Loneliness and Social Isolation Among Older Irish People

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As Chairperson of the National Council on Ageing and Older People, it gives me great pleasure to introduce this report *Loneliness and Social Isolation Among Older Irish People*. The report presents the results of research that employed a range of quantitative and qualitative methods to measure levels of loneliness, to record social isolation, to explore the experience of loneliness as described by older people themselves and to identify the strategies for intervention that older people use and/or believe would be useful in alleviating or preventing loneliness and social isolation.

The Council is pleased that the results of this research dispel an enduring stereotype of old age by demonstrating that the majority of a representative sample of older people is not socially isolated or lonely. Furthermore, the findings demonstrate the importance of being able to adapt to transition times in older age and the necessity for economic, social and personal resources to facilitate this adaptation and to promote 'successful ageing'. Finally, the results highlight how critical it is for older people to be able to 'get out of the house' and the Council urges that the recommendations that it has made in this regard be acted on in the short-term in order to ensure that older people do not become socially excluded in their third and fourth ages.

On behalf of the Council, I would like to thank the older people and service planners and providers who took part in this research. I would like to thank sincerely the authors Prof. Pearl Treacy, Dr Michelle Butler, Ms Anne Byrne, Mr Jonathan Drennan, Dr Gerard Fealy, Ms Kate Frazer and Dr Kate Irving of the Research Unit of the School of Nursing and Midwifery in University College Dublin.

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Eibhlin Byrne

Cllr Éibhlín Byrne
Chairperson

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Contents

Council Comments and Recommendations	1
Executive Summary	11
Chapter One: Background	21
1.1 Introduction	22
1.1.1 Aims and Methodology of the Literature Review	22
1.2 The Importance of Being Older in Ireland	23
1.2.1 Health and Quality of Life	24
1.2.1.1 Health and Wellness, Morbidity and Mortality	27
1.3 Social Networks, Social Interaction and Social Isolation among Older People	28
1.3.1 Social Networks	28
1.3.1.1 Social Networks among Irish People	29
1.3.2 Social Support and Support Networks	30
1.3.3 Patterns of Sociability	31
1.3.4 Social Isolation	33
1.3.5 Correlates of Social Isolation	33
1.3.5.1 Circumstances	33
1.3.5.2 Social Contacts	35
1.4 The Nature and Prevalence of Loneliness	36
1.4.1 Conceptual Definitions	37
1.4.1.1 Related Concepts	37
1.4.2 Social and Emotional Loneliness	39
1.4.3 The Experience and the Prevalence of Loneliness	40
1.4.3.1 Prevalence of Loneliness	41
1.4.3.2 Prevalence of Loneliness among Older People in Ireland	42
1.4.4 Correlates of Loneliness	44
1.4.4.1 Descriptive Factors and Personal Characteristics	44
1.4.4.2 Age and Gender	45
1.4.4.3 Loneliness, Social Networks and Social Isolation	46
1.4.4.4 Communities and Families	49
1.4.4.5 Quality of Life and Functional Ability	50
1.4.4.6 Loneliness, Morbidity and Mortality	51
1.4.4.7 Loneliness and Psychological Morbidity	52
1.5 Strategies for Preventing and Alleviating Loneliness	54
1.5.1 Policies and Programmes	56
1.6 Conclusions	57

Chapter Two: Study Design and Methods	59
2.1 Introduction	60
2.2 Quantitative Methods	60
2.2.1 The Survey Instruments	60
2.2.1.1 Demographic Data	61
2.2.1.2 Using Survey Instruments to Measure Emotional and Social Loneliness	61
2.2.1.3 Social and Emotional Loneliness Scale for Adults – Short Form (SELSA-S)	62
2.2.1.4 Examining the Construct of Social Isolation through the Measurement of Social Support Networks	63
2.2.2 The Sample	65
2.2.2.1 Sample Size	66
2.2.3 Conduct of the Telephone Survey	66
2.2.4 Data Analysis	67
2.3 Qualitative Methods	68
2.3.1 Strand One	68
2.3.1.1 In-depth Interviews	68
2.3.1.2 Focus Groups	69
2.3.1.3 The Sample	70
2.3.2 Strand Two	72
2.3.2.1 Focus Groups with Key Stakeholders	72
2.3.2.2 The Sample	72
2.3.3 Analysis	73
2.4 Ethical Considerations	74
Chapter Three: Survey Findings	75
3.1 Introduction	76
3.2 Profile of the Respondents	76
3.3 Social and Emotional Loneliness	77
3.4 Prevalence of Loneliness	85
3.5 Factors Associated with Social and Emotional Loneliness	86
3.6 Social Isolation and Support Networks of Older People	90
3.6.1 Network Assessment Instrument	90
3.6.2 Social Network Type, Social Isolation and Loneliness	93
3.6.2.1 Family-dependent Support Network	95
3.6.2.2 Locally Integrated Support Network	96
3.6.2.3 Local Self-contained Support Network	97
3.6.2.4 Wider Community-focused Support Network	97
3.6.2.5 Private Restricted Support Network	98
3.6.2.6 Borderline Networks	99
3.6.2.7 Summary of Social Networks	100
3.7 Activities to Alleviate and Prevent Loneliness and Social Isolation	100
3.7.1 Family and Friends	101
3.7.2 Church-related Activities	101
3.7.3 Organised Clubs and Activities	101
3.7.4 Personal Hobbies and Activities	101
3.8 Summary	101
3.9 Conclusions	102

Chapter Four: The Experience of Loneliness and Social Isolation	105
4.1 Introduction	106
4.2 Demographics	106
4.2.1 Interviews	106
4.2.2 Focus Group Interview	107
4.3 Findings	107
4.3.1 Category One: Personal Context, Circumstances and Philosophy	107
4.3.1.1 Personal Context	107
4.3.1.2 Personal Circumstances	107
4.3.1.3 Personal Philosophy	108
4.3.1.4 Summary for Category One	110
4.3.2 Category Two: Social Interaction	110
4.3.2.1 People-related Social Networks	110
4.3.2.2 Activity/Organisational-related Social Networks	113
4.3.2.3 Barriers to Social Interaction	116
4.3.2.4 Summary for Category Two	122
4.3.3 Category Three: Isolation	123
4.3.3.1 The Experience of Isolation	123
4.3.3.2 Factors Associated with Isolation	124
4.3.3.3 Coping Mechanisms	126
4.3.3.4 Summary for Category Three	127
4.3.4 Category Four: Loneliness	127
4.3.4.1 Differentiation between Loneliness and Isolation	128
4.3.4.2 The Experience of Loneliness	128
4.3.4.3 Coping Mechanisms	132
4.3.4.4 Lonely Times	137
4.3.4.5 Summary for Category Four	137
4.4 Summary	138
4.5 Conclusions	140
 Chapter Five: The Extent of Loneliness among Older People and Effective Measures to Deal with Loneliness	 143
5.1 Introduction	144
5.2 Findings	144
5.2.1 Stakeholders' Perceptions of the Extent of Loneliness among Older People In Their Areas	145
5.2.1.1 Social Isolation Is Not the Same as Loneliness	145
5.2.1.2 Factors Involved in Loneliness	145
5.2.2 Measures that Stakeholders Perceive to Be in Place to Deal with Loneliness and the Effectiveness of These Measures	149
5.2.2.1 Group Activities	150
5.2.2.2 Visiting and Befriending Interventions	151
5.2.2.3 Day Centres and Social Centres	153
5.2.2.4 Interventions Aimed at Enabling Older People to Stay in Their Homes	154
5.2.2.5 Interventions Aimed at Providing Alternative, Suitable Accommodation	155
5.2.2.6 Rural Transport Initiatives	156
5.2.2.7 Involving Older People in the Planning and Delivery of Services	156
5.2.3 Other Measures Stakeholders Would Wish to See in Place	157
5.3 Summary	158
5.4 Conclusions	159

Chapter Six: Discussion	163
6.1 Introduction	164
6.2 Study Participants	165
6.2.1 Profile of the Sample of Older People Involved	166
6.2.2 Education, Income and Access to Transport	167
6.2.3 Health, Care and Access to Services	168
6.3 Social Networks, Social Interaction and Social Isolation	169
6.4 The Prevalence and the Experience of Loneliness	176
6.4.1 Loneliness and Social Network Types	178
6.4.2 Factors Involved in Loneliness	181
6.5 Strategies to Reduce or Alleviate Loneliness and Social Isolation	184
6.5.1 Strategies and Coping Mechanisms Adopted by Older People	185
6.5.2 Effective Measures for Preventing and Alleviating Loneliness	186
6.6 Conclusions	188
6.6.1 Developing Appropriate Policy Responses: Strategies of Intervention and Good Practice	191
6.6.1.1 State/Community-level Interventions versus Individual-level Interventions	191
6.6.1.2 Strategies of Intervention and Good Practice	192
6.6.1.3 Summary of Strategies of Intervention	203
References	205
Appendices	217
Terms of Reference	229

List of Tables

Table 2.1: Cronbach's alpha (confidence intervals) and intercorrelations of the three SELSA-S subscales for the overall sample	63
Table 2.2 Network types (Wenger, 1994)	64
Table 3.1: Demographic comparisons of the gender, age, marital status and location of residence of the study sample and the population aged 65 years and over in Ireland	77
Table 3.2: Profile of social and emotional loneliness subscales (SELSA-S)	78
Table 3.3: Overall levels of loneliness and levels of loneliness by gender	80
Table 3.4: Marital status and levels of loneliness	81
Table 3.5: Age and levels of loneliness	81
Table 3.6: Socio-demographic variables and levels of loneliness	83
Table 3.7: Intercorrelations between social loneliness and socio-demographic variables	87
Table 3.8: Intercorrelations between family loneliness and family and demographic variables	88
Table 3.9: Intercorrelations between romantic loneliness and demographic variables	89
Table 3.10: Network Assessment Instrument questions and responses	91
Table 3.11: Network type	93
Table 3.12: Network type and loneliness	99
Table 6.1: Strategies of intervention and good practice	193

List of Figures

Figure 1.1: Alienation-connectedness continuum (Kileen, 1998)	38
Figure 2.1: Profile of telephone numbers utilised	67
Figure 2.2: The composition of focus groups with key stakeholders	73
Figure 3.1: Prevalence of romantic loneliness	85
Figure 3.2: Prevalence of social loneliness	86
Figure 3.3: Prevalence of family loneliness	86
Figure 3.4: Network type and area of residence	94
Figure 3.5: Network type and gender	94
Figure 3.6: Network type and accommodation	95

Council Comments and Recommendations

Council Comments and Recommendations

Introduction

Loneliness and social isolation are associated with reduced quality of life for older people (Farquhar, 1995). The Council proposes that an understanding of these concepts is critical to the development of recommendations and actions that promote social inclusion and quality of life in the third and fourth ages. The present study adds to this understanding as it provides evidence on the prevalence of loneliness and social isolation among a representative sample of older Irish people. It also provides information about the precursors of loneliness and proposes interventions (from older people's own perspectives in addition to those of planners and providers of services for older people) that may be of assistance in preventing or alleviating loneliness and social

living in either rented accommodation or with relatives, poor self-rated health and lack of transport) and life events/transition times were identified by the respondents as being related to the onset of loneliness and social isolation among older Irish people.

Identifying Those at Risk of Loneliness and Social Isolation

In the absence of a multidisciplinary, holistic assessment of older people's needs and preferences, the development of which the Council has recommended on numerous occasions, the Council recommends that the socio-economic correlates of loneliness be combined with life events/transition times and used to develop an At Risk of Loneliness and Social Isolation Index. Given current resource constraints, the Council proposes that this index be developed in conjunction with the roll-out of the Primary Care Strategy. If an integrated approach to care planning for dependent older people is to become a consistent feature of the health system as promised in the recent National Health Strategy (Department of Health and Children, 2001), then this implies the development of a tool with which to identify those who are dependent.

Successful Ageing and Adaptation in Older Age

The results of this study indicate that the majority of a representative sample of older Irish people are neither lonely nor socially isolated and have successfully adapted to the absences or losses that can accompany growing older (particularly at transition times in older age). These findings support an increasing emphasis in gerontology on positive adaptation and 'successful ageing', even when, for some, their circumstances are less than optimal (Johnson, 1996).

Much research has been dedicated to investigating the strategies used in successful adaptation to older age.² Many of the theories of successful ageing refer to the importance of one's own resources, skills and capabilities. These resources can be economic, social or personal (Cohen and Edwards, 1989), and the Council proposes that measures to enhance them will contribute to the prevention and alleviation of loneliness and social isolation, as follows.

2. One such strategy described by Baltes and Baltes (1990), the *Theory of Selective Optimisation and Compensation (SOC)*, proposes that as people experience losses as they get older, a parallel decline in quality of life is prevented through individuals becoming more selective in their personal goals, while using their resources to optimise functioning in selected goals and compensating for whatever losses they have experienced with available resources.

Economic Resources

This report and international literature have demonstrated that low income is associated with the experience of loneliness and with difficulties in overcoming social isolation at times of crisis. **The Council recommends that adequate provision for retirement income in the future will require both improvements in the basic social welfare pension (which is low by international standards) and the development of the private pension system. In addition, consistent with previous recommendations (Fahey and Russell, 2001), the Council recommends that there be active policies, developed by both private and public sector employers, encouraging people to save to ensure that a sharp drop in their living standards is not experienced upon retirement.**

Once again, the Council wishes to highlight the particular vulnerability of older women to poverty and deprivation (Layte *et al.*, 1999), particularly upon the death of a spouse, which effectively halves the household income. The Council welcomes the Homemaker's Scheme introduced in 1994. It has made recommendations in the past that this be extended retrospectively to enable more older women to avail of the Contributory Pension. **However, for those ineligible for the Homemaker's Scheme, particularly widows, the Council recommends the development of other income support measures.**

Social Resources

A meaningful social network and social interaction appear to be the strongest supports against loneliness and social isolation (Holmén and Furukawa, 2002). This was confirmed by this report which noted much lower levels of social and emotional loneliness among those older people who have regular verbal interactions with relatives, friends and neighbours.

According to the older participants in this study a very important factor in facilitating social interaction was 'getting out of the house'. Everybody, not least older people, needs to be able to do so. Whether social interaction is the intended purpose or not, it allows older people to feel that they are part of a wider community. Being able to 'get out of the house' can be particularly important at transition times when extended contact with family members and the community is needed. However, the older people who took part in this study noted a number of psychological and interpersonal, physical and environmental barriers to being able to 'get out of the house'.

Physical Barriers to 'Getting Out of the House'

For a minority of older people, mobility is severely restricted and opportunities to 'get out of the house' are curtailed as a result. In this regard, the Council notes the critical 'lifeline' that the Senior Help Line provides for lonely or isolated older people. The Help Line, which is run by older people for older people, provides advice and support seven days a week. In addition, organisations such as Friends of the Elderly and the Society of St Vincent de Paul that organise home visits to older people are invaluable in this regard.

It has also been recognised that 'having an advocate to communicate with, and work alongside can help to increase all levels of access thus offering greater opportunities within the community to all' (Goodbody Economic Consultants, 2004). **The Disability Bill (2001) included provision for the establishment by Comhairle of advocacy services for people with disabilities, including, specifically, a Personal Advocacy Service. The Council recommends that these advocacy services be established at the earliest opportunity.**

Environmental Barriers to 'Getting Out of the House'

Many of the older people interviewed described barriers in their immediate environments that made it difficult for them to 'get out of the house' and interact even when in good health. Transport was mentioned specifically in this regard. **The Council welcomes the Rural Transport Initiative that is managed by Area Development Management Ltd. (ADM) on behalf of the Department of Transport. The Council recommends that further resources be invested in this Initiative and that its coverage at county level be increased.** While the availability of transport for older people needs to be improved, accessibility issues must also be addressed. **Given that the majority of people with disabilities are older people, the Council supports recommendations that the National Disability Authority has made with regard to accessibility of public transport.**

The respondents in this study highlighted the importance of the availability of opportunities for socialisation within the local community and how such opportunities are often lacking. O'Shea (2003) reported that the provision of services and activities for older people is often hampered by lack of funding, premises and people with the necessary skills to develop a programme of activities. **The Council, therefore, recommends that volunteer bureaux be developed within local communities. The Council would also like to reiterate its concern at the inhibiting effect of the costs of public liability insurance on the development of opportunities for socialisation for older people (O'Shea, 2003), and again recommends that a national support structure**

be put in place to review and reduce the costs of public liability insurance for community groups for older people. Many organisations for older people rely on fundraising in order to sustain their activities. **The Council recommends that Citizen's Information Centres (CICs) produce leaflets providing information on the grants and funds that are available at local, regional and national levels.**

Restricted mobility after a fall or indeed the fear of falling can often prevent an older person from 'getting out' as often as they would like or at all. A recent Council report (Shiely and Kelleher, 2004) noted that of the injuries reported by respondents, 66 per cent were caused by a fall. **In this regard, the Council has proposed the development of a National Falls Prevention Strategy. It also supports the development of a National Injury Prevention Strategy (DOHC, 2001), which takes account of the major causes of injury among older people.**

Personal Resources

Psychological Barriers to 'Getting Out of the House'

Participants in the study referred to the fact that older people are often reluctant or lack the motivation to 'get out of the house' and engage with others because they may be 'shy', 'feel unwanted' or 'feel as if they are a burden to others'. Bowling (2002) has proposed that older people should be encouraged to develop their personal resources, i.e. self-perception and positive thinking, so that they learn to be and feel more in control of their everyday lives when facing the challenges of older age.

Transition times place a real demand on psychological and spiritual resources, especially when something taken for granted has been threatened or taken away. Even when economic and social resources are available, one must still find it within oneself to come to terms with change and the losses that may accompany that change. It is one of the challenges of older age to use and enhance existing personal resources to sustain one through difficult transition times.

It is clear that personal resources including strong psychological and emotional capabilities and good mental health are prerequisites for coping with stressful events. Though information on the overall prevalence of mental disorders in older Irish people is limited, where it is available, it confirms a large psychiatric morbidity among older people (Keogh and Roche, 1996).³ **Therefore, the Council recommends that the Department of Health and Children quantify the scale and prevalence of mental**

disorders among older people. The Council recommends that preliminary investigations in this regard begin immediately.

The Council reiterates its recommendation that the Department of Health and Children, in consultation with all concerned parties in the area, develop a national strategy for the future development of mental health services for older people (Shiely and Kelleher, 2004). The Council also considers that 'health promotion practitioners have a particular role to play in relation to mental health education and awareness for older people at community level' (Shiely and Kelleher, 2004).

The Council further recommends that any new strategy for the future development of mental health services for older people contain clear and specific guidelines with regard to the detection and treatment of those at risk from suicide. The Council endorses the recommendations contained in the Health Promotion Strategy for Older People (Brenner and Shelley, 1998) that encourage:

- raised awareness in the general population of the importance of early detection of psychiatric disorders, especially depression and alcohol misuse, in the prevention of suicide in older people
- fostering attitudes which view the suicide of an older person as equally tragic and regrettable to that in a younger person.

Importance of Information for Successful Adaptation

Successful adaptation to and coping with stressful transition times will depend, among other things, on their predictability. Indeed, a recent Council report (Ruddle *et al.*, 2002) recommended that older people should plan, as far as possible, for important transition times in later life. Information is a prerequisite for such planning. **The Council recommends that the Action Plan for information provision that was developed on the basis of best evidence from older people and service providers (Ruddle *et al.*, 2002) be adopted and introduced on a pilot basis, evaluated and rolled out as appropriate.** Accessible, timely and accurate information will not only facilitate older people to access the services that they require at a particular time but will also facilitate successful adaptation by enabling older people to plan for stressful events where possible.

