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# (Dis)Connecting Through COVID-19: Experiences of Older Persons in the Context of a Volunteer–Client Relationship

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Résumé

La pandémie de COVID-19 et les contraintes de distanciation physique ont eu un impact significatif sur les programmes de bénévolat pour les personnes âgées. De nombreux programmes établis depuis longtemps ont été abandonnés, ou ont été transférés en version virtuelle. Dans cette étude, nous avons recueilli des données d'entrevues qualitatives réalisées auprès de 23 clients et 33 bénévoles afin de sonder leurs expériences durant la pandémie de COVID-19 et les effets sur la relation bénévole/client. Trois thèmes ont été identifiés : les émotions liées à la pandémie, la gestion des interactions sociales et la croissance personnelle en temps de pandémie de COVID-19. Ces résultats fournissent un éclairage sur les expériences des organisations offrant des soins palliatifs, leurs bénévoles et leurs clients pendant la pandémie de COVID-19. Ils soulignent l'importance de reconnaître à la fois la vulnérabilité et la résilience des personnes âgées, d'adopter des approches communautaires compassionnelles en matière de soins et de concevoir des moyens novateurs afin de favoriser les relations bénévoles-clients lorsque les visites physiques ne sont pas possibles.

Abstract

The coronavirus (COVID-19) pandemic and mandated physical distancing requirements significantly impacted volunteer programs for older persons with many long-standing programs either ceasing altogether or pivoting to connecting through virtual technologies. In this study, we collected qualitative interview data from 23 clients and 33 volunteers to investigate their experiences during the COVID-19 pandemic and the effects on the volunteer–client relationship. Three themes were identified: pandemic emotions, negotiating social interactions, and growing through the COVID-19 pandemic. These findings provide important insights into the experiences of hospice organizations and their volunteers and clients during the COVID 19 pandemic, further highlighting the importance of acknowledging both older persons' vulnerability and their resilience, of building in compassionate community approaches to care, and of finding innovative ways to foster volunteer–client relationships during times when physical visiting is not possible.

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Introduction

Hospice volunteers play an important role within the health and social care sectors, providing social, emotional, and instrumental support for people with declining health across care settings. Hospice volunteers are ideally situated to support a palliative approach to care in which interventions to improve quality of life are implemented early in the palliative trajectory (Sawatzky et al., 2017), ideally when persons are beginning to experience the losses related to advancing chronic illness. Volunteers are also the backbone of the compassionate community approach to palliative care in which communities assist with the many social needs that arise as a result of declining health (Kellehear, 2013). A recent development has been the use of social prescribing as a way to address non-medical needs that impact quality of life. Health care providers refer to community-based organizations to assist with meeting the social needs that impact health. A realist review of such programs identified the important role of volunteers who served as connectors to resources that help build social capital and patient engagement (Tierney et al., 2020).

Some of the most serious consequences of living with declining health are social isolation and loneliness. Factors such as living alone, sensory deprivation, cognitive difficulties, and the

inability to perform daily functions put individuals at high risk (National Academies of Sciences, Engineering, and Medicine, 2020). Further, as functional ability declines, older persons increasingly report difficulties with self-care, mobility, and maintaining interpersonal interactions (Abdi, Spann, Borilovic, de Witte, & Hawley, 2019). These needs have been increasingly difficult to meet because of the financial cutbacks in Canada's community-based health care system (Johnson et al., 2018). This potentially leaves persons within declining health in a liminal state at the intersection of functional decline, decreasing quality of life, and lack of available health care services. It is in this liminal state that the role of the hospice volunteer can make a critical contribution to care.

A growing body of evidence demonstrates the benefits of volunteer involvement in social care. In addition to augmenting, filling in for, and providing discrete social services (Cameron, Johnson, Willis, Lloyd, & Smith, 2020), volunteers promote active engagement, enhance the client's quality of life across the illness trajectory, and support bereaved families (Claxton-Oldfield, 2015; Vanderstichelen et al., 2018). Moreover, grounded in the formation of close relationships, volunteering is reciprocal in nature – benefiting both the client and volunteer (Claxton-Oldfield, 2015; Lilburn, Breheny, & Pond, 2018). Cameron et al. (2020) describe that volunteering gives older persons and volunteers a sense of purpose and meaningful social interaction.

Recognizing the important roles that volunteers have in health and social care for older persons, we designed a volunteer intervention called Nav-CARE (Navigation- Connecting, Advocating, Resourcing, Engaging). In Nav-CARE experienced hospice volunteers receive additional training in community-based navigation. They learn competencies related to improving quality of life, advocating for clients, facilitating access to resources, and fostering engagement. Volunteers are matched with clients based upon the judgement of a volunteer coordinator who knows both persons. Then volunteers visit clients in the home on average every 2 weeks for 1 to 2 hours. The volunteer focus is on supporting older persons living at home with declining health through connecting them to persons, resources, and services in the community to improve their quality of life. Examples of things that volunteers do include listening and identifying priority concerns; helping identify and discuss important decisions; getting access to supports for daily needs (e.g., house, pet, yard care); assisting with filling out forms or navigating technology; and facilitating clients to stay connected to the relationships and activities that are meaningful to them. Volunteers work one-on-one with clients in the home over the long term, in many cases, until the end of life. Nav-CARE is an evidence-based intervention having been developed through a systematic process of competency (Duggleby et al., 2016) and curriculum development (Duggleby et al., 2018), pilot studies (Duggleby et al., 2020; Pesut et al., 2017), and knowledge translation studies (Pesut et al., 2020a; Pesut et al., 2020b). During the time that data were being collected for this study, Nav-CARE was being scaled out to sites across Canada for the purpose of further building its evidence base. Near the conclusion of this scale-out, the coronavirus (COVID-19) pandemic occurred and all client/volunteer in-person visits were suspended and only virtual visits were allowed. As a result, we shifted to studying the experiences of these clients and volunteers with the COVID-19 pandemic, the resulting public health precautions, and the effects on the volunteer/client relationship.

