacts more. If you expand it, I think that sounds grim [...] but maintaining contact takes time and energy. |
| | I6 (M) | (24) Well, we have a large network and we don’t need to strengthen that. But I can imagine that it is applicable for people who are living alone, or are in a nursing home due to circumstances, who cannot receive visitors. |
| | I15 (F) | (25) I don’t know, I don’t know, because those people are older and I have noticed that their circle is so small now, that they also miss interest to connect. |

Abbreviations: F, female; M, male.
loneliness and increased social support (Chopik, 2016). Older adults acknowledge the benefits of technology to improve social relationships and make communication easier (Chopik, 2016). Some older adults already use technology to prevent the feeling of loneliness (Vošner et al., 2016). Another coping strategy was to keep themselves busy to avoid thinking about the risks and fear associated with the virus and feel less emotionally affected (Brooke & Clark, 2020). Moreover, most participants wereceptive of the situation as they felt ‘in it together’ and adapted to the situation. These findings were in contrast with reports in the Dutch media which were dominated by the sad stories of isolated older adults in nursing homes. Besides, preliminary results in the Dutch population also show an increase in perceived loneliness due to the Covid-19 isolation measures (van Tilburg et al., 2020). The strong contrast of perceived loneliness is likely explained by the differences in health and resilience between these groups. While the media focused on frail older adults in nursing homes who often were unable to understand the situation due to cognitive decline, the current sample was generally vital and socially well connected. Although we did not measure resilience in this study, the responses of participants are illustrative of their abilities to adapt to the changed situation (Chen, 2020). Although the questions asked about participants’ own experiences, many participants indicated that they believed that the impact of the measures was greater for others. These views were based on what they saw in their frail peers with small networks, and was reinforced by the negative reporting in the media. However, there is still a stigma to admitting the feeling of loneliness as a result of which older adults might not always dare to admit this feeling (Rokach, 2012). Therefore, it is easier to talk about others than about themselves as being lonely.

Participants experienced the reduced social and physical contact with close relatives as difficult. Social isolation and disconnectedness are associated with perceived loneliness, which can cause mental health issues such as depressive symptoms and anxiety (Newman & Zainal, 2020; Taylor et al., 2018; Wu, 2020). This may partly explain why, particularly for older adults, it is difficult to continue to adhere to the measures despite awareness of COVID-19 and potential consequences (Betsch, 2020).

The lockdown experience did not motivate participants to expand their social networks. Most participants were satisfied with their existing social network, to which they felt a sufficiently close emotional connection despite the physical distance. Rather than wanting to expand their network, they became more appreciative of the contacts they had, and aware of the importance of investing in these relationships. Furthermore, some participants mentioned that maintaining good contact with their existing social network was time consuming. They mentioned that if their social network expanded further, it would be hard to keep this up. These findings coincide with previous literature that found that for older adults, the quality of contacts is more important than the quantity for their experienced social loneliness and well-being (Bruine de Bruin et al., 2020; Green et al., 2001).

A strength of this study is the timing. The interviews were held at the end of the first peak in COVID-19 infections in the Netherlands and during the third and fourth month of self-isolation and social distancing. This means that participants had experienced the lockdown situation for 2–4 months at the time of the interview. Thus, they had had some time to adjust to the situation, but were also still experiencing it. This study ties with a similar study performed in the United Kingdom which also aimed to explore the experiences of older adults (aged 70 or above) during the COVID-19 isolation and showed some similarity in results (Brooke & Clark, 2020).

Another strength is that the interviews were held over the phone. Research has shown that people prefer phone interviews over face-to-face interviews, as it offers privacy (Sturges & Hanrahan, 2004), is more anonymous and creates a safe environment to provide honest answers. Lack of personal contact could potentially also lower the threshold for false answers; however, we did not get the impression that this was an issue, as participants appeared very open and honest. An important limitation that needs to be taken into account is the limited representativeness of the sample. The sample is representative of relatively vital and highly educated community-dwelling older adults who were living with a partner. As discussed above, the experiences of frail older adults with smaller networks may have been very different. However, after the first 16 participants were interviewed and it appeared that saturation was achieved, we purposively recruited four additional participants with lower levels of education and/or smaller networks and found similar results. Future research should target frailer older adults who live alone or have smaller social networks.

In conclusion, this group of vital and well-connected community-dwelling older adults experienced minimal socio-emotional problems due to the government-imposed measures in response to the COVID-19 outbreak. The measures had a great impact on their daily lives and they missed physical contact with close relatives, but they accepted the situation and adapted to it. Rather than feeling a need to expand their networks, participants felt a need to strengthen existing contacts. These experiences of this group of vital and well-connected older adults probably differ from those of frailer older adults with smaller social networks who have seriously increased feelings of loneliness.

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CONFLICT OF INTEREST
The authors declare to have no conflict of interest.

AUTHOR CONTRIBUTION
J. Janssen, G. Peeters and E.M. Kremers conceived and planned the study. E.M. Kremers and J. Janssen carried out the study. J. Janssen contributed to recruitment. E.M. Kremers, J. Janssen and M. Nieuwboer contributed to the data analyses. All authors
contributed to the interpretation of the results. E.M Kremers and J. Janssen drafted the manuscript. G. Peeters, M. Oldekkert and M. Nieuwboer provided critical feedback on drafts of the manuscript. All authors approved the final draft of the manuscript.

DATA AVAILABILITY STATEMENT
The anonymous transcript data is available upon request due to ethical and privacy considerations.

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SUPPORTING INFORMATION
Additional supporting information may be found online in the Supporting Information section.

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