3. A recent Council publication (Shiely and Kelleher, 2004) found that the proportion of people aged 55 and over reporting being moderately or extremely anxious or depressed was 25 per cent.

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Executive Summary

Executive Summary

Background

Currently in Ireland, there are more than 435,000 persons aged 65 years and over representing 11.2 per cent of the population. Many older people are increasingly living alone or with an elderly partner and a large body of international and Irish research indicates that loneliness and social isolation are a part of the experience of old age. This study was commissioned by the National Council on Ageing and Older People to explore the prevalence and the experience of loneliness and social isolation among older people in Ireland. The research was undertaken by a research team from the School of Nursing and Midwifery, University College Dublin.

The aim of this study was to document the prevalence and the experience of loneliness and social isolation among older people in Ireland. In particular it sought to:

randomly selected using random dialling. In the survey, loneliness was assessed using the Social and Emotional Loneliness Scale for Adults – Short Form (SELSA-S) and social isolation was measured using the Network Assessment Instrument. This enabled the network of family, friends and neighbours that older people use for companionship, advice and instrumental help to be profiled. Both survey instruments were combined with demographic questions to form the questionnaire for the telephone survey. An open-ended question was also asked at the end of the interview to ascertain strategies used by each respondent to reduce their loneliness and social isolation.

Qualitative methods were used to explore how older people describe the experience of loneliness and social isolation and the strategies that older people prefer to alleviate loneliness and social isolation. The research explored these questions with older people and then with key stakeholders and providers of services for older people. A grounded theory approach was employed in order to gain an understanding of the concept of loneliness. In-depth interviews were conducted with a purposive sample of people aged 65 years or older from two health board regions. One focus group discussion was also conducted with older people to identify potential strategies for the alleviation of loneliness and social isolation. In addition, four focus groups were conducted with key stakeholders involved in the planning or provision of services for older people in the two regions. The research also involved an extensive critical review of the national and international literature on concepts of loneliness and social isolation.

Findings

A total of 683 people aged 65 years and over participated in the survey representing an overall response rate of 78 per cent. The sample was largely representative of the total population of older Irish people with a confidence interval of 95 per cent. In addition, 34 older people participated in the in-depth interviews and a further nine older people participated in a focus group. Finally, 39 planners and providers participated in the focus groups with key stakeholders.

Socio-demographic Profile

The survey respondents comprised 39.1 per cent male and 60.9 per cent female. The age of the respondents ranged from 65 years to 99 years (Mean 73.5, SD 7.1). Almost 50 per cent of the respondents were married (49.6 per cent, $n=333$) and resided with their spouse (95.7 per cent, $n=276$). Of those that were widowed ($n=237$), the majority were women (80.7 per cent, $n=188$).

Sixty per cent of the respondents defined their area of residency as urban, with 39.9 per cent defining their area of residency as rural. Just over 91 per cent lived in property that they owned. Over 60 per cent of the female respondents (61.6 per cent) reported weekly incomes of up to €200. Almost twice as many of the male respondents reported weekly incomes between €201 and €400 (61.9 versus 34.0 per cent).

Health Status/Access to Transport and Services

Survey respondents were asked about their hearing, eyesight and general health. Over a third of the respondents rated their general health as very good or excellent. Only a small minority of the respondents reported their hearing ability as fair or poor. One fifth of the male respondents (20.2 per cent) and over a quarter of the female respondents (26.5 per cent) rated their vision as fair or poor.

With regard to transport, 43.8 per cent of respondents reported that they had access to a car. A further 17 per cent of respondents (n=116) reported that they had access to public transport only. There were however 11.7 per cent of the respondents who reported that they had no access to any mode of transport.

Over 87 per cent of respondents reported that they travelled a distance of less than five miles to the post office and bank, and 11.6 per cent reported travelling distances of up to 15 miles. Urban dwellers were considerably more likely to travel distances of less than one mile than rural dwellers.

Social and Emotional Loneliness

Loneliness is a complex, multidimensional phenomenon and its two principal variants are social and emotional loneliness. The Social and Emotional Loneliness Scale for Adults – Short Form (SELSA-S) was used to measure social and emotional loneliness amongst those participating in the survey. This identifies three types of loneliness: social loneliness; family loneliness; and romantic loneliness (absence of close friend or partner).

Overall loneliness scores were low for the sample. The highest percentage of loneliness was identified in older people being romantically lonely, with just under 50 per cent identifying themselves as moderately lonely in this category. Social loneliness was the next category indicating that 10 per cent were moderately lonely and less than 2 per cent very lonely. The lowest report of loneliness was identified in the family category, with 7.2 per cent of respondents indicating that they were moderately lonely. Reports of being very lonely were infrequent.

Only slight differences were found between males and females in relation to social and family loneliness; however, romantic loneliness was significantly higher in females. Respondents who were single reported significantly higher levels of family loneliness compared to respondents who were either married or widowed. Single and widowed respondents scored moderate to high romantic loneliness scores when compared to married respondents. The oldest old (85 years and over) reported the highest levels of social and romantic loneliness. Levels of family loneliness tended to be low across all age groups. Respondents living in rented accommodation or with relatives reported higher levels of social loneliness, family loneliness and romantic loneliness compared to those owning their own homes. Respondents who reported their health as poor reported statistically significant higher levels of loneliness in social and emotional subscales when compared to their counterparts who reported their health as good. Statistically significant higher levels of social loneliness, family loneliness and romantic loneliness were reported in those who had no access to transport.

Social loneliness was significantly correlated with increasing age, lack of access to transport, having to travel greater distances to bank and post office, poorer health and living in a rural area. Family loneliness was significantly correlated with increasing age, poorer health, living in an urban area and not being married. Number of children was also associated with loneliness; the greater the number of children, the lower the levels of family loneliness. Romantic loneliness was significantly correlated with increasing age, poor overall health, being female, lower level of education, caring for a relative and not being married.

Findings from interviews with older people identified that while participants had some difficulty differentiating between loneliness and social isolation, distinguishing factors could be identified. Interview participants described loneliness in terms of a void or indirectly as boredom, not knowing what to do, having too few things to worry about, an awareness of the home being empty, feeling no-one cares and having no meaning. Several negative emotions in relation to the experience of loneliness were also described including pain, depression, feeling worn down, broken-hearted and fearful for the future. Importantly participants highlighted the nature of loneliness as a self-fulfilling experience in that feeling lonely made one less inclined to go out. In addition, participants noted that loneliness and isolation were not mutually inclusive, with different strategies proposed for their resolution. While isolation could lead to loneliness, as a problem it was considered responsive to a number of factors that addressed issues of security of person and property.

Social Networks, Social Interaction and Social Isolation

The Network Assessment Instrument (Wenger, 1994; Wenger and Berholt, 2002) was used in the national telephone survey to explore the social networks of the sample of older people surveyed. This instrument enables five types of support network to be identified and demonstrates how individual older people are linked to other groups within society and the core group of people they rely on for advice, help and support. It is based on eight questions around the closeness and availability of children and relatives, level of involvement with neighbours, friends and relatives, and involvement in church and community/voluntary groups.

Overall, the majority of respondents had regular contact with relatives, friends and neighbours. Contact with family was high with the vast majority living within five miles of their nearest relative. The importance of the church in the lives of older people was also evident with 90 per cent regularly or occasionally attending religious services. Community groups were less important in the lives of older people although over half attend such groups.

Overall the vast majority of respondents (73.2 per cent) were in locally integrated support networks, indicating that they had close relationships with family, friends and neighbours. However, a significant minority of older people were living in networks where they were socially isolated and lonely. Contact with neighbours was minimal and levels of loneliness were higher than in any other network. This network is characterised by an absence of close relationships and older people within this network have become isolated from family, friends and neighbours. Nearly 10 per cent of respondents were in borderline or inconclusive social networks, indicating that their support network may be in a state of flux or shifting from one network type to another due to a change in family circumstance or increasing old age. The majority of respondents in this network were the oldest old, indicating that their network type may be changing due to ill-health or increasing dependency.

A higher percentage of older people living in urban areas (75.5 per cent) than those from rural areas (69.7 per cent), were living in locally integrated social networks.

A higher percentage of older people from rural areas were living in family dependent and wider community focused networks when compared to urban dwellers. However, no statistically significant differences were identified between urban or rural areas, or between males and females in relation to type of social network.

In-depth interviews with older people provided further insight into their social networks. Participants described individual contextual factors that mediate both the amount of

social interaction possible and the utilisation of many of the coping mechanisms. Maintaining Independence was very important to participants in preventing loneliness and isolation. In relation to the social networks of older people, the importance of family and an ever-diminishing circle of friends was highlighted. Participants valued the opportunity to get out of their homes to engage as part of the general social milieu through shopping, walking or travelling and to interact with other like-minded people with shared backgrounds or interests. A number of barriers to social interaction were identified, in particular lack of transport and environmental issues. Access to flexible services was highlighted as an important enabler to social interaction.

The experience of isolation was also explored in in-depth interviews. Negative features of isolation were feeling lonely and feeling vulnerable to injury to person or damage to personal belongings. Features associated with isolation were insufficient company, poor relationships and lonely times. Generally, feelings of isolation could be experienced at times when it was harder to attain or maintain social interaction, such as night-time, winter or in an emergency. The period following the death of a loved one was also indicated as a time when participants could feel very isolated. Participants talked about taking practical measures to deal with feeling isolated, for example having a personal alarm system or a telephone.

Strategies to Prevent and Alleviate Loneliness

Various strategies were identified by the respondents in the telephone survey and in interviews in relation to the prevention and alleviation of loneliness. The strategies related to four specific areas:

- family and friends which involved either caring or visiting
- church-related activities
- participation in organised clubs and activities
- personal hobbies.

The personal hobbies were likely to be home-based in contrast to the other activities, which were more likely to be community based and involve interactions with other people. Transport was considered a key factor and interview data indicated that flexible transport arrangements were necessary.

An absence or a limited cohort of family and friends, reduced or infrequent access to transport, limited education and limited income are factors which can impact on the opportunities available to older people in relation to undertaking activities to reduce or prevent loneliness and isolation. Individuals who have limited social supports and reside in rural areas may have less opportunities to engage in activities compared to their counterparts residing in urban areas.

Interventions for preventing and alleviating loneliness proposed by the key stakeholders incorporated both social/community-level strategies and strategies that stressed the position of the individual older person. Strategies for alleviating loneliness among older people can involve improving older people's social networks with the aim of increasing the likelihood of social interaction. A range of existing measures were identified which they considered worked well in preventing or alleviating loneliness. These included group activities, visiting and befriending interventions, interventions aimed at enabling people to stay in their homes for as long as possible, interventions aimed at providing alternative, suitable accommodation, day centres, social centres and rural transport initiatives. However, they pointed to the patchy nature of service provision for older people between and within regions and suggested that this be addressed.

Strategies of Intervention and Good Practice

The following strategies of intervention and good practice in the prevention of loneliness and social isolation among older people are proposed; they draw on the salient findings of the study and from the literature, including the findings from previous studies undertaken in Ireland.

1. Individuals and agencies with responsibility for developing and implementing social policy in relation to older people should recognise the capacity of individuals themselves to promote social interaction and prevent, alleviate and/or cope with loneliness. Social interactions and individual-level coping mechanisms used by older people to prevent and/or alleviate loneliness should be facilitated, where possible.
2. Individuals and agencies with responsibility for developing and implementing social policy in relation to older people should recognise that chronological age is not in itself a cause of loneliness and social isolation *per se*; factors other than chronological age alone can precipitate loneliness. Professionals involved in statutory and voluntary provision of services for older people should be alert to a range of possible precipitating factors, including the loss of a spouse, infrequent visits from siblings and sensory impairment (Dugan and Kivett, 1994). The possibility of

preventing loneliness arising out of these factors can be improved if there is recognition that older people's needs and experiences are about things other than assistance with functional activities.

3. Individuals and agencies with responsibility for developing and implementing social policy in relation to older people should act to improve older people's access to public transport in order to enhance their mobility and thereby improve their social networks. This requires the promotion and development of public transport policy and practice that recognises that not all people are car-mobile, and it should include the development and/or maintenance of good rural public transport. This might include the provision of funds to finance taxi services for older people in rural areas, where public transport is limited or absent.
4. Individuals and local communities should act to promote the development and organisation of group social activities for older people within their communities, in order to promote better social inclusion of older people. The responsibility for such organised activities lies with the community itself, but also with statutory and voluntary bodies with responsibility for older people. This can involve the organisation and development of local day centres and social/community centres where these do not already exist, and the organisation and development of local visiting and befriending schemes.
5. Individuals and agencies with responsibility for developing and implementing social policy in relation to older people should promote interventions aimed at helping older people to cope with living alone, including support for older people to stay at home. The older person's immediate family network may take responsibility for this. However, where the immediate family network is absent or limited, responsibility rests with voluntary and statutory bodies including local authorities and health and social service providers. By the same token, where living alone is detrimental to the older person's well-being, these same bodies have a responsibility to act to provide alternative, suitable accommodation.
6. A number of other community-level strategies of intervention may help to prevent and/or alleviate loneliness and social isolation. These might include the provision of information on local services available for older people through a range of media, including local radio and newspapers, and financial and other support for specific groups of vulnerable older people, such as the recently bereaved, to promote their social contacts and social integration. In this context, it is recognised that the clergy have a role, by virtue of their pastoral ministry, during times of bereavement and other major events in older people's lives.

7. Funding for strategies preventing loneliness and social isolation should be so structured as to take account of the individual older person's right to choose the services that meet their individual needs and the resources that they identify as required.

Chapter One

Background

Chapter One

Background

1.1 Introduction

This report outlines the findings of a study commissioned by the National Council on Ageing and Older People (NCAOP), which explored loneliness and social isolation among older people in Ireland. The study was conducted over a six-month period from November 2003 to May 2004 by a research team from the School of Nursing and Midwifery, University College Dublin. The study included a review of literature, a national telephone survey, in-depth interviews with older people and focus group interviews with key stakeholders.

The aims of the study were to document the experiences of loneliness as described by older people and to identify the strategies of intervention and good practice that older people themselves believed would alleviate or prevent loneliness. The study will

conceptual and operational definitions in order to inform the research element of the present project and to inform future research.⁴

The review of the literature is presented in four parts. Section 1.2 presents a brief discussion of the experience of being older in Ireland, with particular reference to quality of life issues. Section 1.3 discusses the concepts of social networks and presents the findings of Irish and international literature regarding the phenomenon of social isolation. Section 1.4 concerns the phenomenon of loneliness; it comprises a discussion on the concept of loneliness and the findings of Irish and international empirical research concerning the prevalence of loneliness and its correlates. Section 1.5 presents a discussion on the strategies for preventing and alleviating loneliness.

1.2 The Importance of Being Older in Ireland

At the start of the twenty-first century, one of the most profound social changes to occur in developed societies is that the population is older. This change is a result of social and scientific developments over the course of the previous century, resulting in the addition of 25 years to life expectancy (Dean, 2003). This demographic trend has meant that, in Europe, older people represent 20 per cent of the proportion of the total population and demographic projections anticipate significant increases in this section of the population; these projections predict that the proportion of older people in Europe as a whole will increase to 25 per cent by the year 2025 (European Commission, 2000).⁵

Over the last four decades of the twentieth century, life expectancy at birth increased substantially for Irish men and women, although life expectancy remains poorer for men than for women (Department of Health and Children, 2001). Currently, in Ireland, there are over 435,000 persons aged 65 years and over, representing 11.2 per cent of the total estimated population (Central Statistics Office, 2002). Population projections for the first two decades of the twenty-first century demonstrate that not only will the population increase but that older people will form a larger portion of the population. It is projected that, by 2031, the proportion of older people in Ireland will have almost doubled to between 837,000 and 858,000 people, representing between 18 and 21 per cent of the population (DOHC, 2001).

4. The literature search included national and international websites, such as the Department of Health and Children, the NCAOP and the European Commission, as well as academic and professional journal databases, such as CINAHL, MEDLINE, PsychINFO, Science Direct, Ingenta and Synergy. The keywords used in the search included 'older persons', 'loneliness', 'social networks', 'isolation', 'social isolation', 'networks', 'sociability', 'health', 'illness', 'ageing', 'elderly', 'older people', 'gender', 'experience', 'prevention', and 'quality of life'. Inclusion criteria for the search included literature written in the English language, either directly or translated, since the year 1973 (post the seminal work of Weiss) and all published material in written and electronic media concerning these topics.
5. Where the terms 'elderly' and/or 'elderly people' are used throughout the study, they reflect the original terminology used by the author(s) of the study being cited.

Assumptions and stereotypes concerning older persons abound and include the common view that older people are passive and not interested in actively participating in social life (O'Leary *et al.*, 2004). Horkan and Woods (1986) caution against adopting extreme stereotypes that, at one extreme, emphasise the negative aspects of ageing, while at the other, envision a romanticised or oversimplified picture of old age. Older people are not a homogenous group, either in terms of their needs or their functional ability (European Commission, 2000). Their heterogeneity is a function of many factors, including their social and economic circumstances, which can give rise to their self-worth, and can render their experiences different from others whose circumstances are different (Berghorn *et al.* cited in Horkan and Woods, 1986). Older people also differ qualitatively in the rate at which they age, and in the quality and quantity of their social interactions (Horkan and Woods, 1986). On this basis, individuals and societies are challenged to recognise that older people are individuals who have unique and individual life experiences. Although older people can be defined as belonging to a distinct social group, their lifestyles, wishes, desires and needs will differ qualitatively from one individual to the next. Aspects of specific stereotyping of older people will be reprised throughout the course of this review.

1.2.1 Health and Quality of Life

As already observed, older people are not a homogenous group. They are more diverse than younger people, they experience greater differences in their quality of life and in their mental and physical ability, and they experience more discrimination than younger people (Dean, 2003). Older people are listed among that proportion of the population at highest risk of poverty and social exclusion on the basis that they are not in a position to earn a wage income, and this risk is exacerbated for those living alone (Department of Social and Family Affairs, 2003). Demographic data concerning the social circumstances of older people in Ireland indicates that older people are increasingly living alone or with their elderly partner. National census figures from the mid-1990s indicated that upwards of 30 per cent of older people lived alone and a quarter lived in a household consisting of an older couple (Fahey and Murray, 1994).

Older age presents many opportunities for change and should not be confused with illness (Bowling cited in Dean, 2003). Nevertheless, maintaining the health and well-being of the older population is viewed as an important aspect of social policy. The health promotion needs of older people were highlighted in *Adding Years to Life and Life to Years: A Health Promotion Strategy for Older People* (Brenner and Shelley, 1998). In setting targets for improving older people's health, the Strategy included among its goals the need to 'provide a supportive physical environment to enable older people to remain independent and, for as long as they choose, resident in their own homes', and

the need to 'help maintain the well-being and autonomy of older people by increasing their involvement in social activities'. These goals imply that the health of older people is promoted by their remaining independent and, at the same time, maintaining social interactions. Implicit in the latter goal is the risk to health posed by social isolation.

Many older people live long and independent lives, free from the need for either social assistance or assistance with the activities of daily living; however, the utilisation of health and personal social services increases with age and this utilisation is not just in relation to services specifically aimed at older people, but all services (DOHC, 2001).