Literature Review

COVID-19 public health orders related to physical distancing have led to the temporary cessation of established volunteer activities with direct contact for older people, yet very little research describes the resulting impact. The research evidence that does exist describes the wide-reaching impact of the pandemic on the well-being of older persons living in the community. Increased age and having multiple comorbid conditions are associated with COVID-19-related mortality and severe disease, making older adults the most vulnerable population during the pandemic (Banerjee, 2020; Jordan, Adab, & Cheng, 2020). Disruptions in everyday activity brought about by shelter-in-place policies have had a significant psychological impact. Evidence points to an increase in older persons' experience of anxiety and depressive symptoms, loneliness (Krendl & Perry, 2020; Parlapani et al., 2020), sleep disturbances (Parlapani et al.), and posttraumatic stress symptoms (Sun et al., 2021), although, the magnitude of impact is mediated by family, social connectedness (Buenaventura, Ho, & Lapid, 2020), and perceived strength of the relationship (Krendl & Perry). Simultaneously, research is showing how older persons find sources of joy and comfort, harnessing pre-pandemic coping resources to manage higher stress levels (Whitehead & Torossian, 2020), reflecting resilience alongside vulnerability.

In terms of volunteerism, since the start of the pandemic, there has been a surge in new citizen-led volunteer activities that, in the short term, sought to help older persons who may have a reduced ability to do daily tasks such as shopping or who may experience social isolation due to visitor restrictions (Miao, Schwarz, & Schwarz, 2021). Anecdotally, some established volunteer programs also pivoted to online interactions (Lachance, 2020). However, many established programs were put on hold, and how clients and volunteers experienced the disruption in this work has received very little attention. In an Australian report, researchers observed declines in well-being and mental health in volunteers who stopped their work (Biddle & Gray, 2020). In a short reflective essay (Dickerson, 2021), a student hospice volunteer described how she shifted from in-person interactions to writing letters and sending cards with attempts to maintain a social connection. She also reflected that, while technology was available to her, verbal communication was difficult for clients who were nearing the end of life, particularly those with cognitive impairment; thus, technology-mediated relationships did not work well within this context. Similarly, Fearn et al. (2021) described volunteer perceptions of switching to virtual visits from in-person visits with older adults living in nursing homes. While "remote befriending" certainly filled an important relational gap, volunteers expressed that virtual visits were a poor substitute for in-person connection. In light of the paucity of evidence describing the impact of the COVID-19 pandemic on volunteer–client relationships, we sought to explore the experiences of clients and volunteers in the context of one intervention for older persons living with advanced chronic illness.

Theoretical Framework

Our understanding of the volunteer role and volunteer–client relationship is theoretically grounded in Duggleby et al.'s (2016) Navigation Model (Figure 1), which forms the conceptual basis for Nav-CARE. This model was developed through a Delphi process. Designed originally to build capacity in hospice palliative care services in rural areas, navigation is defined as:
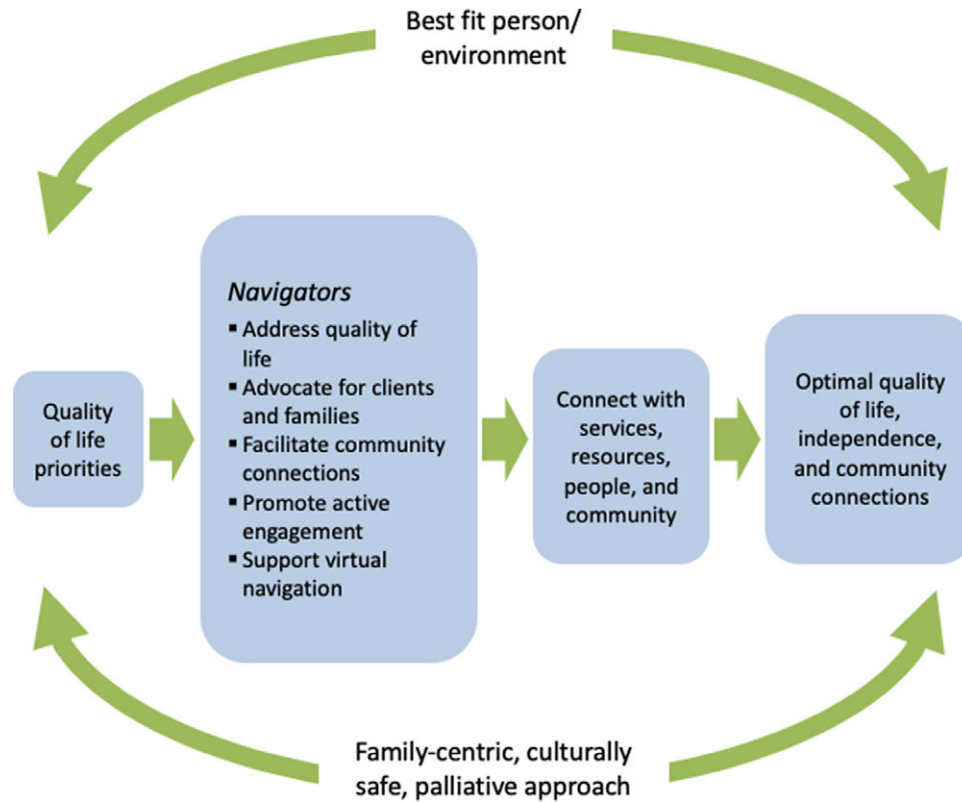
Figure 1. Navigation model. (Adapted from Duggleby et al., 2016)