The quality of life experienced by older people is also an important concern for social policy-makers; the National Health Strategy emphasises improving older people's quality of life (DOHC, 2001). In the UK, research evidence points to the fact that quality of life is poorer for people aged 70 and over, and that it is poorer for women in this age category (Dean, 2003). The quality of housing, the quality of health and forced choice about retirement appear to be particularly important factors in determining the quality of life for older people (Dean, 2003). Studies in Ireland indicate that environmental and societal factors, including housing, social contact, security, transport and income, can impact on the quality of life of older people (Whelan and Vaughan, 1982, 1984; Horkan and Woods, 1986; Garavan *et al.*, 2001). For many older people in Ireland, their quality of life may be a function of their worry over the availability of and accessibility to social care and health services, and the quality and cost of those services, and less a function of their income level *per se* (Layte *et al.*, 1999). This becomes especially important to them if they become frail and dependent or if they require long-term institutional care (Layte *et al.*, 1999). Quality of life and levels of satisfaction with life are also influenced by the individual older person's ability to 'make the best out of the circumstances in which they find themselves', which can, in turn, be influenced by the person's early life experiences and by their present disposition (Horkan and Woods, 1986).

Quality of life is especially related to the social circumstances in which older people find themselves. Older people can experience a high degree of social exclusion, in the form of social isolation, fear of crime, reduced access to basic services and exclusion from civic activities (Scharf cited in Dean, 2003). Poverty and race can be contributing factors in social exclusion. Central Statistics Office (CSO) figures for the 1999 and 2000 Household Budget Surveys (CSO, 2000) showed that upwards of 40 per cent of pensioners resided in households with the lowest incomes and that State transfers (Old Age, Retirement and Widows' Pensions) were increasingly becoming the most important sources of income for older people. Data from the 1997 Living in Ireland Survey provided evidence of a relationship between level of income and its effects on the health and psychological well-being of older people in Ireland (Layte *et al.*, 1999). While the

majority of households in Ireland, even those with a low income, are able to avoid extremes of deprivation, certain groups are vulnerable to poverty and deprivation, especially older women. This is due to the fact that many have had to leave the workforce for a variety of reasons, including child rearing or caring for an incapacitated person.

The National Council for the Elderly (NCE) asked 'to what extent is the "problem of ageing" created and constructed by our attitudes and by our economic policies?' (NCE, 1994). This question raises issues about the attitudes and values that reside at the heart of civil society, and which give rise to the experiences of older people as citizens, and the ways that older people experience social services and the economic system more generally. Societal attitudes and values, and the practices that exist because of these attitudes and values, shape older people's quality of life (Horkan and Woods, 1986). In developed countries, prevailing social and economic structures and the way that the economy is managed create a system of institutions and rules that promotes dependency among older people (Townsend, 1981). This is evident in the ways that older people who are dependent on a pension experience difficulty in maintaining their quality of life and have reduced independence in areas such as transport (NCE, 1994). Additionally, constructing old age in terms of the 'problem of ageing' tends to give rise to policy solutions that are developed without reference to older people themselves or their potential contribution (NCE, 1994). Along with forced dependency created by the social and economic system, the image that is projected of older people is one that incorporates a subtle message that growing old increases helplessness (Chamberlain cited in Horkan and Woods, 1986).

Quality of life is also related to a range of objective and subjective factors, including the range and quality of social networks and the experience of loneliness. While there may be a widely-held stereotype associating old age with social isolation and with loneliness (Forbes, 1996), international research evidence indicates that the majority of older people are neither lonely nor socially isolated (Victor *et al.*, 2002). Loneliness is a complex phenomenon, with numerous definitions that describe a subjective and/or relational experience that is linked with a perceived or actual lack of connectedness with other human beings. In this way, loneliness comprises emotional and social dimensions, and related concepts include 'aloneness', 'solitude', 'estrangement' and 'alienation' (Kileen, 1998). The various conceptual definitions of loneliness are explored more fully later in this chapter. A meta-analysis of research into loneliness demonstrated that only 5 to 15 per cent of older adults report experiencing frequent loneliness (Pinquart and Sorensen, 2001). While living alone does not necessarily imply loneliness and isolation (Power, 1980), one of the key factors involved in the quality of life for older people may be their experience of loneliness and social isolation. Further, it is suggested that older people from more vulnerable groups, that is those in poor health, in bad housing and

with inadequate income, are more likely to experience loneliness and social isolation (Horkan and Woods, 1986). One impact of social isolation is that older people may feel that they are not valued by society or cannot make an important contribution to society, thus reducing their sense of self worth.

1.2.1.1 Health and Wellness, Morbidity and Mortality

Ageing and health status are related, although the relationship does not imply that all older people experience poor health. A study of health and autonomy among those aged 65 and over in Ireland conducted in the early 1990s indicated that the majority of those surveyed were living 'independently without any major physical or psychological impairment', and two thirds rated their health as good or very good (Fahey and Murray, 1994). Older people engaged in a range of activities to promote their health, including hobby and leisure activities. Nevertheless, despite the self-rated health status of older people, almost half had a 'major illness or disability' and morbidity patterns for older people showed that old age life expectancy for those aged 65 and over in Ireland was the lowest in the developed world, suggesting that the basic level of health status for older people in Ireland was 'relatively poor' (Fahey and Murray, 1994). Decline in some aspects of health occurred with increasing age and functional capacity tended to reduce. The study authors concluded that, while impaired health and physical functioning is 'quite common in old age, it is by no means universal' (Fahey and Murray, 1994).

Data from the 1994 Living in Ireland Survey demonstrated that people aged 65 years and over experience higher levels of chronic illness, and also have a higher degree of usage of medical services than the population as a whole (Layte *et al.*, 1999). Higher levels of chronic illness tend to hamper their daily activities and mobility and to affect self-rated health adversely. While Fahey and Murray (1994) demonstrated that older people in Ireland do not seem to be 'particularly prone to psychological distress', the Living in Ireland Survey found that older Irish people experience higher levels of psychological distress than the population as a whole, with older women experiencing higher levels of distress than their male counterparts. Higher levels of psychological distress were associated with higher levels of chronic illness. Income poverty and deprivation and having a chronic illness increase the likelihood of psychological distress (Layte *et al.*, 1999).

The self-rated and actual health status of older people can have an impact on their sense of wellness and on their quality of life, including their objective circumstances and their subjective experiences. Objective circumstances and subjective experiences can, in turn, influence health status. Circumstances, such as reduced functional ability and related social dependence and living alone, can give rise to feelings of social isolation,

which, in turn, can be associated with patho-physiological morbidity. Social isolation has been reported as a predictor of morbidity and mortality, including a range of conditions from cancer to cardiovascular disease (Hawkley and Cacioppo, 2003), and the socially isolated can experience higher rates of mortality over time than the less socially isolated (Berkman and Syme, 1979).

Aside from the objective circumstance of social isolation, the related subjective experience of loneliness is associated with patho-physiological and psychological morbidity and with mortality, and several researchers have identified that there is a relationship between loneliness and health status (Forbes, 1996; Holmén and Furukawa, 2002), including both mental and physical health (Russell *et al.*, 1997). Thus, perceived loneliness can mediate perceived physical health, it may also be implicated in altered health, and both loneliness and social isolation can be associated with mortality and with patho-physiological and psychological morbidity.

1.3 Social Networks, Social Interaction and Social Isolation among Older People

Establishing social contact with others is generally assumed to be a natural human need, and, conversely, it is assumed that lack of social contact is a threat to psychological well-being. Social contact is established and maintained through a range of social networks that can include a single strong emotional contact with a significant other, contact with kin, friends and neighbours, and contact with formal social structures, such as the workplace and social services. Social contact has both qualitative and quantitative dimensions: it is the content and quality of social interactions, more than their quantity and range, that appear to be important to psychological well-being. Social networks, social interaction and the experience of social isolation among older people were a focus of concern for the present study.

1.3.1 Social Networks

Meaningful social contacts are an important part of well-being.

(Holmén and Furukawa, 2002)

'Social network' is a concept that has roots in anthropology and sociology, and the concept can have a variety of meanings depending on the context in which it is being considered. In mental health, for example, it can refer to the 'ego-centred network' or

'anchorage', that is, the network of acquaintances and social interactions of a single individual (Andersson, 1998). An average individual's social network comprises about 25 people, of which three to six will be intimates (Andersson, 1998). While social network may be operationally defined differently across empirical studies, international research indicates that the average size of a social network among older people can vary from six to over ten individuals (Moorer and Suurmeijer, 2001). Having social networks can increase the likelihood of other social networks. For example, living with a spouse in later life can result in improved social networks (Kim and Baik, 2002).

The nature and quality of social networks in which older people are involved are as complex and as variable as they are for any other section of the population (Whelan and Whelan, 1988). In their daily lives, older people experience a range of both positive and negative interpersonal encounters that have the potential to affect their emotional well-being (Rook, 2001). While social networks within families may be beneficial for older people, they may also be a source of distress (Whelan and Whelan, 1988). Within family and non-family social networks, the dynamics of the social relationships of older people are complex, and while some older people regard living alone as a way of maintaining their independence and self-esteem, loneliness may result from the social isolation that stems from lack of interaction with family and friends (Brenner and Shelley, 1998). The assumption that older people wish to enlarge their social network may not be true (Moorer and Suurmeijer, 2001). For some people, living alone can be a positive experience, especially for those who choose to do so (Holmén *et al.*, 1992). However, most older people in Ireland wish to maintain social contact with relatives and friends (Garavan *et al.*, 2001).

1.3.1.1 Social Networks among Irish People

Studies into social contact in Ireland indicate that Irish people have generally high levels of social contact and suggest that family networks remain strong, representing the basis of much of the social contact that people experience. The factors that facilitate good social contact include good transport and communication systems (NCE, 1994). While historically in Ireland family networks have formed the central part of older people's social networks, non-family social networks are also important (Fahey and Murray, 1994). However, wider changes related to social values, such as the process of individualisation, can greatly alter the characteristics of social networks and cause changes in family orientation and living arrangements (de Jong-Gierveld and van Tilburg, 1999).

Despite demographic data indicating that older Irish people are increasingly living alone, they are still less likely than their counterparts in other countries to live alone and more likely to live among kin (Layte *et al.*, 1999; Fahey and Murray, 1994). However, recent evidence from the HeSSOP report indicates that a sizeable proportion of older Irish people do live alone and spend time alone (Garavan *et al.*, 2001). In exploring the views of older people on the health and social services available to them in two health authority regions in Ireland, the HeSSOP report explored aspects of their social contacts and support. The authors reported that of the sample of 937 older people, 28 per cent lived alone, 41 per cent were widowed and 23 per cent experienced limitations in their everyday independence due to mobility problems. Two thirds of those living alone were women and over 50 per cent of these women were aged 70 and over. Among those living alone, almost half (46 per cent) spent an average of ten to fourteen hours alone during the day (Garavan *et al.*, 2001). Older people's basic needs in the area of mobility include daily life activities, such as shopping, attending health care facilities, walking and leisure; their mobility may be restricted by fears related to the use of public transport and by altered health or decreased stamina (O'Leary *et al.*, 2004).

1.3.2 Social Support and Support Networks

A concept related to that of social networks is 'social support'. The types of social support network for older people in Ireland was a key focus of this study. The literature provides numerous definitions of social support and, while the terminology used in defining social support differs, the various definitions possess common characteristics, including the notion of some type of positive interaction or helpful behaviour provided to a person in need of support (Hupsey, 1998). Social support comprises notions of structure (the existence and extent of relationships) and function (the extent to which social relationships provide help and companionship) (Kim, 1999). Social support is defined in terms of support provided by others and the intentions of the provider, the perceptions of the individual receiving support, and reciprocity in support-giving and social networks; the concept may include other aspects which may determine if social support is requested, accepted and/or received (Hupsey, 1998). Social support thus comprises the idea of support networks, supportive behaviours, and subjective appraisal of support received (Vaux cited by Hupsey, 1998). Andersson (1998) defines social support as the opposite to loneliness (in this way social isolation is equated with loneliness) and points to the fact that the two phenomena tend to be respectively represented as objective and subjective. The experience or presence of social support can have a direct effect on the individual's well-being and it may also have a buffering effect on the detrimental effects of stressful situations. The basic source of social support for older adults comes from other people, including other family members, neighbours, volunteers and professionals and, at times, strangers (O'Leary *et al.*, 2004).

Support networks, which are considered to be an important source of support for older people, have been defined as 'those people available (or perceived by the older person to be available) on a day-to-day basis to provide companionship, advice and instrumental help with a wide range of tasks', and comprise local family, neighbours and friends (Wenger, 1994; Wenger and Keating, 2002). Based on a twenty-year longitudinal study of ageing in Wales, Wenger developed a typology of support networks of older adults. The typology of support networks was as follows: 'local family-dependent' (primarily local family members); 'locally integrated' (local family, friends and neighbours and involvement in local community); 'local self-contained' (primarily neighbours, some local kin); 'wider community-focused' (mainly local friends, no local kin and involvement in local community); and 'private restricted' (no local kin and minimal contacts with local community) (Wenger, 1994; Wenger and Keating, 2002). These various networks, most especially the local family-dependent and the locally integrated networks, can evolve into 'care networks' when older people's circumstances require care, and they can augment essential social services by providing companionship and emotional support (Wenger and Keating, 2002). The typology of social networks is the basis of the Network Assessment Instrument (Wenger, 1994) used in this study; the Instrument permits the identification of the support that individuals receive within their social network.

For research purposes, social networks may be examined with reference to their size, range or extent (the number of people in the network), the degree to which members know each other, the extent to which one member can communicate with other members and the extent to which relationships are reciprocal (Andersson, 1998). Findings from the Quality of Life and Management of Living Resources Survey demonstrate that older adults in Ireland perceive social support to be insufficient (O'Leary *et al.*, 2004).

1.3.3 Patterns of Sociability

Patterns of sociability relate to the frequency of an individual's social contact with different types of people, and includes membership of clubs and organisations; information on patterns of sociability can illuminate both social interaction and participation, and social exclusion (Layte *et al.*, 1999). Patterns of sociability among older people may be a function of the sort of activities that they engage in within their communities that, in turn, may be related to individual preferences and characteristics; some older people may participate in cultural activities, while others may prefer activities related to sport and recreation (Moorer and Suurmeijer, 2001). Furthermore, older people may engage in activities not in order to meet people, but rather because they are interested in the activities themselves (Moorer and Suurmeijer, 2001). Garavan

et al. (2001) reported that the majority of older people in Ireland were interested in maintaining social contact with family and friends and many expressed an interest in becoming a member of a social club or group. Many older people also believed that 'getting out in the community and socialising' was critical to their mental health.

Participation in social activities has been found to result in significantly larger social networks among older people (Moorer and Suurmeijer, 2001). While a decline in social networks associated with ageing reduces the quantity of social interactions, the quality of social interaction is also related to ageing, with reduced activity and physical dependency altering the balance of social relationships (Fahey and Murray, 1994). Data from the 1994 Living in Ireland Survey provided information on patterns of sociability among persons aged 65 and over in Ireland (Layte *et al.*, 1999). Findings from the Survey revealed that, when compared with most other OECD countries, older Irish people are less likely to live alone and that both older men and women in Ireland have high levels of contact with neighbours and with friends and family. Findings also revealed that the frequency of social contact among older people living alone was high, with over 94 per cent talking with a neighbour or having contact with friends and relatives, at least once or twice a week. Men and women differed little in their patterns of contact, with over 90 per cent of both sexes seeing a neighbour or friends and relatives at least once or twice a week (Layte *et al.*, 1999).

Patterns of social interaction appeared to be associated with physical location, with rural older people having less daily interaction than those living in urban areas. However, while there were little overall differences between the sociability patterns of older people in urban and rural areas, differences existed in relation to rural men and women. In rural Ireland, women were significantly less likely to see a friend or relative than their male counterparts (Layte *et al.*, 1999). Gender differences also exist in respect of membership of a club or organisation, with men more likely than women to have affiliations to a club or organisation. Income level appears to be a variable in determining patterns of sociability, with income affecting different types of contact in different ways. For example, older urban poor were more likely to be members of a social club than their younger urban or older rural counterparts, suggesting that older people may be substituting social contacts with neighbours, friends and family for more expensive leisure pursuits (Layte *et al.*, 1999). From the high levels of social interaction evident among single older people, Layte *et al.* (1999) drew the inference that this cohort of older people may be engaging in some form of compensatory behaviour. Layte, Fahey and Whelan (1999) identified a significant decrease in the proportion of older people in rural areas having daily contact with friends, neighbours and relatives. Rural older people also had lower participation rates in clubs and organisations than their urban counterparts.

1.3.4 Social Isolation

One of the principal reasons why social researchers devote so much attention to the social lives of older people is the concern that older people are at high risk of social isolation (Fahey and Murray, 1994). Confusion can exist between the related concepts of living alone, social isolation and loneliness; it is possible to consider living alone as the most objective of these concepts and loneliness as the most subjective, with social isolation containing both objective and subjective attributes (Victor *et al.*, 2002). Thus, while living alone, social isolation and loneliness are related, they are not necessarily co-existent (Victor *et al.*, 2002).

As an objective state that is based on the absence of contact with other people and integration with other members of society, social isolation can be quantified (Wenger and Burholt, 2003). Objective measures of social isolation can describe the number, type and duration of social contacts between individuals and their wider social environment (Victor *et al.*, 2002). Patterns of social isolation in individuals are identifiable, including long-life isolates (the loner who lives a marginal lifestyle) and isolates in old age (Wenger and Burholt, 2003). As a subjective experience for older people, social isolation can be experienced as a *relative* experience and can also be experienced with reference to others and to their earlier experiences. According to Townsend (cited in Wenger and Burholt, 2003), social isolation can be experienced by older people in four typical ways: in comparison with contemporaries; in comparison with younger people; in comparison with themselves as younger people; and in comparison with earlier generations of older people.

1.3.5 Correlates of Social Isolation

Social isolation among older people is one of the most common themes in discussions of ageing in modern societies, and is often linked with an increase in the incidence of older people living alone, with long-term decline in family size, retirement, the death of a spouse, siblings and same-age friends, with disability and illness, and with poverty (Fahey and Murray, 1994). Social isolation can increase with advancing age and this increase can be related to these same factors (Wenger and Burholt, 2003). Sensory acuity may diminish with old age, leading to limitations in the frequency and quality of social interactions (Saxon and Etton, 1987).

1.3.5.1 Circumstances

The literature indicates that a range of people in a range of circumstances may experience social isolation. These include long-term care-givers (Dorsey and Vaca,

1998) and persons with a chronic illness, such as those using long-term home oxygen treatment (Ring and Danielson, 1997). Social isolation may result from a lack of social cohesion and social exclusion; social exclusion relates to those who 'are subject to discrimination, segregation or weakening of the traditional forms of social relations' and it can involve non-participation in working life and/or inequality of access to housing, health and social services (NCE, 1994).

Historically, family networks in Ireland have been strong and are important in reducing the experience of social isolation among family members. Enhancement of quality of life and the development of community networks are essential where the traditional community and neighbourhood no longer exist. The 1999 study by Layte *et al.* of deprivation and well-being in Ireland indicated that persons aged over 65 were less likely to live alone and were more likely to live with kin. However, contacts with previous colleagues are often lost on retirement, partners and siblings may die first and social interactions may also be reduced through disability, resulting in subjective feelings of isolation. Accordingly, it is suggested that the need to maintain the well-being and autonomy of older people through social interactions is necessary to reduce the feelings of isolation. With marital fertility remaining high until the 1960s, a reduction in emigration since the 1960s and survival of lateral kin, such as brothers, sisters and cousins, older people in Ireland in the last decade of the twentieth century enjoyed a large extended family. In comparison to other western countries, older people in Ireland in the mid-1990s enjoyed large active kinship networks, with most older people having large numbers of children, grandchildren and siblings who lived in Ireland, and with whom they had regular contact (Fahey and Murray, 1994). Furthermore, neighbours and friends also formed a part of this social network. For these reasons, the great majority of older Irish people were not socially isolated.

For a minority of older people, however, who never married, the family network could be qualitatively different. Family formation patterns for people born in the 1920s revealed that a fifth of women and a quarter of men did not marry by the age 50 and, as a consequence, a fifth (20.4 per cent) of all women and almost a quarter (24 per cent) of all men aged 65 and over were single at the start of the last decade of the twentieth century (Fahey and Murray, 1994). This 'never married' group, with fewer nuclear family relatives, represented a sizeable minority by international standards, and, as Fahey and Murray demonstrated, had fewer relatives and was more likely to live alone and have little or no contact with family members. Nevertheless, since the majority of the 'never married' group maintained regular contact with friends and neighbours, the risk of social isolation remained a minority experience for this group.

1.3.5.2 Social Contacts

Horkan and Woods (1986), who described the experiences of 45 older persons living alone in suburban Dublin, reported that more than a third of those interviewed experienced feelings of isolation in addition to experiencing loneliness. While bereavement was cited as a major factor in causing loneliness in the sample, it was also cited as the principal factor associated with feeling isolated. Other factors associated with isolation included the decline of the older people's generation, decreasing social contact, and retirement from employment. Respondents defined isolation as being 'out on a limb with no one to turn to' and the experience of social isolation fuelled fears of illness, being alone or dying alone and being undiscovered (Horkan and Woods, 1986).

While telephone and car ownership has increased dramatically among the population in general, the lowest levels of telephone and car ownership are among both rural and urban older people (NCE, 1994). These findings imply that older people have reduced access to two important means of maintaining social contact. Living in a rural area may exacerbate social isolation, because of the relative weakness of public transport and the relative low density of housing, when compared with living in a city (Layte *et al.*, 1999).

As already observed, social isolation may result from the loss of social networks due to retirement and, with increasing age, from the loss by death of colleagues, friends and siblings (Brenner and Shelley, 1998). Retirement is a particularly significant life event that can represent either a new challenge or a threat for the individual. Upon retirement, people are often considered as 'naturally' disengaging, and retirement can force older people to accommodate and to adapt to negative expectations (NCE, 1994). The transition to retirement can result in loss of role and status, especially in cultures that place a high value on work and paid employment (Townsend, 1981). In addition, the lower social status ascribed to retired people tends to be extended to older persons who have not been engaged in structured employment, such as women working in the home, and reflects wider inequalities, such as those produced by class, gender and ethnicity (NCE, 1994).

Marginalisation and social exclusion are frequently a part of the experience of groups that are discriminated against. Some people living in the community have had life experiences that have made them unable or unwilling to accept services. Statutory and voluntary workers providing services find it difficult to meet the needs of these people as in many cases their needs are unknown (Hurley *et al.*, 1997). In the above study it was concluded that 3.8 people per thousand of the population could be described as reclusive. It is important to this study to note that service refusal was evident in people both under and over 65 years of age and no statistics were given solely for the

population aged 65 and over. This group of people was reluctant to accept social support. Sixty two per cent of the group lacked family support, lived in poor housing conditions and displayed poor personal hygiene. One third reported alcoholism and psychiatric illness. While this group could be described as isolated in an objective sense, it is not known if they experienced loneliness (Hurley *et al.*, 1997).

Using an objective measure of social isolation, based on the quantity and quality of older persons' weekly contacts, Townsend (1973) calculated a numeric score of social isolation from or involvement in family and society for a cohort of over 200 older people. Those obtaining a score of over 35 (contacts per week) were deemed to be not isolated, those obtaining a score of 21 or less were designated as being isolated, while those obtaining a score of between 25 and 35 were designated as rather isolated. Townsend (1973) reported that those obtaining a low score on the social isolation scale were usually living alone, were older than average, were without children or other relatives living nearby, were retired from work and were infirm. It was the combination of three or more of these factors, and not any single one, which produced isolation. Most of the socially isolated had few surviving relatives and comprised a high number of unmarried or childless people.

Social isolation has been shown to be associated with patho-physiological morbidity and it is a predictor of morbidity and mortality (Hawkey and Cacioppo, 2003). Socially isolated people demonstrate higher rates of mortality over time than the less socially isolated (Berkman and Syme, 1979). Social isolation has been associated with poor survival from coronary artery disease, with reported evidence of higher mortality rates among socially isolated/small social network individuals with coronary artery disease (Brummett *et al.*, 2001).

1.4 The Nature and Prevalence of Loneliness

While loneliness is a universal human experience, it is a phenomenon that has proved difficult to define; its nature as a highly subjective experience is part of the difficulty in defining it (Kileen, 1998). Although loneliness is principally a subjective experience (Victor *et al.*, 2002), the experience can be objectively ascertained and measured as a research variable. In this study, the experience of loneliness among older people is explored from the subjective viewpoint of the individual, using a combination of quantitative and qualitative techniques.

1.4.1 Conceptual Definitions

There are numerous definitions of loneliness: most describe a subjective experience and many infer that the phenomenon is relational and linked with the human condition of perceived or actual lack of connectedness with other human beings. Loneliness has been variously described as an emotion, an emotional response and a combination of either emotional or social responses. Forbes (1996) similarly defines loneliness as 'an unwelcome feeling of lack or loss of companionship, or feeling that one is alone and not liking it'. As a subjective experience, loneliness is a set of 'unwelcome feelings or perceptions ... associated with [an] unsatisfactory level of communication and closeness with others' (Wenger and Burholt, 2003).

The phenomenon of loneliness comprises a complex set of feelings that encompass reactions to the absence of intimate and/or social needs (Ernst and Cacioppo, 1999). In this way, it can be construed as 'the emotional response to the discrepancy between desired and available relationships' (Walton *et al.*, 1991). Kileen (1998) similarly defines loneliness in terms that imply its relational nature; it is 'a discrepancy between a person's social and/or emotional needs/wants, and their social reality'.

Loneliness has been described as a process of 'temporal change'; it is not a static event, its intensity can increase or decrease over time and it can alter seasonally and according to the day of the week (Victor *et al.*, 2002). Rook (1984) defines loneliness as an enduring condition or emotional state that arises when a person feels estranged from others, is misunderstood or rejected by others, and/or lacks appropriate social partners for desired activity, particularly activities that provide a sense of social integration and opportunities for emotional intimacy. While loneliness may be a transient experience, for some it may be a chronic state (Ernst and Cacioppo, 1999). Forbes (1996) cautions that loneliness in older people cannot be regarded as the simple and direct result of social circumstances; rather it is 'an individual response to an external situation to which old people vary in their reactions'.

1.4.1.1 Related Concepts

Concepts related to loneliness include aloneness (the voluntary or involuntary objective state of being by oneself), solitude (the voluntary process of being on one's own), estrangement (the objective experience of being detached from society) and the related concept of alienation (the subjective experience of disconnectedness from society or from oneself) (Kileen, 1998). For some people, solitude may be a way of life that temperamentally suits them (Forbes, 1996). The feeling of loneliness may be connected with a general negative perception about oneself and one's relations to other people (Åkerlind and Hörnquist, 1992).

As already observed, being alone may be a positive experience. In this connection, Forbes (1996) points to the individual nature of loneliness and solitude, observing that a situation leading to loneliness for one person can be a source of contented aloneness for someone else. Therefore, some people may feel isolated and lonely even when they have many people visiting them, while others who have less need of social contact may not feel lonely even if they have no visitors. While loneliness is often confused with social isolation (Forbes, 1996), social isolation is conceptually related to loneliness, in that it may be seen to reside on a point on the same alienation-connectedness bipolar continuum on which loneliness exists as shown in Figure 1.1 (Kileen, 1998). Thus loneliness is subjective, while social isolation can be objectively measured, using criteria such as the number of social contacts the person has (Forbes, 1996).

Conceptual clarification of loneliness may be offered in research data. Based on in-depth interviews among older people, Victor *et al.* (2002) identified three distinct definitional categories of loneliness, which were functional, a state of mind and friends network related. Functional loneliness is defined in terms of loss of a range of abilities and loss of some practical aspect of daily life, such as loss of health. As a state of mind, loneliness is related to one's ability to fill time, find happiness when alone and being able to motivate oneself. Loneliness related to one's social network is defined in terms of the closeness of others and includes the presence or absence of a confidant.

Figure 1.1: Alienation-connectedness continuum (Kileen, 1998)

1.4.2 Social and Emotional Loneliness

Weiss, the seminal writer on loneliness, cautions that it is misleading to define loneliness as 'caused by the condition of being alone'; instead he holds loneliness to be a condition caused by 'being without some definite needed relationship or set of relationships' (Weiss, 1973). In this way, the concept of loneliness is defined with reference to its cause and the emphasis is on the role of close and intimate relations. The experience of loneliness appears to be a response to the absence of 'some particular relational provision', either the provision of an intimate attachment, a meaningful friendship, or a linkage to a coherent community (Weiss, 1973). On this basis, Weiss (1973) distinguishes between two dimensions of loneliness, the 'loneliness of emotional isolation', a condition arising out of the loss or absence of a close emotional attachment, and the 'loneliness of social isolation', that condition arising out of the absence of 'an engaging social network'.

The loneliness of emotional isolation is associated with loss of a spouse, children or a confidant, and the experience can engender symptoms similar to those that a small child experiences with the fear of abandonment by its parents, and might indeed be a re-experiencing of childhood abandonment. It is experienced as a sense of pervasive apprehensiveness, what Weiss (1973) terms a 'nameless fear', involving poor concentration, vigilance to threat, tension, and the organisation of one's perceptual and emotional energies towards finding a remedy for the loneliness. Emotional isolation also involves the experience of a sense of 'utter aloneness', involving feelings of the absence of others in the environment and feelings of emptiness. The role of a single emotional attachment (a close friend or a romantic partner) can act as a buffer in staving off loneliness in those at risk (Ernst and Cacioppo, 1999).

The loneliness associated with the absence of a close emotional attachment may not be remedied by entry into new platonic relationships, such as those offered in social support groups or other social networks, but may only find remedy in the integration of a new emotional attachment or in the reintegration of the lost one. Bereavement has been cited as one of the most common causes of loneliness among older adults (Costello, 1999). While the experiences of grief and loneliness initiated by the loss in conjugal bereavement are separate but related experiences, the grief of loss in older adults may be, in Costello's terms, 'an initiating mechanism of loneliness'.

The loneliness of social isolation is associated with the disruption in linkages to one's supportive social network. It is characterised by a lack of integration and may be associated with a number of contributing factors, including instability of residence, infrequent contact with friends, children and siblings, lack of participation in social

groups, and a decline in sensory acuity and health (Dugan and Kivett, 1994). Social isolation resulting in the loss of a supportive network may expose the older person to feelings of vulnerability, marginality, tension and boredom (Weiss, 1989). The loneliness of social isolation can find remedy in the establishment of new social networks. Nevertheless, while it may be assumed that the way to overcome loneliness arising out of social isolation is to end social isolation, this may not be appropriate, since individuals in social groups can still experience loneliness, as Weiss (1973) observes:

Only those who are not lonely suppose that loneliness can be cured by ending isolation. Not only is random sociability no antidote to loneliness, but under some circumstances, it can exacerbate it.

Weiss also refers to 'loneliness syndromes', common symptoms that arise out of a range of social conditions that give rise to loneliness, including a yearning for 'a relationship with kin', restlessness and irritability with relationships that impede access to a desired relationship. This way of conceptualising loneliness may be to assume a pathological model of loneliness; nevertheless, Weiss's model comprises the major elements of the conceptualisation of social support, which are social support and social isolation (Andersson 1998). In summary, whereas social loneliness involves inadequate social networks, emotional loneliness is related to the absence of an intimate attachment relationship (Holmén *et al.*, 2000).

1.4.3 The Experience and the Prevalence of Loneliness

Loneliness may be a phenomenon that all people experience at some time in their lives and, as such, is a temporary state that dissipates as people's circumstances change (Lauder *et al.*, 2004). For some individuals, however, loneliness is a persistent feature of their lives (Ernst and Cacioppo, 1999). The experience of loneliness is found across the spectrum of ages, from children to the oldest old. While it may be a part of the phenomenon of lifestyle dissatisfaction prevalent in industrialised countries (Lauder *et al.*, 2004), loneliness is a human experience that is evident across cultures and societies, from the developed industrialised to the agrarian. Nevertheless, culture may moderate the extent to which people experience the feeling of being lonely (Rokach *et al.*, 2002).

Andersson (1998) points to the fundamental distinction between the objective state of being alone and the subjective experience of feeling lonely, and proposes a four-fold typology for considering loneliness and aloneness. Loneliness may or may not be experienced by the person who is alone and the person who experiences loneliness may

or may not be alone (Andersson, 1998). Notwithstanding this distinction, the experience of loneliness is generally more prevalent among those living alone.

Loneliness is also experienced by a wider range of older people in a wide range of circumstances. Those experiencing loneliness include older married women, older people who live with married children, those living in residential care or in sheltered housing, older people who are care-givers, and older immigrants, particularly those who do not speak the language of their host country (Forbes, 1996).

1.4.3.1 Prevalence of Loneliness

Recent research among the community at large indicates that loneliness may be a pervasive experience. For example, from the results of a telephone survey conducted among a sample of over 1,200 residents of a mixed rural and non-rural community in Central Queensland, Australia, Lauder *et al.* (2004) reported a prevalence rate of one third being 'quite lonely'. Most international research indicates that the majority of older people are not lonely, with estimates of reported loneliness ranging from 5 to 16 per cent; in one English study, older people reported lower levels of loneliness than younger people (Victor *et al.*, 2002). However, research conducted among older people in the United States would seem to indicate that loneliness may be quite prevalent in that country and may exist as a significant negative factor in older people's lives. Dugan and Kivett (1994) reported that 21 per cent of rural older Americans experienced 'much loneliness'. Johnson *et al.* (1993) reported that as many as 62 per cent of older people in America experience loneliness, while Ryan and Patterson (1987) found that loneliness was ranked as secondary only to fears about crime and ill-health among older Americans.

International research points to considerable variance in the prevalence of loneliness; the high incidence of loneliness reported among older Americans contrasts with that reported among Chinese, with just 3.5 per cent of a sample of older Taiwanese rural dwellers reporting experiencing a 'high level' of loneliness (Wang *et al.*, 2001). Forbes (1996) reported that only one in ten people experienced serious loneliness in Britain, and in a qualitative study among a large sample of older people in Britain, Victor *et al.* (2002) reported that only a small minority (7 per cent) of older people reported that they were 'severely lonely'. While the number of older people reporting loneliness is relatively small, it is possible that the prevalence of loneliness has not decreased in the past 60 years (Victor *et al.*, 2002).

1.4.3.2 Prevalence of Loneliness among Older People in Ireland

A number of studies of the economic and social circumstances of older people in Ireland have incorporated exploration of the experience of social isolation and/or loneliness. Among these is an early study conducted under the auspices of the Society of St Vincent de Paul (Power, 1980), which surveyed older people who lived alone. A study commissioned by the Economic and Social Research Institute (ESRI) that examined the economic and social circumstances of the elderly in Ireland, included evidence concerning the experience of loneliness (Whelan and Whelan, 1982). The NCAOP has commissioned a number of studies that, partially or exclusively, have examined the experiences of loneliness and/or social isolation among older people. These included a study into the experience of loneliness among rural older people (Daly and O'Connor, 1984), a qualitative study on the perspectives on life among older people in suburban Dublin (Horkan and Woods, 1986) and a study of health and autonomy among people aged 65 and over which included a description of family networks (Fahey and Murray, 1994). The 1993 Eurobarometer Survey of Age and Attitudes explored the issues of social contacts and the experience of loneliness (Commission of the European Communities, 1993). In addition, an NCAOP commissioned study entitled *Income, Deprivation and Well-being among Older Irish People* by Layte, Fahey and Whelan (1999) included an examination of social interaction and participation. The Quality of Life and Management of Living Resources Survey, which examined mobility among older adults in nine European countries, presented some findings related to the experience of social support and loneliness among Irish older adults (O'Leary *et al.*, 2004).

Although prevalence figures for loneliness among older people show some variance across international studies, as already observed, most international research indicates that the majority of older people are not lonely. The prevalence figures for Ireland are generally consistent with those of international studies, although there is a considerable variance in the range of prevalence. The recent HeSSOP report indicated that the majority (90 per cent) of older Irish people were not 'bothered by loneliness' (Garavan *et al.*, 2001). Power (1980) reported that 7 per cent of older people felt lonely persistently, 7 per cent felt lonely frequently, while over 40 per cent felt lonely occasionally. Daly and O'Connor (1984) noted that older rural women were more likely to experience loneliness than their male counterparts, and that those living alone for a short period of time were more likely to experience loneliness. The Eurobarometer Survey of Age and Attitudes (Commission of the European Communities, 1993) reported that, despite high levels of social contact with family, up to 14 per cent of older Irish people reported feelings of loneliness.

Horkan and Woods' (1986) study of older people in Dublin identified themes of loneliness and isolation from a group of 45 older persons who lived alone. Using in-depth interviews, they described older people's experiences in coping with their circumstances. One of the principal themes of the study was the experience that 'life can be lonely and isolated' and about half of the sample identified loneliness as a major disadvantage of living alone. Only twelve participants stated that they never felt lonely. Loneliness and isolation were a concern for the majority of those interviewed, with the absence of company and desolation following bereavement being the factors most frequently associated with loneliness (Horkan and Woods, 1986). Some of those who experienced loneliness viewed it as inevitable after being widowed. Loneliness was also attributed to factors related to ageing, such as the fact that people were unwilling to listen.

In an investigation of the social networks among a sample of 909 people aged over 65 in Ireland, Fahey and Murray (1994) examined aspects of the content and the quality of their social relationships, including the experience of loneliness and the related experience of 'being cared for'. Despite the existence of large and extensive social networks, with social contact based around kinship, friends and neighbours, and despite the majority (94 per cent) experiencing 'being cared for by family members', almost one third (32 per cent) of men, and almost a half (49 per cent) of women reported feeling lonely more often now than when they were younger. The Quality of Life and Management of Living Resources Survey reported that 'a lot' of older European adults experience loneliness; the experience of loneliness was 'particularly stressed' in Ireland and appeared to be related to increasing death rates among peers, decreased opportunity and willingness to make new friendships, and distances from neighbours (O'Leary *et al.*, 2004). As noted previously, this study also reported that older adults in Ireland perceive social support as insufficient.