Working in collaboration with patients, families, and communities to: a) negotiate the 'best fit' for the needs of persons, their families, and communities, and resources; b) improve access to needed services and resources at the end of life (including death) and bereavement; and c) promote quality of life, foster independence, and facilitate community connections using a culturally-safe palliative approach. (Duggleby et al., 2016, p. 212)

This model foregrounds an upstream palliative approach to care, to assist individuals and their families with identifying and accessing health and social care systems with the intent to develop social capital and connections within their community. Volunteers work from a person-centred approach and play an instrumental role in advocating for clients and families, connecting them to resources within their community and promoting active engagement. The volunteer–client relationship develops over an extended period of time. As such, at the heart of the navigation model is the formation of close relationships. These relationships are important in supporting the socio-emotional well-being of clients and families, offsetting feelings of loneliness and isolation, or simply making life feel more livable (Pesut et al., 2017; Pesut et al., 2020a; Pesut et al., 2020b). Studies evaluating the intervention to-date indicate that volunteers and clients build close relationships over time. As a result of that relationship, clients cite specific benefits of social support; assistance with decision-making and transition support; greater access to and awareness of resources to improve their quality of life; and enhanced engagement in life (Pesut et al., 2020a; Pesut et al., 2020b).

The navigation model provides a useful lens through which to explore the impact of the COVID-19 pandemic on volunteer–client relationships. Given that these relationships are developed over time and within a particular context, when these are disrupted by external forces beyond the clients' or volunteers' control, the nature of the relationship is reconfigured. It stands to reason that the pandemic, as a global disruptive event, will reshape people's individual and collective narratives of who they are, their relationships, and what is important. With stay-at-home orders and advisement to practice social distancing, quality-of-life priorities may have shifted, what "best fit" looks like may no longer be applicable, and, with access to formal and informal health and social services greatly reduced, remaining connected to the community will have also changed. This poses unique challenges for older adults living with declining health who may have become reliant upon volunteers to help them with instrumental tasks or were an important source of social support. Therefore, this sudden removal of an important social connection has potential to negatively impact the older persons' and volunteers' quality of life.

Methods

This study used a qualitative descriptive approach (Sandelowski, 2010). Older persons and volunteer navigators, who were already participants in a study in which their experiences of volunteer navigation were being evaluated, were interviewed regarding their experiences amidst the COVID-19 pandemic. Ethical approval was obtained for the change in the interview protocol.

The research context was Canadian hospice organizations located in urban ($n = 3$) and rural ($n = 6$) communities during the COVID-19 pandemic. Older person participants were living in the community with advanced chronic illness. Volunteer participants were affiliated with community hospice organizations and were providing in-home community visiting to older persons. At the time of data collection, no face-to-face visiting was allowed

between volunteers and clients, masks were recommended or required in public spaces, persons were instructed to remain at least 6 ft apart, and social gatherings were limited.

Participants were invited to participate in the study through a telephone call. All participants provided written informed consent for the interviews. Data were collected using a semi-structured interview guide. Participants were asked about their general experiences of the COVID-19 pandemic and how their experiences with the intervention had changed as a result of the public health restrictions. For example, participants were asked, "How is your volunteer working with you during this time?" Data were collected from April of 2020 to September of 2020. Probes around technology use were also included. Interviews were audio recorded, transcribed, and anonymized through a unique participant ID. Interviews were analyzed using inductive thematic coding. Several transcripts were read by two investigators, and broad thematic categories were identified and negotiated. These categories were then used to code all transcripts. The categories were developed into more specific codes, using a constant comparative method (Glaser & Strauss, 1967). Codes were then developed into a thematic account of participant experiences during the COVID-19 pandemic. Three investigators participated in the analytic process to support the quality of the findings. Multiple review sessions were held to determine consistency across the three investigators during coding. Participants included 33 volunteers and 23 clients (see Table 1 for demographic information). The majority of volunteers were older persons as well, and, so, these data reflect findings from two groups of older persons.

Results

Three themes were developed from the findings: pandemic emotions, negotiating social interactions, and growing through the COVID-19 pandemic. The experiences of volunteers and clients had a great deal of commonality, even though their life contexts were different. However, there were also substantial differences.

Table 1. Demographic characteristics of study participants

		Clients (*n* = 23)	Volunteers (*n* = 33)
Age		Mean = 72.06	Mean = 64.81
		SD = 12.998	SD = 10.059
		Missing = 2	Missing = 1
Sex		Male = 6	Male = 5
		Female = 17	Female = 28
		Missing = 0	Missing = 0
Living arrangements		At home = 14	NA
		At home with family = 4	
		Assisted living = 2	
		Other = 1	
		Missing = 2	
Years of volunteer experience		NA	0-5 years = 8
			5-10 years = 7
			≥ 10 years = 17
			Missing = 1

We will highlight those similarities and differences in the subsequent analysis.

Since data collection occurred during the early days of the pandemic, the participants' general experiences of the COVID-19 pandemic and a life disrupted were at the forefront of their attention. Adapting to a "new normal" in a context shaped by uncertainty impacted the way study participants went about all aspects of their everyday life, not just how their interactions changed in the context of the study intervention. As such, the swirl of pandemic emotions, negotiating social interactions, and trying to find new ways of being in the world all related to the pandemic, in general, in addition to their experiences of disrupted volunteer activities; and, at times these could not be untangled. While interview questions focused on how the volunteer–client relationship was impacted during the pandemic, responses often were more generalized in both the clients' and volunteers' accounts.