The phenomenon of loneliness is not unique to older people and much research has been conducted on loneliness at different stages of the lifespan; the prevalence of loneliness has been demonstrated in persons in their middle years (Ellaway, Wood and MacIntyre, 1999). However, loneliness in childhood and adolescence is often only temporary and adults may undergo periods of loneliness only (Donaldson and Watson, 1996). While loneliness is not a problem for all older people, it presents a significant problem for those who experience it, and it may lead to physical and psychological ill-health. Persons who experience loneliness as a chronic state tend to act in a socially withdrawn fashion, to have a lack of trust in self and others, to experience little control over success or failure in their lives, and to experience dissatisfaction in social relationships (Ernst and Cacioppo, 1999).

In an Irish study conducted by Power (1980), living alone was shown to imply neither loneliness nor isolation. Often older people may not admit to feeling lonely due to the social stigma associated with the condition. This may offer an explanation as to why loneliness was not seen as an issue in studies by Forbes (1996) and Garavan *et al.* (2001). However, the experience of loneliness may be exacerbated by the fact that people who are lonely do not admit to the experience; loneliness can be a taboo subject in societies that value and promote human interaction and sociability.

1.4.4 Correlates of Loneliness

In empirical research into loneliness, cause and effect are difficult to disentangle; both predictors and consequences of loneliness may be inferred from a range of objective and subjective variables. Thus relationships among variables associated with loneliness are generally reported as correlates of loneliness. Predictors and consequences of loneliness may be associated with people's circumstances or with their personal characteristics (Kileen, 1998). In the process of loneliness, it may be *changes* in factors such as health status and social relationships that are more important than the factors themselves (Tijhuis *et al.*, 1999).

1.4.4.1 Descriptive Factors and Personal Characteristics

Loneliness research among older people points to the impact of a wide spectrum of demographic, personal and social factors (Mullins *et al.*, 1996). International studies indicate that loneliness is associated with a range of socio-demographic or descriptive variables, such as age, social and economic circumstances, living arrangements, social networks, family function and the quality of social relationships. A range of personal characteristics of older people, such as physical health, cognitive integrity, self-esteem and pre-morbid personality are also associated with loneliness. Other associated factors include social norms and values; the expectations of support associated with certain types of relationships and the individual's evaluation of their available network of social relationships (Lauder *et al.*, 2004).

Cultural background may be an influencing factor in causing loneliness, as Rokach *et al.* (2002) demonstrated in a comparative study of a sample of over 1,000 subjects in North America and Spain: factors representing the 'causes' of loneliness included personal inadequacies, developmental deficits, unfulfilling intimate relationships, relocation or significant separations and social marginality. Loneliness may be associated with a range of individual psychological and personality differences, including depression, hostility, pessimism, social withdrawal, alienation, shyness and negative effect (Ernst and Cacioppo, 1999).

International research into loneliness has examined the relationship between loneliness and a range of possible adverse physical and psychological effects. In an examination of factors associated with loneliness, Victor *et al.* (2002) referred to 'risk factors' for loneliness and they identified broad interrelated categories of risk, including socio-economic, health resources, material resources, social resources and social networks. Variables related to people's social circumstances, marital status, social networks, transport, income and level of independence were reported as contributory 'causes' of loneliness. Some of these factors, such as not being married and increased time spent alone, appeared to increase older people's vulnerability to loneliness, while others, such as having an educational qualification, appeared to have a protective effect (Victor *et al.*, 2002).

Associations with loneliness and variables related to personal characteristics, including self-esteem, depression, shyness and educational levels have also been reported (Kileen, 1998). While objective demographic variables such as age and gender may be possible predictors of loneliness, other personal characteristics such as health status may be associated with loneliness either as predictor or consequential correlates. A study of a sample of over 1,000 older Floridians showed that loneliness was greater among men, among those with no children and those with no friends, those more physically disabled, those who subjectively felt that their health was poorer and those who subjectively felt that their economic condition was inadequate (Mullins *et al.*, 1996). In a study of older Swedish people, the most important factors associated with feelings of loneliness were the loss of a spouse, depression of mood and lack of friends (Berg *et al.*, 1981).

1.4.4.2 Age and Gender

International research into loneliness has examined time and cohort trends (Tijhuis *et al.*, 1999). With increasing age, there is an increasing risk of losing more relatives and friends, and such losses may reduce the number of meaningful relationships and thus increase the incidence of loneliness (Walton *et al.*, 1991). Pinquart and Sorensen (2001) identified a U-shaped association between age and loneliness in late adulthood. In a large-scale study among older people in Britain, loneliness was most likely to be reported in specific groups of older people including the very old, women, the non-married, those living alone, those lacking material resources (home, car), those lacking an educational qualification and the physically/mentally frail (Victor *et al.*, 2002). Thus living alone, being very old and being female appear to be key risk factors for loneliness (Victor *et al.*, 2002). Early research among older people in Sweden revealed a clear gender difference between men and women in the prevalence of loneliness, with loneliness being a problem for 24 per cent of the women and 12 per cent of the men (Berg *et al.*, 1981). In a later Swedish study of a sample of 589 older

people, Holmén *et al.* (2000) found that women reported both social and emotional loneliness significantly more than men and older subjects in the older age group reported more frequent loneliness than their younger counterparts. The fact that women survive to a greater age and live without a partner for longer than men may provide a simple demographic explanation for the reported higher incidence of loneliness among women (Tijhuis *et al.*, 1999; Holmén *et al.*, 2000).

Chronological age may itself be a predictor of loneliness, although there is contradictory evidence concerning this variable; some reports suggest that among the very old, loneliness increases with increasing age and the very old appear to be most prone to loneliness, with older men reporting more loneliness (Tijhuis *et al.*, 1999). However, a survey of over 2,000 older North American urban dwellers provided counter evidence regarding chronological age and loneliness. The study indicated that loneliness decreased across the adult life-span, with respondents aged 65 and over being the least lonely and most satisfied with their social relationships (Revenson and Johnson, 1984). The increase in loneliness associated with increasing age may not be related to age *per se*, but may be associated with situational factors, including loss of a partner or failing physical health (Tijhuis *et al.*, 1999). Thus, changes in loneliness over time may not be a simple linear function of time, but rather may be related to transitional life events, such as changes in marital status and health; age-related critical life events such as widowhood tend to engender emotional loneliness (Dugan and Kivett, 1994). Loneliness has been described as a process of 'temporal change'; it is not a static event and its intensity can increase or decrease over time, and it can alter seasonally and according to the day of the week (Victor *et al.*, 2002).

Like the evidence concerning age differences and loneliness, evidence concerning gender differences is also contradictory (Tijhuis *et al.*, 1999). For example, while research appears to point to a greater incidence of loneliness among women, a study of 1,071 older people in Florida showed that loneliness was greater among men (Mullins *et al.*, 1996). Revenson and Johnson (1984) reported that neither gender nor living alone was related to loneliness.

1.4.4.3 Loneliness, Social Networks and Social Isolation

Living alone, isolation and loneliness are three different experiences and do not necessarily coexist (Townsend, 1973; Horkan and Woods, 1986). Townsend (1973) makes a clear distinction between loneliness and social isolation in the following terms:

To be socially isolated is to have few contacts with family and community; to be lonely is to have an unwelcome feeling of lack or loss of companionship. The one is objective, the other subjective, and the two do not coincide.

Social isolation implies absence of, or limited contacts with, other people; contacts can be defined in terms of prearranged or customary meetings and involve more than the casual exchange of greetings (Townsend, 1973). Emotional isolation, such as that which results from the death of a spouse, explains a greater amount of loneliness than does social isolation (Dugan and Kivett, 1994).

The link between loneliness and social isolation may have a precursor in natural human evolution. As a part of the natural human defence mechanisms of our ancestors, such as the fight or flight reflex, the experience of loneliness may have functioned as a natural 'proximity promoting mechanism' that worked to increase awareness of isolation and resultant vulnerability to danger (Kileen, 1998). In this way, loneliness had a positive function in promoting human well-being by stimulating human contact. However, in modern societies, where the threat of physical harm is absent or greatly reduced, the experience of loneliness can be a destructive emotion (Kileen, 1998). While vulnerability to danger may not be the result of isolation, the experience of loneliness that may arise out of such isolation can, nevertheless, represent a sense of vulnerability to danger on the part of the person experiencing loneliness.

While psychological and physiological models can be applied in explaining the function of loneliness, cultural factors play a role in the way that loneliness is experienced and expressed. For example, where stoicism is valued in society, people may not wish to reveal their loneliness to others and the experience may be hidden. In this same connection, a higher incidence of loneliness among women may be explained by the fact that it is culturally more acceptable for women to express their emotional difficulties than it is for men to do so (Tijhuis *et al.*, 1999).

In a discussion on the relationship between loneliness and social networks, Victor *et al.* (2002) observed:

The presence of large social networks does not necessarily imply the presence of a confiding relationship or protection from feelings of loneliness. Likewise living alone is not necessarily synonymous with reported loneliness.

This assertion notwithstanding, international research points to a relationship between the experience of loneliness among older people and aspects of their social network. The results of a Swedish study indicate that a meaningful social network, defined in terms of 'satisfaction with friend contacts', appears to be a support against loneliness and social isolation (Holmén and Furukawa, 2002). Social network type, network size, level of satisfaction with network, ethnic attachment and functional status of the network have been shown to be predictors of loneliness (Kim, 1999). A Norwegian study among the oldest old, which compared community and nursing home residents with regard to the experience of loneliness and the influence of social relationships, found that residents in nursing homes who had existing contacts with former neighbours reported significantly lower levels of loneliness, when compared to institutional residents without such contacts (Bondevik and Skogstad, 1996). Similarly, for residents in the community, there were significant differences in the experience of loneliness between those who had frequent contacts with family members and neighbours and those with infrequent contacts.

48

The quality of older people's social networks and social support may moderate the experience of loneliness. Participation in social activities has been found to result in significantly larger social networks and reduced feelings of loneliness among older people (Moorer and Suurmeijer, 2001). Both social and emotional loneliness have been shown to be correlates of each other (Green *et al.*, 2001) and social relationships, their extent and their quality, are associated with loneliness. For example, Hall-Eston and Mullins (1999) found that older people who are married with no children or friends experience greater loneliness, while Victor *et al.* (2002) reported that widowhood and divorce are risk factors for loneliness. Holmén *et al.* (2000) found that older people living alone experienced more social and emotional loneliness, when compared with those living with someone. In addition, loneliness has also been shown to be associated with older people's level of satisfaction with social contacts (Holmén and Furukawa, 2002). A supportive family and a partner appear to have a key role in preventing loneliness (Victor *et al.*, 2002). Thus, living alone in older old age and having a poor social network are correlated with both social and emotional loneliness (Holmén *et al.*, 2000). Rokach (1989) reported that the causal factor most commonly associated with loneliness was 'loss in general'.

Having a spouse provides an important source of both social and emotional support. Marital status is frequently reported as a correlate of loneliness; the absence or loss of a partner has been reported as being associated with increased loneliness among the very old (Tijhuis *et al.*, 1999). In rural settings, where there are limited opportunities for developing social attachments, the loss of a spouse may be particularly significant in precipitating loneliness (Dugan and Kivett, 1994). Data from the 1988 National Survey

of Families and Households in the United States demonstrated that widowed men and women reported higher levels of loneliness and depression when compared with married parents, regardless of parental status, and indicated that divorced parents were significantly more vulnerable to loneliness and depression (Koropeckyj-Cox, 1998).

A number of Irish studies have contributed to the body of knowledge concerning loneliness and its empirical correlates, including its association with social isolation. Whelan and Vaughan (1982) reported that the experience of loneliness was related to the quality and not the quantity of social contacts. Of the 10 per cent of older Irish people in the HeSSOP study who reported being 'bothered by loneliness', 40 per cent spent an average of 10 to 14 hours alone each day (Garavan *et al.*, 2001). Horkan and Woods (1986) found that those who identified living alone as a major disadvantage in their lives experienced a degree of loneliness, and the absence of company and the desolation following bereavement were the major factors associated with loneliness. Horkan and Woods (1986) also found that people who did not experience loneliness belonged to one of two sub-groups: those who had a positive attitude to life, keeping physically and mentally active, and those who were natural loners, liking their own company. Fahey and Murray (1994) reported that being widowed and living alone had the strongest association with the feeling of increased loneliness, far exceeding that of never being married. These same authors concluded that the *quantity* of social contact may have little bearing on the experience of loneliness, and that a single strong bond may be more important than multiple weaker ones in social relationships. In their analysis of data related to social contacts and the experience of feeling lonely, Fahey and Murray (1994) found that the sense of loneliness appeared to be unrelated to the levels of contact with family members.

1.4.4.4 Communities and Families

The type of society in which older people live may be an important variable in predicting loneliness; the prevalence of loneliness appears to be less common in rural areas, where a sense of community exists, than in more densely populated urban communities (Forbes, 1996). For example, rural older people in Taiwan, even those with no family living close to them, appeared to have a low incidence of 'high level' loneliness because of the closely knit nature of the Taiwanese rural community and the rural living arrangements that facilitate close interconnection among neighbours (Wang *et al.*, 2001). The level of loneliness among a sample of older Korean women was found to be negatively related to their level of social support network, social support satisfaction and family function, with family function reported to be a 'significant predictor' of loneliness (Kim and Baik, 2002).

In a meta-analysis of the correlates of loneliness in late adulthood, Pinquart and Sorensen (2001) reported that the quality of the social network was correlated more strongly with loneliness than its quantity. Contacts with friends and neighbours showed stronger associations with loneliness, when compared to contacts with family members. Being a woman, having a low socio-economic status and low competence, and living in a nursing home were also associated with higher levels of loneliness (Pinquart and Sorensen, 2001). An international comparative study of the living arrangements of older adults in the Netherlands and Italy demonstrated that the proportion living alone was much higher among older people without partners in the Netherlands, while the proportion co-residing with their adult children was higher in Italy than in the Netherlands (de Jong-Gierveld and van Tilburg, 1999). The study demonstrated that older adults in the Netherlands experienced more loneliness than those in Italy, indicating that household composition was still the most important determinant of loneliness. A Norwegian study of older people aged 85 and over demonstrated that a high frequency of social contacts with family, friends or neighbours was negatively related to both emotional and social loneliness (Bondevik and Skogstad, 1998). Moorer and Suurmeijer (2001) demonstrated that older people mostly have 'substantially sized social networks' and that they have few feelings of loneliness. It may be that social networks and loneliness are more strongly related to the psychological or social characteristics of older individuals, and are hardly influenced by the characteristics of their neighbourhoods (Moorer and Suurmeijer, 2001).

1.4.4.5 Quality of Life and Functional Ability

People's subjective quality of life can be a function of both individual and community factors. However, individual-level variables appear to be more consistently associated with subjective quality of life than community-level variables, such as a sense of community (Bramston *et al.*, 2002). The experience of loneliness is especially important in determining an individual's subjective quality of life; lonely people consistently reported significantly lower subjective quality of life, in relation to intimacy, community involvement and emotional well-being (Bramston *et al.*, 2002). Nevertheless, community factors can be important in older people's subjective quality of life. For example, a fear of crime can adversely affect their quality of life and ability to socialise (Benson, 1977).

The literature indicates that older people's functional ability in relation to their personal activities of daily living is associated with their perceived levels of loneliness. Functional independence corresponds with high levels of social and emotional loneliness, while dependence in certain activities of daily living, such as going to the toilet, transferring and dressing, has been shown to be significantly associated with low levels of both

social and emotional loneliness (Bondevik, 1997). A Norwegian study which examined the associations between functional ability, social relationships and loneliness among a sample of 221 older people aged 85 and over resident in Bergen revealed a range of associations among all three categories (Bondevik and Skogstad, 1998). Functional dependence corresponded with levels of emotional and social loneliness, dependence in activities of daily living, such as toileting and transferring, corresponded with low levels of social loneliness, while dependence on the environment in activities of daily living corresponded with low levels of emotional loneliness. The study also demonstrated that the frequency of the subject's social contacts was associated with loneliness and functional ability; high frequency of social contacts with family, friends or neighbours was related to lower levels of both emotional loneliness and social loneliness (Bondevik and Skogstad, 1998). It would seem that giving functional assistance provides the frequent social contacts that, in turn, can prevent or reduce loneliness.

In a Dutch study, which examined whether patterns of social network size, functional social support and loneliness were different for older persons with different types of chronic disease, Penninx *et al.* (1999) reported that greater feelings of loneliness were found for persons with lung disease and arthritis, while receiving more instrumental support was mainly found for persons with arthritis or stroke. A Scottish study comprising 318 people aged over 40 years and 373 people aged over 60 years demonstrated that loneliness was significantly associated with frequency of consultation at the GP's surgery (Ellaway, Wood and MacIntyre, 1999). Loneliness has been identified as a predictor of emergency department use among older people, independent of chronic illness (Geller *et al.*, 1999). Among a sample of approximately 3,000 older rural Americans, Russell *et al.* (1997) demonstrated a positive correlation between loneliness and admission to a nursing home over a four-year time period. Higher levels of loneliness were found to increase the likelihood of nursing home admission and to decrease the time until nursing home admission, and nursing home placement appeared to be a strategy to gain social contact with others (Russell *et al.*, 1997).

1.4.4.6 Loneliness, Morbidity and Mortality

While the mechanisms by which the social world impacts on physical health are poorly understood (Hawkey and Cacioppo, 2003), loneliness and social isolation have been shown to be associated with mortality and with patho-physiological and psychological morbidity. Loneliness may have implications for the health of the person experiencing it (Forbes, 1996) and it is an important predictor of well-being among older people; several researchers have demonstrated a relationship between loneliness and health status (Holmén and Furukawa, 2002). Health status can be both a predictor and a consequence of loneliness, and loneliness may act as a precipitant of declines in mental

and physical health (Russell *et al.*, 1997). For example, physical disabilities and mobility problems are associated with increased loneliness and loneliness may result in an increase in depression, altered sleeping pattern and disturbed appetite (Tijhuis *et al.*, 1999). Loneliness is also related to dietary inadequacies in older people (Walker and Beauchene, 1991).

In the way that it can adversely impact on an individual's ability to interact with others, altered physical and/or mental health can result in social isolation and loneliness (Kileen, 1998). By the same token, perceived loneliness can mediate perceived physical health: a study of a sample of older southern Americans demonstrated that feelings of loneliness decreased older people's evaluation of their physical well-being (Fees *et al.*, 1999). Loneliness may be a significant risk factor for a range of physical illnesses, from colds to heart disease (Geller *et al.*, 1999). Greater loneliness and low levels of both emotional support and companionship were found to be associated with an increased probability of having a coronary condition (Sorkin *et al.*, 2002).

A variety of different physiological mechanisms may operate to explain the long-term and short-term effects of loneliness on health across the life span; these include a weakening of the body's normal reparative processes and the initiation of physiological stress mechanisms (Cacioppo *et al.*, 2003). In a two-part study that examined the possible deleterious effects of loneliness on health, Cacioppo *et al.* (2002) demonstrated that cardiovascular activation and sleep dysfunction were associated with being lonely. The effects of loneliness on these pre-disease mechanisms also indicated an age-related association, with the effects greater in older adults. It is proposed that the physical effects of loneliness unfold over a relatively long time period (Hawkey and Cacioppo, 2003).

While loneliness has been correlated with physical health status in older adults, the predictive direction of either correlate is unclear (Fees *et al.*, 1999). Physical health may be a predictor of loneliness. Penninx *et al.* (1999) found that chronic disease characteristics played a differential role in the experience of loneliness; greater feelings of loneliness were mainly found for persons with lung disease or arthritis. This relationship may be a simple one, whereby altered health status affects older people's levels of physical activity (Victor *et al.*, 2002).

1.4.4.7 Loneliness and Psychological Morbidity

Åkerlind and Hörnquist (1992) suggest that loneliness may be significant at all stages in the course of alcoholism, both as a contributing and maintaining factor in the growth of alcohol abuse and as an encumbrance in attempts to give it up. The literature provides evidence of concordant reports demonstrating that alcoholics feel lonelier than members

of most other groups and this is compounded by the fact that the supportive value of the social network of alcohol abusers appears to be less stable when compared with that of people with other health problems (Åkerlind and Hörnquist, 1992).

Distinct types of loneliness may have differential associations. For example, social loneliness is associated with mental health problems, anxiety and depression, supporting the conceptualisation of loneliness as a multidimensional phenomenon (Cramer and Barry, 1999). Holmén, Ericsson and Winblad (2001), who examined the effects of loneliness on the state of mood of cognitively impaired and cognitively intact older people, demonstrated that loneliness and 'sad mood' were prevalent among cognitively impaired older people and that loneliness had a negative impact on their state of mood (Holmén, Ericsson and Winblad, 2001). Loneliness has been shown to be associated with psychological health and with people's sense of mental well-being. While loneliness is not a pathological state *per se*, its prevalence and its experience among older people may be associated with pathological states, most notably depression. Loneliness has been found to be positively associated with depression in people aged 65 and over (Minardi and Blanchard, 2004) and, along with chronic diseases and self-rated health, loneliness was reported to be the clearest predictor of depressed mood in people aged 75 and over (Heikkinen *et al.*, 2002). A sense of isolation and loneliness can be experienced as part of the experience of profound loss associated with severe mental illness (Baxter and Diehl, 1998). Alpass and Neville (2002) reported that loneliness was the most significant relationship to depression among older men in New Zealand, with lonelier men reporting higher scores on the Geriatric Depression Scale (GDS). Saklofske and Yackulic (1997) demonstrated a correlation between personality type and loneliness, suggesting that general and social loneliness were inversely related to extraversion, but positively related to neuroticism and emotional loneliness.

The report *Mental Disorders in Older Irish People: Incidence, Prevalence and Treatment* demonstrated that upwards of 23 per cent of persons aged 65 and over in the community had reliably diagnosable depression (13.1 per cent) or had depressive symptoms (9.7 per cent) (Keogh and Roche, 1996). The HeSSOP report (Garavan *et al.*, 2001) identified depression (7 per cent) among older people, with the highest prevalence being among older women and those living in rural areas. In the public mind, depression may be associated with suicide, and suicide, in turn, may be associated with loneliness and social isolation. However, the reasons for suicide may differ from those of younger adults and may also be associated with poor quality of health or social life (Keogh and Roche, 1996). Suicide among males over 65 years has doubled since 1980 and 12 per cent of all suicides were people aged 65 and over (Brenner and Shelley, 1998). However, suicide is difficult to measure and its prevalence may be under-represented in official statistics (Keogh and Roche, 1996).

Cognitive decline among older people may be a cause of loneliness (Russell *et al.*, 1997). However, this causative relationship may be complex. For example, in mild cognitive impairment, loneliness may result from older people avoiding social contact in order to hide their disability (Holmén and Furukawa, 2002), while in the more extreme cognitive impairment of dementia of old age, loneliness may result from older people's communication difficulties and inability to maintain meaningful social contacts (Holmén *et al.*, 1992). Holmén *et al.* (2000) reported that older people with dementia and those with increasing levels of cognitive impairment report higher levels of social loneliness. Holmén *et al.* (1999) reported a correlation between cognitive function and the experience of loneliness among a sample of older Swedish urban dwellers: a higher incidence of loneliness was found among subjects with cognitive impairment and experiencing loneliness had a negative influence on older people's state of mind.

1.5 Strategies for Preventing and Alleviating Loneliness

A key focus of concern for this study was to ascertain the strategies used to prevent and/or alleviate loneliness. Advocating and developing strategies for preventing and/or alleviating loneliness assume that loneliness is an undesirable and unwelcome state, and one that may be amenable to a range of possible interventions. Proposed interventions for preventing and alleviating loneliness range from social/community-level to individual-level approaches, with no apparent consensus as to which are the most effective strategies. Since loneliness is a complex human experience, the merits of the social/community-level approach may not necessarily counteract the demerits of the individual-level approach and vice versa.

Strategies for alleviating loneliness among older people can simply propose ways of improving older people's social networks with the aim of increasing the likelihood of social interaction. For example, Forbes (1996) proposes a range of activities, including adult education classes, involvement in community action schemes and locally organised outings, with the aim of providing lonely people with 'opportunities to reach out to others'. Similarly, Lauder *et al.* (2004) consider that understanding the cultural and sociological factors related to loneliness can provide the basis of interventions aimed at preventing and/or alleviating loneliness, and that the focus should be on community rather than individual-level interventions. However, such strategies implicitly assume that loneliness is associated with reduced or absent social contact and they fail to take account of the complex multidimensional nature of the loneliness experience, or the potential multiplicity of factors that contribute to the experience. Given the fact that loneliness can occur in the presence of social contacts, social intercourse will not, in and

of itself, prevent or alleviate loneliness. The fact that the experience of loneliness is ultimately a subjective one, suggests that individual-level strategies must feature in any attempts at preventing or alleviating loneliness. Rane-Szostak and Herth (1995) point to the importance of identifying those strategies employed by older individuals who, despite experiencing decreased socialisation or physical function, are not lonely, as a way of helping other older people to avoid loneliness and cope with the related losses so frequently experienced in later life.

Rane-Szostak and Herth (1995) have observed that, while most studies into loneliness focus on individuals who are already lonely, the findings suggest interventions that are dependent upon factors external to the individual, such as socialisation and functional status. They caution that such interventions are not always feasible for older adults, who may have experienced social and functional losses. Victor *et al.* (2002) warn that policies developed to alleviate loneliness should focus on 'the complex combination of factors that influence quality of life rather than respond to individual risk factors'. Loneliness interventions should be based on knowledge of and sensitivity to the precipitating factors other than mere chronological age; strategies for alleviating loneliness must be sensitive to factors such as loss of a spouse, infrequent visits from siblings and sensory impairment (Dugan and Kivett, 1994).

While the number of contacts with others may not be an important factor in remedying loneliness, the quality of the contacts with others may be a crucial element (Layte, Fahey and Whelan, 1999). Referring to the role of health care professionals in loneliness interventions, Lauder *et al.* (2004) caution that interventions that merely react to individual cases as they present may be ineffective, and may identify cases at a very late stage when other health problems have developed. Targeting loneliness for interventions in a preventative mode may be the most effective way for health care professionals to act. In this context Lauder *et al.* (2004) advocate the development of relationships and community networks that make for a healthier society, what they term 'social capital'.

A meaningful social network appears to be a fundamental support for reducing loneliness and social isolation (Hagberg, 1987); where social isolation is a factor in loneliness, strategies for promoting a meaningful social network are warranted. Dugan and Kivett (1994) propose that strategies for dealing with social isolation among older adults should be aimed at promoting communication and social contacts with siblings and peers. In a qualitative Irish study, Horkan and Woods (1986) described older people's ways of coping with loneliness, including 'getting out of the house', praying and communicating with friends by telephone or by writing. Mechanisms for coping with loneliness also included watching television, knitting, listening to the radio and visits by

the clergy (Horkan and Woods, 1986). Ways employed by individuals to overcome loneliness can include making moderations to lifestyle that reduce the likelihood of social isolation (Wenger and Burholt, 2003).

1.5.1 Policies and Programmes

In developing appropriate policy responses for alleviating loneliness, it is first of all necessary to understand the meaning that older people themselves ascribe to their loneliness experience and to understand their response to that experience (Victor *et al.*, 2002). Programmes for alleviating loneliness need to take account of the fact that loneliness may be either social or emotional. A programme that promotes the development of new social networks may be of little benefit in alleviating emotional loneliness caused by the loss of a spouse; what is needed are programmes that focus on attachment loss and provide opportunities for lonely people to meet potential attachment figures (Dugan and Kivett, 1994). This requires that the grief issues associated with the loss must first be addressed and resolved, and strategies to secure a replacement attachment figure be explored (Dugan and Kivett, 1994). The use of a bereavement support group may be beneficial in this regard. Despite the inappropriateness of strategies that promote social intercourse when emotional attachments are needed, maintaining social contacts over a period of time can reduce loneliness in the recently bereaved (Caserta and Lund, 1996).

Since loneliness and social isolation can be a function of older people's social circumstances, such as living alone and lower income, national strategies for reducing social exclusion can also act to reduce loneliness. The Irish Government has recognised the need to put in place 'special supports' for vulnerable groups, such as older people, in order to prevent social exclusion and achieve social inclusion (Department of Social and Family Affairs, 2003). Termed 'equality infrastructure', such supports bring together legislation and institutions, and include the Office for Social Inclusion, the Social Inclusion Consultative Group and the establishment of an Annual Social Inclusion Forum for people experiencing poverty and social exclusion. This infrastructure also aims to improve people's chances of employment and increases people's income through social welfare payments. For older people, additional resources for promoting social inclusion have been provided in recent years, including community support services, improvements in home help services, additional day care places for older people and economic support for voluntary organisations, such as the Alzheimer Society (Department of Social and Family Affairs, 2003).

1.6 Conclusions

This review examined the body of Irish and international literature concerned with loneliness and social isolation among older people. It critically examined the literature using the themes of older people's social networks, social relationships and social isolation, the nature, prevalence and experience of loneliness among older people, strategies for preventing and alleviating loneliness, and methodological issues in researching loneliness and social isolation. The review also examined demographic data relating to older people and their experiences.

Older people are not a homogenous group. Their heterogeneity is a function of their social and economic circumstances, and older people differ qualitatively in the rate at which they age, and in the quality and quantity of their social interactions (Horkan and Woods, 1986). Demographic data concerning the social circumstances of older people in Ireland indicate that they are living longer and are increasingly living alone or with an older partner. The quality of life experienced by older people is an important concern for social policy-makers, and such concern has given rise to a large body of empirical research into the phenomena of loneliness and social isolation among older people.

Irish people have generally high levels of social contact and family networks remain strong within Ireland, representing the basis of much of the social intercourse between people. Social isolation can be part of the experience of being old and, while it can be construed as an objective state by social researchers, older people may experience it subjectively. A range of factors is associated with social isolation: its predictive correlates include the range and quality of social networks, while one of its principal consequential correlates is loneliness.

The literature suggests that loneliness is a complex, multidimensional phenomenon of which there are two principal variants, social and emotional loneliness. The experience of loneliness impacts on individuals across the lifespan and its prevalence has been explored in groups ranging from teenagers to the oldest old. Loneliness is prevalent across the entire population, and international empirical research indicates that, despite there being a widely held stereotype associating old age with social isolation and with loneliness, only 5 to 15 per cent of older adults report experiencing frequent loneliness (Pinquart and Sorensen, 2001). The literature indicates that loneliness has numerous correlates, some of which are predictive and others consequential. Strategies for alleviating loneliness can propose a range of measures for promoting social intercourse. However, effective alleviation of loneliness must take account of the complexity and individuality of the experience, most especially its precipitating and perpetuating factors, and the meaning of the experience to the individual.

Chapter Two

Study Design and Methods

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2.1 Introduction

This research sought to explore the experiences of loneliness and social isolation as described by older people, and to identify the strategies of intervention and good practice that older people themselves believe would alleviate or prevent loneliness. The study involved both quantitative and qualitative methods. Quantitative methods were used to collect data in order to: record the prevalence of loneliness and social isolation among older people; examine and compare the prevalence of loneliness and social isolation among older groups; and provide a profile of those older people describing loneliness.⁶ Qualitative methods were used to explore how older people describe the experience of loneliness and social isolation, and the strategies that older people prefer to alleviate loneliness and social isolation. The research explored these questions with older people

2.2.1.1 Demographic Data

A number of population characteristics of older people were measured in the survey. The aim was to identify social predictors that are related to loneliness and social isolation. As highlighted in the literature review, a number of previous studies have identified differing levels of loneliness and isolation in groups of older people with different demographic characteristics. It was therefore proposed that the survey comprehensively measure a number of socio-demographic and health characteristics to determine their influence on reports of loneliness and social isolation. These characteristics included age group, gender, marital status, area of residence (urban or rural), health status and family contact.

2.2.1.2 Using Survey Instruments to Measure Emotional and Social Loneliness

The operational definition of the concept of loneliness has led to the development of a number of reliable and valid measurement instruments. Instruments used in the measurement of loneliness can be classified as those measuring the concept as invariant and unidimensional (Allen and Oshagan, 1995; Russell, 1996; Cramer and Barry, 1999) or a multidimensional concept, where loneliness is differentiated into typologies (Weiss, 1973; DiTommaso and Spinner, 1993). Multidimensional typologies generally conceptualise loneliness as either emotional or social (Weiss, 1973). The instruments most commonly used by researchers include: the UCLA Loneliness Scale (Russell, 1996), the Social and Emotional Loneliness Scale for Adults (SELSA) (DiTommaso and Spinner, 1993, 1997), the de Jong-Gierveld Loneliness Scale (de Jong-Gierveld, 1987), the Differential Loneliness Scale (Schmidt and Sermat, 1983) and the Loneliness Rating Scale (Scalise *et al.*, 1984). One of the problems with the majority of these instruments that are available is that they have been administered to limited populations. The single most researched group on the construct of loneliness are convenience samples of university students. This calls into question the external validity of the instruments when used with other populations, such as older people.

Therefore, in identifying a questionnaire for the project, a number of aspects of the instruments reviewed were taken into consideration. These included the utility of the instrument for the older person, comprehension of the items that make up the instrument, the time the instrument takes to complete and the applicability of the questionnaire to the Irish context. Taking these factors into consideration two instruments were identified to measure loneliness and the social support networks available to older people. These were the SELSA (DiTommaso and Spinner, 1993, 1997; Cramer *et al.*, 2000) and the Network Assessment Instrument (Wenger, 1994).

2.2.1.3 Social and Emotional Loneliness Scale for Adults – Short Form (SELSA-S)

The original SELSA is a 37-item multidimensional instrument that measures the constructs of both social and emotional loneliness. It further divides emotional loneliness into subscales that measure family loneliness and romantic loneliness (DiTommaso and Spinner, 1993, 1997; Cramer *et al.*, 2000). It has been claimed that it is a superior instrument to other loneliness measures due to its multidimensional rating of loneliness (Cramer and Barry, 1999). However, one of the major disadvantages of the scale is its length, requiring respondents to answer 37 items on the scale as well as extra demographic data. To counter this problem, DiTommaso *et al.* (2004) recently developed and tested a short-version SELSA instrument (SELSA-S) that consists of 15 items from the original full version, comprising a five-item family loneliness subscale, a five-item romantic subscale and a five-item social subscale. Items are rated on a seven-point scale ranging from strongly disagree to strongly agree. The advantage of using the SELSA-S was that it reduced the burden of older people responding to a large number of questions during a telephone survey.

Examples of items in the SELSA-S include:

1. I really belong in my family. (family loneliness)
2. My family really cares about me. (family loneliness)
3. I have a partner who gives me the support and encouragement I need.
(romantic loneliness)
4. I have friends that I can turn to for information. (social loneliness)
5. I have friends to whom I can talk about the pressures in my life. (social loneliness)

A recent psychometric study of the SELSA-S (DiTommaso *et al.*, 2004) identified that, when used with university students, spouses of military personnel and psychiatric patients, the internal reliability of the three scales was high (Cronbach's alpha ranged from 0.87 to 0.90). No studies were found, however, that examined the reliability of using the SELSA-S with older people in the context of this study or with the administration of the instrument by telephone interview. Therefore, reliability analysis of the social, family and romantic scales was undertaken (Table 2.1). The internal consistency of the three scales ranged from α 0.75 to α 0.90. These results compare

favourably with the reported internal consistency measures reported by DiTommaso *et al.* (2004) and indicate high reliability. The intercorrelations of the three scales were higher than that reported in the literature. However, the results show that the relatively low intercorrelations indicate that the three loneliness subscales are independent constructs.

Table 2.1: Cronbach’s alpha (confidence intervals) and intercorrelations of the three SELSA-S subscales for the overall sample⁷

Subscale	Social	Family	Romantic
Social	0.90 (0.89 to 0.91)	0.44*	0.30*
Family		0.75 (0.72 to 0.78)	0.46*
Romantic			0.80 (0.78 to 0.83)

*p <0.001

Previous testing of the SELSA-S has ascertained content, concurrent, discriminant and construct validity of the research instrument (DiTommaso *et al.*, 2004). Concurrent validity was indicated by statistically significant relationship with other loneliness scales. The differentiation among the SELSA-S scales and other measures of life experiences was also reported to be statistically significant. Factor analysis has previously shown that the SELSA-S fits a three-factor model (DiTommaso *et al.*, 2004).

2.2.1.4 Examining the Construct of Social Isolation through the Measurement of Social Support Networks

The construct of social isolation has not been explored in the literature to the same extent as loneliness. Generally, there are limited operationalised instruments that measure isolation. Those that do exist are combined within loneliness inventories (DiTommaso and Spinner, 1997). Dugan and Kivett (1994) operationalised isolation through the measurement of social interaction with the older person’s children and relatives, the number of times they had moved home in three years, the frequency of talking on the telephone and the number of times they met with friends or took part in group/social activities. However, recently, a more comprehensive method for identifying social networks, the Network Assessment Instrument, has been identified by Wenger (Wenger, 1994; Wenger and Burholt, 2002).

The constructs of loneliness and social isolation are associated with the level of support an individual receives from their social networks. Wenger identified social networks as

7. n=669. Cronbach’s alpha on the diagonal and correlations above the diagonal.

individuals, family and communities who are involved with the person in a significant way. These networks include members of the older person's household, the provision of companionship and friendship, emotional support and help from individuals and the community. The instrument developed by Wenger allows for the identification of the support the individual receives within their social network. These supports are identified in five areas, as shown in Table 2.2.

Table 2.2: Network types (Wenger, 1994)

Network type	Description of network
Family-dependent support network	This network is focused mainly on close local family ties, with few peripheral friends or neighbours. Individuals in this category have the majority of their support needs met by their family. Community involvement is low. Older people falling into this profile have been found to be more likely to be widowed, older and in poorer health than people in other networks.
Locally integrated support network	This category is associated with close relationships with family, friends and neighbours. Respondents in this category are usually found to be living long-term at their residence and have active community involvement in either religious or voluntary organisations.
Local self-contained support network	This category groups the respondent as having infrequent contact with at least one relative living in the same community (sibling, niece or nephew). Reliance for social contact and support is mainly on neighbours and lifestyle is focused on the household. Community involvement is very limited.
Wider community-focused support network	This network is classified by an absence of local relatives (including children). However, contact is maintained over a distance and there is an engagement in community and voluntary organisations. Individuals in this network make a distinction between family and neighbours.
Private restricted support network	This network is characterised by a lack of local relatives and very little contact with neighbours or community involvement. Older people in this group tend to rely on their spouse or are withdrawn and have become isolated from local community involvement.

Examples of items in the Network Assessment Instrument include:

1. How often do you see any of your children or other relatives to speak to?
2. If you have friends in this community/neighbourhood how often do you have a chat or do something with one of your friends?
3. Do you attend meetings of any community/neighbourhood or social groups, such as old people's clubs, lectures or anything like that?