Pandemic Emotions

Participants described a range of emotional responses to the COVID-19 pandemic – a phenomenon that can be described as "pandemic emotions." While one participant described the pandemic simply as *a nuisance* (C23), most participants characterized these emotions as fear/anxiety and sadness/loss. *There is an aspect of me that feels it is more of a fear pandemic than an actual coronavirus pandemic* (v83). Participants described how, even though these emotions were a normal part of their lives, they had become heightened during the COVID-19 pandemic. This was particularly true for those cognizant about their own declining health and those who were already struggling with mental health challenges.

Fear and Anxiety

Participants described experiencing and/or witnessing heighted levels of anxiety and fear from the pandemic. For most study participants, fear and anxiety were expressed as a generalized experience of daily existence: *Everybody is sort of wandering around in their backyard and being careful. It's fearful for a lot of people and that hampers things* (V33). Some participants were less afraid of the virus itself than they were of the impact of the fear of the virus: *I'm watching people, going from being anxious to being paranoid; something is happening with people and they're taking whatever was there before and ramping it up a bit of a notch and so people are beginning to lose it a bit more* (C31).

Significantly, for participants with declining health, there was an additional level of fear about contracting the virus. They were aware that their illnesses put them in the categories of persons at highest risk for severe complications of COVID-19: *Well, I still feel like I can't go to the store… because… I'm not only at risk for the lung thing but is COVID still wandering around out there and how careful do I need to be?* (C28). This same participant wondered about whether they would ever feel safe in public again. Another participant spoke of how the fear of contracting COVID-19 had removed the hope of returning to a normal life: *I find that's the really hard thing for me that I am an immune-compromised health care worker…. I haven't been to work for the last year and a half because of my immunity or compromised immune system… and now I can't go to work and I want to do something* (C06). The losses related to the COVID-19 pandemic were compounded upon a life that had already been limited by illness. Feelings of fear were exacerbated by those already struggling with poor mental

health: *I suffer a lot of…I suffer with some mental illnesses. So, my anxiety goes up and up, and so I've just been cutting back on the COVID information* (C06).

Feelings of Sadness and a Sense of Loss

Alongside feelings of fear and anxiety, participants also expressed feelings of sadness and a sense of loss: *I feel like I'm falling into a hole, you know, a bottomless pit and nobody's doing much about it* (C13). Clients and volunteers described factors of the COVID-19 pandemic that influenced feelings of sadness and a sense of loss. These included a change in daily routines, increased isolation, and changes in personal and professional purpose and roles.

One source of sadness was the loss of a daily routine – activities participants were involved in and routine outings. While clients reflected that in general terms, their routines were disrupted, volunteers noted that these disrupted routines were especially challenging for their clients, not just because of having *challenges finding enough to fill the day* (V75), but because routines were often the most significant aspect of an older person's day – the things they looked forward to the most. As one volunteer reflected: *The biggest thing of their day is to get out to go get groceries or to go out and get gas* (V37). These routines contributed to the clients' sense of independence and so the loss of these routines was also a loss of independence.

Volunteers, too, missed the structure and sense of accomplishment their routines provided: *I am lonely and bored. I'm the kind of person that I need to accomplish something in my day. I have to have something to look forward to doing, I have to have completed something in my day or I feel lost* (V73). For volunteers, the loss of routine also affected their sense of purpose, particularly when their purpose was related to assisting those in their community: *I used to go every week and visit people at the hospice. I also had a one-to-one client I would visit, too. I'm hoping that changes soon* (V36).

Another source of sadness was from a sense of increasing isolation, which resulted in increased sadness and loss: *I think all of us have gone through our own feelings of grief and loss* (V64). Clients struggled with this increased isolation, expressing their sadness with losing their connections: *I did have friends and connections, but now they don't want to visit anymore or they don't want me to visit because of the virus* (C36). For those nearing the end of their lives, this forced isolation could lead to a sense of sadness and regret for opportunities lost to connect with others. One volunteer reflected on the circumstances of regret she heard from her clients: *If COVID hadn't hit, maybe I could have brought her home, or my kids could've come home, or we could've went out more, for drives, so the regret comes up a lot* (V82).

Sadness was also reflected as a sense of loss related to the volunteer role. This was especially prevalent in volunteer accounts, which manifested in a couple of different ways. First, volunteers expressed sadness, reflecting on the general impact of the pandemic on their clients: *When you think about the way that elderly people are suffering or have suffered, it's really hard emotionally to be okay with that* (V20). This volunteer recognized how important it was to feel the sadness of the situation without allowing that sadness to develop into something more: *It has just on the emotional level I think it's been kind of challenging not to fall into you know a real deep sadness about what's going on. I mean to feel sadness is fine but not to go into real darkness* (V20). Another volunteer explained that clients are *already losing all kinds of things… health wise and, and here we are they're losing now a little bit more of their community*

and their independence because of COVID and they can't do what they normally do (V38).

The second way in which sadness and loss were expressed in volunteers' accounts related to their struggles abdicating their home-visiting role given how important these visits were in their clients' lives: *The sick people are still sick and the people that need help still need help and, and we can't really do a whole lot for them at the moment… it's a challenge and it's hard* (V51). Volunteers worried that they had "abandoned their participant" and that this sense of abandonment would be even more acute because a relationship had been established: *I didn't want to be part of leaving her in a space that was more lonely* (V37). Volunteers recognized the increasing isolation and fear experienced by clients but had to also deal with their own fears of COVID-19 exposure: *I saw that there was a lot of fear of being left alone and with COVID, it kind of pushed me to be part of that leaving her alone physically and I, that was hard* (V37).