This instrument, in conjunction with demographic data, was used to enable the researchers to identify social networks that the majority of older people living in Ireland are a part of today. This enabled the researchers to identify groups in society who are living in low-level support networks.

2.2.2 The Sample

Currently in Ireland, there is no sampling frame that specifically identifies older people. Respondents were therefore randomly contacted by telephone using a technique known as Random Digital Dialling. The process involved respondents being introduced to the study, given information about the study and being asked for permission to continue.

A total number of 9,711 calls were made.

If no-one was available in the household after five contacts, the next random telephone number was contacted until the desired sample size was reached. This was to ensure accurate sample coverage and to reduce sampling error. 874 older people were contacted and 683 agreed to take part in the study.

The use of telephone surveys has been found to be effective in reassuring respondents about a survey as well as clarifying points that an individual may not understand (Dillman, 2000). The percentage of households in Ireland with a fixed telephone line is 88.4 per cent in urban areas and 90.6 per cent in rural areas (CSO, 2001). The availability of free telephone and line rental for those aged 65 and over justifies this method as a means of communication. Other studies completed in Ireland have utilised this method of contacting populations, for example, the Department of Public Health Medicine and Epidemiology in UCD, the Food Safety Authority of Ireland and the Royal College of Surgeons in Ireland.

2.2.2.1 Sample Size

The acceptable sampling error was set at 3 per cent at the 95 per cent level of confidence with a possible 80/20 variation. This resulted in a sample of 683 respondents aged 65 and over. The overall response rate for the study was 78 per cent (Figure 2.1). This very high response rate for a public survey compares favourably with other reported telephone survey response rates. Previous studies by Power (1980) highlighted a minority of older people with telephones. However, in a subsequent 1994 report published by the NCE, the extent of telephone ownership in Ireland increased from 25,000 to 78,000 and 90 per cent of these were obtained by older people.

The *Sexual Abuse and Violence in Ireland* report (McGee *et al.*, 2000) reported a response rate of 71.4 per cent and the *Surveys of Lifestyle, Attitudes and Nutrition* (Friel *et al.*, 1999; Kelleher *et al.*, 2003) obtained response rates of 62 per cent and 53 per cent respectively. High response rates suggest that the results can be considered representative of the general population (McGee *et al.*, 2000).

The high response rate was achieved through multiple strategies used to encourage participation. These strategies included:

- use of experienced interviewers
- supervision of interviewer calls
- call-back procedure
- limiting length of questionnaire to maximum of 15 minutes
- lo-call number given to verify study credentials prior to participating
- provision of Senior Help Line phone number.

2.2.3 Conduct of the Telephone Survey

Interviewers were recruited and received training prior to conducting the interviews. In addition, interviewers were supervised throughout the telephone interviews. Each interviewer was provided with a pack outlining the process that the interview should take and describing the system for call backs, respondent queries and non-response. All interviewers were female. The majority of interviews lasted between 15 and 25 minutes. Respondents were not specifically asked if they lived alone because it was felt that this could impact on their sense of security and thus well-being.

Figure 2.1: Profile of telephone numbers utilised

2.2.4 Data Analysis

Data was analysed using descriptive statistics, inferential statistics and multiple regression techniques. Descriptive statistics described the demographic profile of the sample and their experience of loneliness and social isolation. Inferential statistics, mainly chi-square, t-tests and Analysis of Variance (ANOVA), were used to identify differences between various categories of older people, for example, area of residence, marital status and access to transport. The final level of analysis used multiple regression techniques to determine which socio-demographic variables are predictors of loneliness and social isolation. The socio-demographic variables used were age group, gender, marital status, area of residence (urban or rural), health status and family contact. Data analysis was completed using SPSS (version 11.0) statistical package.

2.3 Qualitative Methods

Qualitative methods were used to explore how older people describe the experience of loneliness and social isolation, and the alleviation strategies that they prefer to use. A grounded theory approach was employed in order to gain an understanding of the concept of loneliness. The strength of this design is that it develops theoretical explanations of the realities of the people under study that can be linked to existing theory on the subject of loneliness. As suggested in the term, 'grounded theory' seeks to improve understanding of loneliness as it is grounded in the experience and context of the older person. The research questions were addressed, firstly, to older people themselves (Strand One) and, secondly, to key stakeholders and providers of services for older lonely people (Strand Two). The data collection and sampling for Strands One and Two are outlined in the following sections.

2.3.1 Strand One

The purpose of Strand One was to explore with older people their experiences of loneliness and social isolation. This was achieved through in-depth interviews. In addition, a focus group discussion was conducted with older people to identify potential strategies for the alleviation of loneliness and social isolation.

2.3.1.1 In-depth Interviews

The advantage of the in-depth interview is that it provides the researcher with detailed insights into the reality of the person being interviewed. In studies such as this, where the attempt is to understand the experience of loneliness from the perspective of the person who has experienced it, in-depth interviews are the data collection method of choice (Polit and Hungler, 1991). This is particularly important in the light of research detailing the difficulty some people have talking about the experience of loneliness (Weiss, 1973).

Individual interviews were carried out by a researcher who had extensive knowledge and experience in the care of older people and of undertaking in-depth interviews. In this kind of interview, where participants might identify themselves as a marginalised group, it is important that the researcher builds up a rapport with the participant. Thus, the interview duration was up to two hours.

Interviews were tape-recorded and transcribed verbatim. Technology can be intrusive and inhibitory but the interviewer endeavoured to make the participant feel as

comfortable as possible. For example, the researcher began each interview with a non-threatening conversational style and offered a certain amount of self-disclosure. These techniques can offset this problem and the benefit of having a verbatim record of the data is invaluable for rigorous investigation (Field and Morse, 1985). A semi-structured approach was adopted for interviews to allow for new lines of questioning to develop as interviews progressed, while at the same time ensuring that the breadth of data collection required was achieved. This approach also allowed for participants' views to emerge with little imposition of the researcher's perspective (Polit and Hungler, 1991). Questions were developed to explore loneliness, isolation, and prevention and coping mechanisms. In addition, examples from the participants' life experiences were sought.

An interview guide was developed around the research questions, the areas covered in the telephone survey and by drawing on a review of the literature. Once a number of interviews had been conducted, the research team undertook a review of the interview transcripts. At that stage it was decided that beginning each interview with a more detailed personal history would help to highlight recent changes in lifestyles and would provide a basis for later discussion. It was also felt that a deeper exploration of the quality of participants' friendships would be useful. The interview guide for subsequent interviews was revised accordingly.

2.3.1.2 Focus Groups

Over the course of the interviews it became apparent that only a minimal number of suggestions for strategies and policies for the prevention of loneliness and social isolation were identified. Therefore, the decision was made to conduct one focus group discussion with older people living in a rural area. A total of nine older people took part in the focus group discussion and the sampling criteria used for this group were the same as those used to guide the one-to-one interviews.

Since focus group discussions were conducted with managers and providers of services for older people in order to discuss existing policy approaches to the issue and to identify strategies for the alleviation of loneliness, it was thought appropriate to give older people themselves an opportunity to discuss ideas and strategies in the forum of a focus group.

The focus group topic guide was informed by ideas and suggestions that arose in the one-to-one interviews. In order to protect the privacy of older people attending the focus group, questions and discussion of a personal nature were avoided and the moderator kept the discussion focused on general ideas and suggestions for the alleviation of social isolation and loneliness, rather than on experiences of loneliness *per se*. The focus group was approximately one hour in duration and was tape-recorded and transcribed verbatim.

2.3.1.3 The Sample

For individual interviews, a purposive or judgement sample was used initially, whereby participants were chosen on the basis of existing theory about the members of society who are known to experience loneliness. Within the grounded theory approach, theoretical sampling is crucial to the generation of theory. Theoretical sampling involves continued sampling on the basis of concepts that have proved to have relevance to the evolving theory on loneliness (Strauss and Corbin, 1990). Thus, items identified as interviews progressed were taken up and explored in subsequent interviews. This necessitates that sampling and data analysis happen hand in hand as one informs the other.

The following criteria were used to guide the selection of participants:

1. The person is over 65 years old.
2. The person describes themselves as lonely at some time in their life.
3. The person does not have a profound hearing problem.
4. The person does not have severe mental health problem/cognitive disability (for example is under the care of a psychiatrist).
5. The person can speak English.
6. The person can give fully informed consent to their participation.

Interviewing the profoundly deaf and cognitively impaired would have necessitated major adaptations and added considerable expense to the data collection, features not realistic within the timescale and financial resources available for the research. In addition, this would have reduced the number of accounts of loneliness that could be meaningfully compared. It could also have led to suggested findings about specific conditions rather than loneliness. For example, people with respiratory problems have been found to be lonely in previous literature (Monso *et al.*, 1998). It is likely that one of the solutions to loneliness in this case is effective management of the disease. This would be a distraction from the study of loneliness *per se*. People with mild dementia symptoms or sensory disabilities were not excluded from the research as long as they met the criteria. Frail older people were not specifically omitted from the study but some felt that they were too frail to be interviewed.

Two health board areas were chosen: the first to reflect urban participation and the other to reflect rural participation. In total, 16 interviews were undertaken in the urban region and 18 in the rural region. Initially, it was intended to interview at least four participants without a telephone. However, identifying such people was not easy. Only one of the samples did not have a telephone; a further participant was identified but failed to meet the inclusion criteria. When the study was explained to participants, only ten people declined to be interviewed. This was on the basis of ill-health, because they did not feel they had anything to contribute, individual preference, or (in one case) they did not want to be tape-recorded.

Participants were identified through public health nurses (PHNs) working in the two areas, nursing homes, active retirement groups, Friends of the Elderly and a community centre. Permission was sought by the above agencies from participants to pass on their details to the research team. Upon their receipt, members of the research team followed this up shortly afterwards with a telephone call and arranged a time to visit to explain more about the study. In some cases, participants asked that the interview be conducted at the time of the initial visit. In some cases, details of the study were presented to group sessions or meetings and participation invited. The study was explained and interested participants were given details of the study and a copy of the information sheet to read. Contact details were obtained at the same time. This was followed up by a telephone call a few days after the meeting and a time was arranged to conduct the interviews. The sample of participants living in the three nursing homes ($n=3$) was identified with the help of the Directors of Public Health Nursing. Directors of Public Health Nursing provided names of nursing homes that might wish to take part in the study. The person in charge of the nursing home was telephoned and the study described, followed by a letter providing further details of the study. Personnel in the nursing home were also given details of the study and identified participants who wanted to take part. A time was arranged for the researcher to visit and answer any questions about the study.

An end point to this sampling described as 'theoretical saturation' should be achieved in order to generate a theory (Glaser and Strauss, 1967). Theoretical saturation had occurred when no new themes central to the substantive area of loneliness emerged from the data. Hence sampling criteria were adhered to and sampling was terminated when the emerging analysis generated produced 'thick' or 'rich' descriptions of categories and their relationships (Seale, 1999).

The focus group was arranged with the help of a PHN and a nurse who worked in a day centre for older people. Both nurses sought the participation of older people in the area by explaining the study and giving interested people a copy of the information sheet.

Participants were given the opportunity to pose questions about the research to the nurses helping to organise the group and also to the researcher before commencement of the discussion.

2.3.2 Strand Two

Strand Two sought to explore the views of stakeholders in relation to older people's experiences of loneliness and isolation, and also to identify strategies for the prevention and alleviation of loneliness using focus group discussions.

2.3.2.1 Focus Groups with Key Stakeholders

Focus group discussions were conducted with planners, managers and providers of services for older people. The major advantage of this method of data collection is that it allows a wide range of participants' views on a topic to be explored in a social setting (Hansler and Cooper, 1986). Focus groups are not concerned with consensus-building; rather they seek to explore all participants' feelings on a topic within a dynamic, discursive environment (Folch-Lyon and Trost, 1981). Separate topic guides for managers' and providers' discussions were devised by the research team and were informed by current literature on the topic. Each focus group discussion lasted approximately one and a half hours, and was tape-recorded and transcribed verbatim.

2.3.2.2 The Sample

Two focus groups were conducted in each health board area (four in total). Each group was largely homogenous and this was achieved through recruiting group members who were cohesive in terms of occupational role. Two focus groups (one in each area) were made up of managers, planners and co-ordinators of services for older people and the remaining two (one in each area) consisted of providers of services for older people. A range of key stakeholders from a variety of statutory and voluntary organisations was represented. The composition of each focus group is detailed in Figure 2.2. Written invitations to take part in the study were sent to potential participants along with an information sheet.

Figure 2.2: The composition of focus groups with key stakeholders

Planners Area A	Providers Area A
Director of Services for the Elderly Director of Public Health Nursing Care of the Aged Committee member Psycho-Geriatrician Information Officer Health Promotion Officer for the Elderly	Public Health Nurse (2) Home Help (2) Social Worker for the Elderly Community Warden (2) Day Centre Voluntary Worker Community Worker Priest Representative from Active Retirement
Planners Area B	Providers Area B
Director of Services for Older People Manager of Services for Older People (3) General Managers (2) Director of Nursing (residential care) Director of Public Health Nursing Representative from Alone Representative from Friends of the Elderly Representative from FARA	Representative from Alone Representative from FARA Representative from Senior Help Line Social Worker Community Psychiatric Nurse General Practitioner Care Attendant Public Health Nurse

2.3.3 Analysis

Data analysis was undertaken in the same way for Strands One and Two using the constant comparison method. Constant comparison is a feature crucial to grounded theory research (Glaser and Strauss, 1967). Constant comparison involves the researcher identifying similar and deviant utterances, and grouping them together around a theme for comparison. Initially, open coding of interview texts was undertaken, whereby signposts were placed on insightful and specific instances in the text. Labels were then applied with as little interference as possible in order not to lead the researcher away from new concepts and relationships that emerged. Subsequently, axial coding was undertaken, grouping of signposts according to their fit into categories and sub-categories (Glaser, 1992). This engages the researcher in a meaningful analysis of the concept of loneliness, related themes and their relationships. It should be stressed that much of the validity of a study such as this lies in the clarity with which the reader can assess and evaluate the researchers' interpretations. Data from the interviews was managed using the computer package NVivo, which ensured that a clear decision trail was authenticated from the data.

2.4 Ethical Considerations

Throughout the planning, conduct and reporting of this study, every effort has been made to ensure that the research complies with the highest standards of ethical practice. Care was taken to ensure that participants were adequately informed about the purpose of the research, what participation would entail for them, and the benefits and risks associated with it. Further to ensuring that consent was provided, the inclusion criteria stipulated that participants with a profound hearing problem, with a severe mental health problem or cognitive disability, or who were unable to speak English should not be included. In the research design, consideration was given to interviewing the very frail and including a question in the survey about whether the participant lived alone. Several people referred by the PHNs felt they were too ill to be interviewed, and for this reason the very frail may not be represented in the sample. In addition, in the telephone survey, participants were not asked if they lived alone because this might have impacted on their sense of security and affected their sense of well-being.

Participants were advised that their participation was entirely voluntary and that they had the right to withdraw from the study at any time. Participants were assured that their confidentiality would be protected and findings reported anonymously. Quantitative information was obtained using anonymous questionnaires. Qualitative information solicited was stored in a locked drawer and in password-protected files and will be destroyed a year after completion of the study. Information was supported with a written information sheet and consent was obtained from all participants.

Care was taken to ensure that participants were properly supported in the event that involvement in the process unearthed feelings of loneliness or distress. This included training of interviewers, ensuring interviews were not rushed and that there was time for the researcher to build a rapport with the respondent. The number of the Senior Help Line was given to participants so that they could use the service if they experienced any delayed feelings of distress.

Approval to conduct the research study was sought from and granted by the Human Research Ethics Committee, University College Dublin. Ethical approval and access were also sought through the appropriate ethics committees of the two health board areas. Where participants were identified through a third party, care was taken to ensure that participants were happy to be contacted by the researchers.

Chapter Three

Survey Findings

Chapter Three

Survey Findings

3.1 Introduction

This chapter describes the findings from the national telephone survey of 683 people aged 65 years and over. Loneliness was assessed using the SELSA-S and social isolation was measured using the Network Assessment Instrument. The SELSA-S measured both social loneliness and emotional loneliness. The Network Assessment Instrument enabled the network of family, friends and neighbours whom older people use for companionship, advice and instrumental help to be profiled. An open-ended question was also asked at the end of the interview to ascertain strategies used by each respondent to reduce their loneliness and social isolation. A number of population characteristics of older people were also measured in the survey. The aim was to identify social predictors that are associated with loneliness and social isolation. A number of previous studies have identified differing levels of loneliness and isolation in groups of older people with different demographic characteristics.

3.2 Profile of the Respondents

To ensure the results obtained were demographically representative, they were compared to national demographic information from the most recent census data (CSO, 2002). Twelve questions gathered data from the respondents specifically related to key socio-demographics including age, gender, marital status, residence, educational level, occupation and family related issues.⁸

The survey respondents comprised 39.1 per cent male and 60.9 per cent female. The age of the respondents ranged from 65-99 years (mean = 73.5, SD 7.1). In relation to age, the sample was very similar for men and women in comparison to general population proportions. There was, however, a smaller proportion of women in the 75-79 years group (16.8 versus 21.2 per cent) and in the 85+ years group (8.0 versus

8. Denominators vary as not all questions in the survey were answered.

11.1 per cent) in the study than that found in the population (Table 3.1). Further socio-demographic profiles are shown in Appendix 2.

Table 3.1: Demographic comparisons of the gender, age, marital status and location of residence of the study sample and the population aged 65 years and over in Ireland

Characteristics	Male		Female	
	Study	General population	Study	General population
Gender (n=675)	39.1%	43.4%	60.9%	56.6%
Age	(n=261)		(n=400)	
65-69 years	34.1%	34.5%	27.5%	27.6%
70-74 years	33.0%	27.3%	32.5%	24.5%
75-79 years	17.2%	19.8%	16.8%	21.2%
80-84 years	9.6%	11.8%	15.3%	14.8%
85+ years	6.1%	6.6%	8.0%	11.9%
Marital status	(n=264)		(n=401)	
Single	12.9%	20.3%	12.5%	15.4%
Married	66.7%	62.8%	38.7%	35.7%
Divorced/separated	3.4%	2.5%	2.0%	1.7%
Widowed	17.0%	14.4%	46.9%	47.2%
Residential location	(n=683)			
Urban	60.1%			
Rural	39.9%			

3.3 Social and Emotional Loneliness

Social and emotional loneliness amongst older people in Ireland was measured using the SELSA-S. Respondents were asked to rate their agreement with the statements on a seven-point Likert scale (1 = strongly disagree; 7 = strongly agree) of how they felt in the last year. The data obtained from the questions that made up the scales was then reduced from seven to three categories: disagree (inclusive of strongly disagree,

disagree and disagree somewhat); unsure (category unchanged); and agree (inclusive of strongly agree, agree and agree somewhat) (Table 3.2).