These feelings of leaving clients alone were even more difficult if the clients' health was declining. One volunteer whose client died during the COVID-19 pandemic described the sadness of not being able to say goodbye: *The whole piece of someone passing away in COVID. You know, it's different because I think for the Nav-CARE volunteer closure is so important. How do you have closure when you don't say goodbye? […] you know we all have our ways as hospice volunteers to process grief and like kind of debrief knowing that closure is coming* (V81). The volunteer recognized the profound loss of not being able to visit and work with her older person in their last moment of life and how that impacted her (volunteer's) loss of the grieving process.

In another example, a client whose health was declining had difficulty understanding why the volunteer had stopped visiting: *You gotta keep telling them the same things so she kept saying 'your visits really help me like visits really help me,' and so I would have to keep explaining to her you know, 'remember I've got to keep you safe'* (V82). Clients acknowledged these feelings of guilt within volunteers: *She's feeling that she's letting me down, because she can't come and visit me because um I've had some problems in the last month and it's only what she hears from me over the phone and she just can't be here to help me* (C22).

Negotiating Social Interaction

In the context of physical distancing measures and social restrictions, participants were challenged to radically change how they interacted with others. This led participants to not only cultivate social interactions in new ways, but also to carefully weigh the risks associated with in-person interactions. Furthermore, while social interaction mediated through technology opened up opportunities to foster and maintain relationships, it also reshaped social connection in profound ways.

New ways of interacting. Participants described their adaptations to physical distancing and the impact it had on their relationships. For example, participants reflected on the new practice of "window visiting": *There was a period where I wasn't actually physically seeing anybody like you know I'd drive to my son's place and visit my grandsons through the window* (V84). However, such arrangements were a poor substitute for physical presence: *We're social creatures. Eventually you have to, you want to get in somebody's space* (V58). Though volunteers and clients recognized the health reasons for physical distancing requirements, they expressed difficulties adhering to them.

The challenges related to physical distancing prompted participants to learn how to *know each other in a new way* (V51). Part of this new way entailed navigating social situations while respecting new touch boundaries: *The lack of, of contact, of meeting somebody on the street that you haven't seen in a while and you'd really like to give them a hug. I think it's just the whole physical interaction has changed* (V76). Not having physical contact was especially difficult: *I think the hardest part for me is not being able to hug my daughter* (C28). For clients receiving home services, it was not just the lack of touch but also the inability to see the faces of the care personnel that was particularly disconcerting: *It's been strange having home support workers who are always masked* (C31).

New ways of interacting were also observed in the volunteer role. Volunteers found innovative ways to stay in touch with their clients. They would do quick check-ins to ensure safety, drop off thoughtful items such as fresh vegetables, help set up virtual health care appointments, and run errands when normal services had been discontinued. Participants described positive accounts of utilizing technology and in the same breath reiterated missing in-person visiting: *I want to have that physical connection and that peopleness, but I like the technology too* (C06). The technology, though offering a new way to stay connected during the COVID-19 pandemic, didn't replace the in-person visiting older persons were missing: "…*when so many of [your connections] are at a distance, that's a little bit different than having someone who is sitting in my living room* (C28). Others found that they were unable to maintain their connections because of a lack of consistent scheduling. In some cases, this was as a result of participants changing schedules or experiencing *health issues* (V18). In other instances, this was due to a limited understanding or desire to utilize the technology: *I kind of gave up on those media, I prefer one-to-one things* (C115). There was a spectrum of feelings towards the new ways of interacting that were necessitated by the COVID-19 pandemic physical distancing requirements.

Weighing risk. Weighing the risk of each social interaction was a necessity in the new social world. Participants balanced the importance of keeping themselves and their family and friends safe with their competing priority of being with or helping others. Participants described having to assess how well others were adhering to the COVID-19 pandemic restrictions while having others do the same to them. For example, one client shared how her decision to go to a party affected the willingness of her home support worker to continue to provide care: *My home support worker said, 'If you go to that party, I'm not coming back until this is over.' … so, I suddenly realized that if I went, what a risk that would put her in so that kind of shut down my little parade for going out and having fun, so that's… that was a bit hard* (C31). This participant weighed her desire to stay socially engaged against the risk of losing home care support. Another participant decided to not return to volunteering because her husband was not comfortable with the risk that it would pose to both of them: *He actually asked me not to go back yet… even though I'd be covered in PPEs, um my husband just didn't feel comfortable right now with me going back so I will go back very soon, I hope* (V51). Balancing risk was difficult when knowledge about the virus and its transmission was constantly changing; even the experts had difficulty calculating risk. Over time, this constant vigilance became tiresome: *I'm getting a little tired of, of not doing things naturally. Of having to think oh, oh boy, should I, or shouldn't I?* (V56).

The weighing of risk extended into health care encounters. Participants reflected that people, in general terms, weighed the risks of going to a health care appointment against the likelihood of contracting COVID-19 during those appointments: *People are so frightened of COVID, they're worrying about if they had a health emergency, what do you do?* (V58). In some cases, this was influenced by participants' assessment of the safety of the health care settings. One older participant flatly refused to access health care services at this time: *I'm not going to the hospital for anything. They can schedule me all they want but I'm not going there. It's just not a safe place, as far as I'm concerned* (C31). In other cases, participants were directly impacted by how others weighed the risk. This was noted by those who received home care services. Health care providers themselves weighed the risk of the interactions resulting in limiting services and refusing to help with some activities of daily living: *Just the last few weeks, they've said they would make my bed for me, but the only other thing they'll do is check my oxygen. I've asked for help getting dressed, I've asked for help taking out the garbage […] they won't help me prep meals, nope…nope absolutely nothing* (C10).

(Dis)Connecting through technology. The disruption of in-person visits between clients and volunteers meant they could only conduct their visits virtually, which meant negotiating technology. While face-to-face technologies were used, participants primarily maintained connection through telephone calls or text messages. For one participant, connecting primarily via telephone was positive, as it offered a sense of control and feelings of not being judged about their interactions: *I actually think that this whole thing with the COVID in a way has been better. You know, because we've got the phone between us. […] Before you actually see each other, and like we all do whether we like it or not, but we judge* (C38).

However, for most participants, while technology was a nice way to connect, it just was not the same as in-person interaction. This was especially prevalent in volunteers' accounts of trying to maintain a connection with their clients. Technology transformed these visits in three distinct ways. Firstly, without face-to-face technology, volunteers had difficulty determining how well their clients were doing: *It's hard not being able to see your clients. Phone calls aren't enough* (V19). Volunteers were unable to use non-verbal communication to assess their clients: *When in person, you can read body language you get a sense of where the person is coming from, just by looking at them. And that's gone* (V76). Secondly, participants found that the use of technology changed the length and nature of the visits. Visits were shorter and technology added a layer of complexity to the intervention: *I find that with Facetime the disorientation and just you know her having to talk more, it was shorter you know?* (V82). Finally, virtual visits were less personal. While they were helpful as a "check-in," they could not take the place of in-person visits in which conversations and friendships deepened: *While I have felt really connected socially to all these people I work with online… it's still different than face-to-face contact or casual friend contact.* (C28). Volunteers spoke to the difficulties in building or maintaining existing rapport with clients via technology: *You get quite a rapport with people and to stop it, boy it's difficult for them as well as for me and I've found it very difficult* (V19). This difficulty in developing rapport was attributed largely to the impersonal nature of technology: *It's just harder, I think, on the phone to get into a more personal place where you talk about those innermost feelings* (V64). Beyond the impersonal nature of technology, there were certain clients for whom technology was particularly difficult, most notably those struggling with cognitive decline and shortness of breath.

The perception that technology was too impersonal is a significant shortcoming in an intervention of this nature where volunteer

visits played an important role in the lives of clients. For example, these visits were important in alleviating loneliness:

> *That was her biggest thing was uh like I said the loneliness and people providing an outlet to talk. I mean she got people coming and she told me that, she says the joy of people coming here all the time but it doesn't take away from the loneliness because they're just doing the job that they're supposed to do and then they leave.* (V45)

These limitations led some volunteers to conclude that, for this population, virtual visits were simply not a good option in light of their needs: *I couldn't have connected with my client in any virtual way that would've been meaningful I don't think* (V33). However, others found ways to use technology in a more personal way. For example, one volunteer and client simply left the phone line open between them as they did parallel activities. Not a lot needed to be said, but there was a feeling that someone was there: *[She] was just watching TV or literally putting her head back not saying anything […] but I'm on Facetime with her and that made her feel good* (V82).

Growth Through the COVID-19 Pandemic

Amidst the pandemic emotions and negotiating social interactions, participants discovered unexpected personal benefits during the COVID-19 pandemic. These included developing new activities, dwelling more deeply in life, and discovering shared suffering.

Developing new activities. As a result of the pandemic, participants talked about the new hobbies and activities they began when their old routines were disrupted. The hiatus in some commitments allowed room for others: *I have found that it's kind of nice that there are some commitments that I realize that I don't miss at all. It's been relaxing* (V43). Activities developed during the pandemic by older persons and volunteers included playing sudoku, practicing languages, working in the garden, engaging in sports, and starting a home business. Volunteers began in-home walking programs, puzzles, Zoom socialization, chair yoga, mindfulness meditation, prayer, and journaling. To stay socially engaged in meaningful activities, volunteers sent cards, mail, postcards, and flowers to their clients as a means of sending them something *tangible* (V63). To assist with preventing COVID-19 transmission, volunteers made homemade masks and hand sanitizer. Letters expressing concerns for the older person population were sent to the municipal, provincial, and federal governments. The organizations for whom these volunteers worked developed ways to connect virtually and hosted classes online. Most of all the disruptions in daily life and the slowing down of life brought a new sense of freedom: *The freedom just to not have to go anywhere. Not to have to do anything* (V20).

Dwelling more deeply in life. Many participants searched for meaning in the pandemic through dwelling more deeply in their lives: *I found I looked inside of me, I figured out what was going on inside of me. So that's been good. For me, to have the time, to take the time to realize what's going on in your head* (V73). Some participants found this meaning through religious explanations: *I feel that it's showing people that we're not in charge of the world, but God is* (C94). Dwelling deeply was also developed through spiritual practices such as prayer and meditation or the development of virtues such as patience in the midst of boredom. Many took more time for quiet contemplation and relaxation: *Since I can't be out in the community over the last couple months, it's basically to be in prayer and meditation when I can* (V66). Family relationships were also

transformed as more time was spent together in conversation: *I feel like COVID kind of helped us have discussions that are pretty big around politics and health and our family values, it gave us time to have some really good conversation* (V37). Volunteers were grateful for the opportunity that the pandemic provided for experiencing such changes: *What it has done for me is made me really appreciate my friends and family. So, it's just coming to terms with all of the changes but really just appreciating where I am* (V18). In addition, this also included a re-evaluation of what was important in life: *Just getting closer to my family, spending more time inward seeking, working an awful lot on my artwork which I put aside for many, many years* (V86). Participants had opportunities to truly reflect on the way they wanted to live their daily lives: *I'm seeking a balance between doing lots of projects and not feeling I have to keep busy all the time* (V50).

Shared suffering. Participants suggested that the circumstances surrounding the COVID-19 pandemic had resulted in a deeper sense of shared suffering. They contrasted this shared sense with the individualistic ways in which we currently experience suffering, particularly in the context of illness and death: *You would normally feel you're the only one who is suffering, now it's everybody is suffering* (V17). Another participant spoke of the shared suffering of not being able to connect with others: *I think because it is global, everyone knows that everyone else is in the same predicament of not being able to see people, right?* (V17). For clients who self-identified as an *introvert* (C23) or as *solitary souls* (C31), *social isolating or whatever you want to call it was nothing new* (C31) and they were *fine being by themselves* (V17). Yet, they recognized that others were probably suffering as a result of social isolation: *It probably doesn't bother me as much as it bothers other people* (C23). In this sense, the pandemic normalized a more solitary life. This shared suffering was also a way for others to experience what those living with a serious illness experience on a day-to-day basis, when being isolated is not a choice: *She said that everyone else is stuck at home now so she does not feel as badly. You know? Like the whole world is feeling what she was feeling* (V50). Finally, there was hope that this shared suffering was resulting in new perspectives on our lives together: *We're all gonna appreciate the little things after this I'm sure. Everybody's in the same place. Like even though in the world, nothing is just one person* (V17).

Discussion

Findings from this study echo the experiences that have appeared in the media during the COVID-19 pandemic. Stories of fears surrounding the virus and its transmission, of the sadness of a lifestyle lost, and of the need to find new ways to connect are common. The most inspiring stories tell of finding time for new activities that reflect the "old ways" such as making bread. However, this study also deepens insight into the nature of the volunteer–client relationship and the effects of the COVID-19 pandemic public health restrictions on that relationship. The findings underscore that the context in which people find themselves significantly shapes their everyday experiences. With such uncertainty during the early days of the pandemic, unsurprisingly, study participants were compelled to talk about their generalized experiences. At that same time, however, these findings illustrate an interplay between generalized and specific experiences drawing attention to the unique context of the volunteer–client relationship. For example, in the theme, "pandemic emotions," while clients may have spoken about their general experiences of fear/anxiety and sadness/loss,

volunteers gave us a sense of the importance of such an experience. Clients spoke generally about a disruption in daily routines, and this is given different specificity when volunteers reflected how these daily routines were imperative to clients' quality of life. For the volunteers themselves, given that a key part of their role is to connect clients to community and to help them establish such routines, such a disruption in these daily routines means they are not able to do their role, which contributes to their own sense of lost purpose. As such, the volunteers' intimate understanding of clients' everyday lives shines a light on the unique relationship that develops, despite the challenges of that relationship flourishing in the context of the COVID-19 pandemic.

Findings from this study also reveal unique experiences of community-dwelling clients living with advanced chronic illness and volunteers who support them. The ensuing discussion foregrounds implications for understanding the complexity of vulnerabilities and resilience for older persons, the communal effects of suffering experiences, and the important role of the volunteer in a relationally oriented approach to care.

Vulnerability and resilience. Understanding the important relationship between vulnerabilities and resilience provides theoretical insights into how to better support older persons during times of public health crises. Although there is a tendency to focus on the vulnerabilities of older persons, it is equally important to understanding their resilience, particularly in the presence of extraordinary or challenging conditions (Alfieri & Borgogni, 2010; Kuchel, 2018; Pan, Bloomfield, & Boyd, 2019). For example, early COVID-19 research indicated that older persons, overall, reported high levels of resilience, psychological coping, and adaptability during the pandemic, unless they were living in poverty (Fuller & Huseth-Zosel, 2021; Riehm et al., 2021). Further, research with older persons in Italy during the pandemic suggested that older adult persons who were optimistic and flexible were more likely to report higher quality of life during the pandemic than those with less optimism or flexibility (Sardella, Lenzo, Bonanno, Basile, & Quattropani, 2021).

This same resilience was evident in the findings of this study when participants described how they had learned to live with social isolation, to develop new routines, and to deepen their lives during the public health measures. These same narratives of growth and resilience were evident in the volunteers' accounts. Even as the participants struggled with pandemic restrictions and the consequent anxieties, they shared of finding new freedoms and activities in life, a reclaiming of their time, and a transformation in their relationships as a result of that time. These studies suggest that older persons are not necessarily more vulnerable, but rather that there are certain situations or personality characteristics that lead to particular vulnerabilities.

Participants in this study revealed what some of those vulnerabilities might be. Those participants who described increasing sadness layered onto pre-existing mental health conditions, who felt isolated, or who were encountering barriers to their independence were more likely to feel affected by the COVID-19 pandemic public health restrictions. The withdrawal of critical services, such as those provided by home care, or the reluctance to seek health care because of fear of contracting COVID-19, contributed further to these vulnerabilities.

Volunteer interventions have the potential to offset vulnerabilities and further develop resilience. For example, volunteers in this study described how they managed to still connect with their clients even amidst the pandemic restrictions, assist them with getting necessities, and advocate on their behalf with local governments.

In the context of a pandemic, volunteers can play an important role in identifying potential vulnerabilities and using targeted interventions to help mitigate risks. For example, it would be feasible to have volunteers assist older persons to weigh the risks and benefits of accessing health services and to educate them about ways in which to mitigate the risks of COVID-19 transmission. Volunteers were not specifically trained to do these roles during the time that the data were collected. However, our previous research has indicated that trained volunteers have the capacity to work with older persons to support those struggling with anxiety, advocate on behalf of those whose services are being limited, and provide education about accessing health care services (Pesut et al., 2020a; Pesut et al., 2020b).

Further, volunteers can help build resilience by uncovering and sharing the ways in which older persons were continuing to thrive under these difficult conditions and by providing much needed social support. Evidence on the effects of social support on mental health during the COVID-19 pandemic indicates that social support can serve as a buffer against low resilience (Li et al., 2021). For example, participants in this study had learned to replace old routines with new ones, to mitigate their anxiety by reducing COVID-19 information, and to use this time to return to old ways and to dwell more deeply in life. These alternative narratives have the potential to model behaviours that others can learn from to build resilience during the pandemic.

Communal nature of suffering experiences. Another significant finding from this study was how participants described the buffering effect of shared suffering. Shared societal suffering served to reverse that feeling of being alone. This was evident when older persons felt some degree of satisfaction that their condition of being isolated in their homes was now being shared by others. It was evident in the volunteer narratives when they spoke of the shared suffering that meant others could better understand the life-worlds of their clients. This shared suffering helped to bring older persons into community in a way that was not possible when they felt that they were suffering alone. These findings make sense in the context of the loneliness that can develop when living with illness near the end of life.

Much has been written about the invisibility of end of life in our society. If dying is viewed primarily as a negative event, then there is a tendency to marginalize and render invisible dying, and, as a result, those who are dying (Cottrel & Duggleby, 2016). This means that persons living with chronic illness can feel increasingly invisible to the larger society. As the losses of chronic illness compound, older persons risk becoming increasingly isolated, discouraged, and often this suffering is born alone. Older persons living with chronic illness often suffer from loneliness (Kvaal, Halding, & Kvigne, 2014). Loneliness is one of the most prevalent sources of existential distress in palliative care (Devik, Enmarker, Wiik, & Hellzèn, 2013; Elofsson & Ohlén, 2004; Vehling & Kissane, 2018).

However, in this study, there were participants who had learned to live with this social isolation over time so that the public health restrictions of COVID-19 did not affect their lives in any significant way. Some took comfort in the fact that others could now share their experiences of living alone in society. This type of social comparison plays an important role in how individuals adjust to chronic illness (Arigo, Suls, & Smyth, 2014). Comparing oneself to others, in which one feels better or worse off than they, can influence how one perceives one's own life, with consequences for both physical and mental health. Although social comparison is a complex phenomenon, and many factors contribute to how social comparison influences overall

well-being, there can be a comfort in knowing that others are sharing our experiences. This willingness to share in the worlds of those living with illness has been the basis for the compassionate community approach to palliative care. This approach builds upon the understanding that dying is everyone's responsibility (Kellehear, 2013). A compassionate community does not isolate persons as they near end of life, or delegate their needs to health services, but rather supports those persons in a whole community approach. Communities are mobilized to recognize and respond to the increasing isolation and unmet needs of persons in community experiencing declining health. Lessons from the COVID-19 pandemic teach us just how important this approach should be in our health practice and policy. Now that we have shared the experiences of living isolated at home and understand its effects, perhaps there will be a greater willingness to build a whole community approach for those who are becoming increasingly invisible to society.

The relational volunteer. Traditionally, volunteers have performed a critical, yet often unrecognized, role in palliative and end-of-life care (Vanderstichelen, Cohen, Van Wesemael, Deliens, & Chambaere, 2020). Although hospice and palliative care societies have a long and distinguished tradition of providing essential services at end of life, a number of barriers prevent the optimal use of these services, the primary one being effective referral (Claxton-Oldfield & Marrison-Shaw, 2014; Vanderstichelen et al., 2018, 2020). Findings from this study echo the findings of other studies that reveal the important relationships that develop between clients and volunteers (Scott, Goossensen, Payne, & Pelttari, 2020; Vanderstichelen et al., 2020; Walshe et al., 2016) and the potential for those relationships to improve the quality of life of both clients and volunteers.

Volunteer and client dyads in this study had developed meaningful relationships that when disrupted resulted in feelings of distress on both sides. Yet, what this study also points to is the critical need for developing strategies that allow that relational continuity to develop during times when physical visiting is not possible (Cheng, 2021; Etkind et al., 2020; Whittall, Lee, & O'Connor, 2016). Participants in this study had varying success with virtual technologies to stay connected. In many cases, it was described as a poor substitute for in-person contact. However, there were examples that suggest that it may be possible to develop strategies that make virtual connections more relationally oriented. For example, one dyad used simple phone technology to hang out together without feeling the need to fill the space with conversation. Such strategies, if successful, have the potential to assist during times of pandemic, but probably more importantly, to build robust relational strategies to augment current volunteer visiting and to extend volunteer reach to those living in remote areas. Further research is required to better understand what these virtual strategies might be.

The study has several limitations. The small sample size and unique context limit the transferability of the findings. Data were collected within Canada in contexts where public health measures were in place and during a time when actual COVID-19 rates and deaths in the community were conservative compared with other countries. Therefore, participants' perceptions of COVID-19 were largely derived from the media. Data were collected over the telephone and so it was difficult to get a sense of the non-verbal communication that would have been evident with in-person interviews. Further, some of these interviews, particularly with clients, were short as clients were too fatigued answer questions in-depth by phone.

Conclusion

There are important implications of these findings for the intervention and, in particular, in relation to our theoretical model. To date, the focus on negotiating best fit; improving access to services and resources; and promoting quality of life, independence, and connections rests upon the assumption that volunteers can be physically present to their clients. Their ability to do their role rests largely upon the development of strong, enduring, and trusting relationships. When this relationship-building is disrupted, the effectiveness of the intervention is jeopardized. It will be important in the future to focus on the potential of building that relational engagement through virtual means. We have subsequently included a module in the volunteer training on virtual engagement.

Overall, these findings provide important insights into the experiences of volunteers and clients during the COVID-19 pandemic, further highlighting the importance of acknowledging older persons' vulnerabilities and resilience, of building in compassionate community approaches to care, and of finding innovative ways to foster volunteer–client relationships during times when physical visiting is not possible.

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