Table 3.2: Profile of social and emotional loneliness subscales (SELSA-S)^{9,10}

Characteristics	Disagree (n)	Unsure (n)	Agree (n)
Social subscale			
1. In the last year I felt part of a group of friends. (n=676)	8.7% (59)	1.0% (7)	90.2% (610)
2. In the last year my friends understood me. (n=671)	3.7% (25)	5.5% (37)	90.8% (609)
3. In the last year I didn't have a friend. (n=672)	94.1% (632)	0.4% (3)	5.5% (37)
4. In the last year I was able to depend on my friends for help. (n=673)	6.3% (43)	1.8% (12)	91.8% (618)
5. In the last year I didn't have a friend or friends who cared about me. (n=672)	93.3% (627)	1.0% (7)	5.7% (38)
Family subscale			
6. In the last year I felt alone when I was with my family. (n=675)	84.0% (567)	0.6% (4)	15.4% (104)
7. In the last year there was no one in my family that I could depend on for support and encouragement. (n=673)	94.7% (637)	0.4% (3)	4.9% (33)
8. In the last year I felt close to my family. (n=670)	1.9% (13)	0.4% (3)	97.6% (654)
9. In the last year I felt part of my family. (n= 671)	2.2% (15)	0.6% (4)	97.2% (652)
10. In the last year my family really cared about me. (n=671)	1.8% (12)	1.3% (9)	96.9% (650)

9. Denominators vary for the three subscales as not all questions were answered.

10. Some items are negatively worded.

Table 3.2 (contd.): Profile of social and emotional loneliness subscales (SELSA-S)

Characteristics	Disagree (n)	Unsure (n)	Agree (n)
Romantic subscale			
11. In the last year I had a partner/friend with whom I shared my thoughts and feelings. (n=675)	35.7% (241)	0.4% (3)	63.9% (431)
12. In the last year I had a partner/friend who gave me the support and encouragement I needed. (n=673)	30.3% (204)	1.8% (12)	67.9% (457)
13. In the last year I wish I had a closer relationship. (n=672)	79.2% (532)	5.1% (34)	15.7% (106)
14. In the last year I had a partner who made me happy. (n=666)	51.4% (342)	0.9% (6)	47.7% (318)
15. In the last year I would have liked a closer relationship with another person. (n=671)	79.1% (531)	7.9% (53)	13.0% (87)

Table 3.2 shows the level of agreement or disagreement by the respondents to each of the questions that comprise the subscales of the SELSA-S. The questions that comprise the social subscale show that the majority of the sample had good support from friends. Over 90 per cent reported that they had a friend and were able to depend on their friends for help. Similarly, the majority of the sample reported that in the last year they received support and care from their family. However, 15 per cent reported feeling alone when they were with their family. The replies from the respondents to the questions regarding romantic loneliness, which measures emotional attachment, showed a large percentage reporting a lack of contact or relationship with a romantic partner or close friend. Over 63 per cent agreed with the statement 'In the last year I had a partner/friend with whom I shared my thoughts and feelings'. However, over a third (35.7 per cent) disagreed with the statement. Over half of the sample (51.4 per cent) disagreed that 'In the last year I had a partner who made me happy'.

The addition of the scores obtained from the five variables in each of the three subscales and division by five calculated the mean levels of social and emotional loneliness. The levels of loneliness reported by each of the subscales ranged from 1 (absence of loneliness) to 7 (severe loneliness).

Overall loneliness scores were low for the sample. The mean levels of reported loneliness ranged from a low of 1.9 (family loneliness) to a medium loneliness score of 3.2 (romantic loneliness). Social loneliness was rated overall at an average of 2.1 (Table 3.3).

Table 3.3: Overall levels of loneliness and levels of loneliness by gender

Characteristics	Social loneliness Mean (SD)	Family loneliness Mean (SD)	Romantic loneliness Mean (SD)
All respondents	2.1 (0.95)	1.9 (0.72)	3.2 (1.32)
Male	2.1 (0.73)	2.0 (0.71)	2.9 (1.31)*
Female	2.2 (1.10)	1.9 (0.73)	3.4 (1.28)*

*($t=4.9$, $df=654$, $p<0.001$)

Males and females had slightly different loneliness scores in relation to social loneliness and family loneliness; however these differences were minimal. Nevertheless, female respondents were significantly more likely to be romantically lonely than males.¹¹ An overall loneliness level of 3.4 indicates moderate levels of romantic loneliness.

Different levels of loneliness were found in relation to marital status (Table 3.4). Respondents who were single reported significantly higher levels of family loneliness compared to respondents who were either married or widowed.¹² However, a loneliness score of 2.5 is relatively low. It should be noted that older people who were married scored a very low family loneliness score of 1.8. Overall levels of social loneliness were slightly higher than family loneliness but still relatively low. The highest loneliness scores were in relation to romantic loneliness. Single and widowed respondents scored moderate to high romantic loneliness scores when compared to married respondents, indicating that in the last year they would have liked to have had a closer emotional relationship with a close friend or romantic partner.¹³ Of those who were widowed, the majority were women (80.7 per cent). The mean length of time widowed was reported as 15.3 years.

11. $t=4.9$, $df=654$, $p<0.001$

12. $F=20.0$, $df=4$, 654 $p<0.001$

13. $F=199.0$, $df=4$, 650 $p<0.001$

Table 3.4: Marital status and levels of loneliness

Characteristics	Social loneliness Mean (SD)	Family loneliness Mean (SD)	Romantic loneliness Mean (SD)
Single	2.2 (1.1)	2.5 (1.1)	4.3 (1.0)
Married	2.0 (0.9)	1.8 (0.6)	2.2 (0.8)
Widowed	2.2 (1.0)	2.0 (0.7)	4.1 (0.9)

Table 3.5 shows the levels of loneliness for the sample in relation to age groups. The respondents aged 65-74 years reported the lowest levels of social¹⁴, family and romantic¹⁵ loneliness of all three groups. The oldest old reported the highest levels of social and romantic loneliness. The highest level of loneliness for all three age groups was in the romantic loneliness category, with the lowest levels reported in relation to family loneliness. Levels of romantic loneliness increased with age. Respondents in the 85+ years category reported romantic loneliness levels of 4.0 on a scale ranging from 1 (absence of loneliness) to 7 (severe loneliness). The oldest old, especially females, were more likely to be widowed than respondents in other age groups. The levels of family loneliness tended to be low across the three age groups, ranging from 1.9 in the 65-74 age groups to 2.0 in both the 75-84 years and 85+ years groups.

Table 3.5: Age and levels of loneliness

Characteristics	Social loneliness Mean (SD)	Family loneliness Mean (SD)	Romantic loneliness Mean (SD)
65-74 years	1.9 (0.8)*	1.9 (0.7)	3.0 (1.3)*
75-84 years	2.4 (1.1)*	2.0 (0.8)	3.4 (1.3)*
85+ years	2.6 (1.1)*	2.0 (0.8)	4.0 (1.0)*

* $p < 0.001$

14. $F=19.3$, $df=2$, 654 $p < 0.001$

15. $F=13.9$, $df=2$, 648 $p < 0.001$

Social loneliness levels, although low, also increased with age. Respondents in the 65-74 years group reported the lowest level of social loneliness of 1.9, while those in the 85+ years group reported the highest levels of social loneliness at 2.6.

Overall, higher loneliness scores were identified among the oldest old for social and romantic types of loneliness, although family loneliness remained stable throughout the older person's lifespan indicating that support and contact from families remained high.

Highest levels of loneliness were also identified in a number of socio-demographic variables, as shown in Table 3.6. The type of residence had a statistical impact on reported levels of loneliness. Respondents living in rented accommodation or with relatives reported higher levels of social loneliness¹⁶, family loneliness¹⁷ and romantic loneliness¹⁸ compared to those owning their own homes. This was especially identified in relation to romantic loneliness where respondents renting or living with relatives scored a mean of 4.3, indicating moderate to high levels of loneliness.

Another significant factor was the impact of ill-health. Respondents who reported their health as poor reported statistically significant higher levels of loneliness in social and emotional subscales when compared to their perceived good health counterparts.¹⁹ However, the overall reports of loneliness in the health category were low.

The accessibility of transport can enhance a person's capacity to interact with family, friends and their locality. The absence of transport, therefore, can potentially reduce the interaction a person may have. Statistically significant higher levels of social loneliness²⁰, family loneliness²¹ and romantic loneliness²² were reported for those who had no access to transport.

Higher levels of loneliness were also identified for respondents who specified primary or 'other' (other than technical college or university) education as their highest level of education completed, lived in a rural area, were renting their home or living with relatives, had poor health, had no access to transport, had a lower income and whose previous occupation had been classified as unskilled or unknown.

16. $t=4.2$, $df=63.8$, $p<0.001$

17. $t=2.5$, $df=59.0$, $p=0.02$

18. $t=7.7$, $df=70.0$, $p<0.001$

19. Social subscale: $t=3.2$, $df=74.1$, $p=0.002$; family subscale: $t=2.7$, $df=176.2$, $p=0.008$; romantic subscale: $t=4.4$, $df=661$, $p<0.001$

20. $t=4.2$, $df=95.0$, $p<0.001$

21. $t=2.8$, $df=83.5$, $p=0.006$

22. $t=5.4$, $df=661$, $p<0.001$

Table 3.6: Socio-demographic variables and levels of loneliness

Characteristics	Social loneliness Mean (SD)	Family loneliness Mean (SD)	Romantic loneliness Mean (SD)
Education			
Primary school	2.3 (1.1)	2.1 (0.8)	3.4 (1.2)
Secondary school	2.0 (0.8)	1.8 (0.6)	3.1 (1.4)
Technical college	2.0 (0.7)	1.5 (0.4)	2.6 (1.3)
University	1.8 (0.5)	1.8 (0.6)	3.2 (1.3)
Other	2.8 (1.6)	2.3 (1.0)	3.3 (1.2)
Area of residence			
Urban	2.0 (0.9)	1.8 (0.6)	3.2 (1.4)
Rural	2.3 (1.0)	2.1 (0.8)	3.3 (1.3)
Type of residence			
Owner occupier	2.1 (1.0)	1.9 (0.7)	3.1 (1.3)
Renting/with relatives	2.7 (1.1)	2.2 (0.9)	4.2 (1.0)
Health			
Good health	2.1 (1.0)	1.9 (0.7)	3.1 (1.3)
Poor health	2.4 (1.1)	2.1 (0.8)	3.6 (1.3)

Table 3.6 (cont.): Socio-demographic variables and levels of loneliness

Characteristics	Social loneliness Mean (SD)	Family loneliness Mean (SD)	Romantic loneliness Mean (SD)
Caring			
Caring for another	2.1 (0.8)	1.9 (0.6)	3.0 (1.1)
Not caring for another	2.1 (1.0)	1.9 (0.7)	3.2 (1.3)
Transport			
Car/public transport	2.1 (1.0)	1.9 (0.6)	3.1 (1.3)
None	2.6 (1.0)	2.3 (1.1)	4.0 (1.3)
Income			
Up to €200	2.4 (1.1)	2.1 (0.8)	4.0 (1.1)
€201-€400	1.9 (0.7)	1.8 (0.6)	2.7 (1.2)
€401 and above	1.7 (0.4)	1.6 (0.5)	2.2 (0.8)
Social class			
Professional	1.8 (0.4)	1.7 (0.5)	2.6 (1.3)
Managerial	1.9 (0.8)	1.9 (0.6)	3.1 (1.3)
Non-manual	2.0 (0.8)	1.9 (0.7)	3.3 (1.4)
Skilled manual	2.1 (0.9)	1.9 (0.6)	2.8 (1.3)
Semi-skilled	2.1 (1.0)	2.0 (0.8)	3.3 (1.3)
Unskilled	2.2 (0.8)	2.2 (0.9)	3.5 (1.1)
Unknown	2.6 (1.3)	2.0 (0.9)	3.5 (1.3)

Although overall levels of loneliness were relatively low, especially in relation to social loneliness and family loneliness, romantic loneliness was relatively high when compared to both social and family loneliness. This indicates that in the last year older people would have liked a closer relationship with a close friend or romantic partner. A number of other factors were also related to higher loneliness scores including being female, increasing old age, living with a relative, poorer health and lack of access to transport.

3.4 Prevalence of Loneliness

Overall the mean loneliness scores from the SELSA-S were collapsed into three measures: low levels of loneliness (respondent's scores less than three); moderate levels of loneliness (scores between three and five); and high levels of loneliness (scores greater than five through to seven) for each of the three loneliness measures. The highest percentage of loneliness was identified for older people being romantically lonely, with just under 50 per cent identifying themselves as moderately lonely in this category (Figure 3.1). Social loneliness was the next category, indicating that 10 per cent were moderately lonely and less than 2 per cent very lonely (Figure 3.2). The lowest report of loneliness was identified in the family category with 7.2 per cent indicating that they were moderately lonely (Figure 3.3). Reports of being very lonely were infrequent. Only 1.6 per cent of the respondents identified themselves as socially very lonely. Older people who reported being very lonely in relation to their family accounted for only 0.3 per cent ($n=2$) of the total. Although a significant minority of subjects reported being moderately romantically lonely, only 1.1 per cent ($n=7$) reported being very romantically lonely.

Figure 3.1: Prevalence of romantic loneliness

Figure 3.2: Prevalence of social loneliness

Figure 3.3: Prevalence of family loneliness

3.5 Factors Associated with Social and Emotional Loneliness

A number of socio-demographic variables such as age, educational level and overall health were measured in the telephone interview. Some were found to be associated with social and emotional loneliness. Tables 3.7 to 3.9 summarise the correlations between the various measures.

Social loneliness was significantly correlated with increasing age, lack of access to transport, having to travel greater distances to bank and post office, poorer health and living in a rural area. Access to transport was problematic for a number of respondents. Less than half (43.8 per cent) of the respondents reported that they had access to a car, with 17 per cent of respondents reporting that they had access to public transport only. A total of 11.7 per cent of the respondents reported that they had no access to any mode of transport. These respondents were significantly more likely to be rural than urban based.²³ No relationship between social loneliness and length of time living in one community or having recently returned to live in Ireland was found (Table 3.7).

Table 3.7: Intercorrelations between social loneliness and socio-demographic variables

Variables	1	2	3	4	5	6	7	8	9
Social loneliness	-								
Age	.25**	-							
Years at current address	-.075	.12**	-						
Access to transport	-.18**	-.31**	-.12*	-					
Overall health	-.17**	-.29**	-.05	.26*	-				
Urban or rural area	.12**	.09*	.07	-.10*	-.05	-			
Returned to Ireland recently	-.033	.04	.08	-.04	-.04	0.02	-		
Distance to bank	.12**	.02	.07	-.07	-.01	-.53**	.022	-	
Distance to post office	.10*	.06	.13**	-.14**	0.01	-.53**	.07	.64**	-
Level of education	-.15**	-.20**	-.07	.19**	.15**	.20**	.02	-.11**	-.15**

**p<0.01 *p<0.05

23. $\chi^2=81.3$, $df=3$ $p<0.001$

Family loneliness was significantly correlated with increasing age, poorer health, living in an urban area and not being married. Number of children was also associated with loneliness: the more children the lower levels of family loneliness. No relationship between family loneliness and gender was found (Table 3.8).

Table 3.8: Intercorrelations between family loneliness and family and demographic variables

Variables	1	2	3	4	5	6
Family loneliness	-					
Age	.10*	-				
Number of children	-.23**	.07	-			
Overall health	-.17**	-.29**	.00	-		
Urban or rural area	-.19**	.09*	.07	-.05	-	
Marital status	-.30**	-.16**	.18**	.21**	-.074	-
Gender	-.03	-.01*	-.04	.08*	-.01	.021

**p<0.01 *p<0.05

Romantic loneliness was significantly correlated with increasing age, poor overall health, being female, a lower level of education, caring for a relative and not being married (Table 3.9).

Table 3.9: Intercorrelations between romantic loneliness and demographic variables

Variables	1	2	3	4	5	6	7
Romantic loneliness	-						
Age	.25**	-					
Overall health	-.25**	-.29**	-				
Urban or rural area	.05	.09*	-.05	-			
Gender	-.19**	-.10	.08*	-.05	-		
Education	-.09*	-.12	.15**	-.20	.02	-	
Care for a relative	-.11**	-.07	.09*	-.10*	.10**	-.01	-
Marital status	-.60**	-.16	.21**	-.07	.22**	.07	.028

**p<0.01 *p<0.05

Overall, different socio-demographic variables were associated with loneliness types. Increasing age and poor health were positively correlated with higher levels of loneliness (social, family, romantic). Respondents living in rural areas, those with no access to transport and living at a greater distance from services such as banks and post offices, were associated with higher levels of social loneliness. Higher levels of family loneliness were associated with having fewer children and not being married. The main association with higher levels of romantic loneliness was marital status (widowed or never married) and being female.

3.6 Social Isolation and Support Networks of Older People

The constructs of loneliness and social isolation are associated with the level of support an individual receives from their social networks. Social networks are identified as individuals, family and communities who are involved with the person in a significant way. These networks include members of the older person's household, the provision of companionship and friendship, emotional support and the help older people receive from individuals and the community. The measurement of older people's social networks was undertaken using the Network Assessment Instrument (Wenger, 1994). The Instrument identifies the core group of people on whom older people rely for advice, help and support. This section of the report describes the types of support network that were identified by older people in this study. The identification of support networks is valuable in that it allows for the planning and implementation of appropriate interventions.

Section 3.6.1 reports on the responses to the eight questions that comprise the Instrument, while Section 3.6.2 discusses the social networks of older people interviewed in the study.

3.6.1 Network Assessment Instrument

The Network Assessment Instrument comprises eight questions that measure three main areas: the closeness and availability of children and relatives; level of involvement with neighbours, friends and relatives; and involvement in church and community/voluntary groups (Table 3.10). Wenger (1994) points out that immediate family members and friends and neighbours provide the most emotional and practical support to older people, in most cases more so than extended family such as grandchildren, nieces and nephews and cousins. Therefore the Network Assessment Instrument is a tool for identifying the extent of support and the social networks in which older people in Ireland are living. By identifying the type and quality of family and community contacts through the use of the Network Assessment Instrument, it is possible to identify an older person's network type. This information can then be used to identify those older people who are at risk of loneliness and social isolation.

Table 3.10: Network Assessment Instrument questions and responses

	No relatives /children (n)	Same house /within 1 mile (n)	1-5 miles (n)	6-15 miles (n)	16-49 miles (n)	50+ miles (n)
1. How far away in distance does your nearest child or other relative live? (n=650) (Spouse not included)	0.9% (6)	47.5% (309)	34.2% (222)	8.6% (56)	3.2% (21)	5.5% (36)
2. If you have any children where does your nearest child live? (n=649)	17.8% (115)	41.2% (266)	30.0% (194)	4.6% (30)	1.9% (12)	4.5% (29)
3. If you have any living brothers or sisters, where does your nearest brother or sister live? (n=650)	18.5% (120)	6.3% (41)	26.5% (172)	21.1% (137)	13.1% (85)	14.5% (94)

	Never (n)	Daily (n)	2-3 times a week (n)	At least weekly (n)	At least monthly (n)	Less often (n)
4. How often do you see any of your children or other relatives to speak to? (n=650)	0.9% (6)	43.1% (280)	33.2% (216)	12.5% (81)	6.5% (42)	3.8% (25)
5. If you have friends in this community/ neighbourhood, how often do you have a chat or do something with one of your friends? (n=649)	3.1% (20)	31.7% (206)	43.3% (281)	15.6% (101)	3.4% (22)	2.9% (19)
6. How often do you see any of your neighbours to have a chat with or do something with? (n=647)	1.1% (7)	44.5% (288)	31.7% (205)	13.0% (84)	3.2% (21)	6.5% (42)

Table 3.10 (contd.): Network Assessment Instrument questions and responses

	Yes, regularly (n)	Yes, occasionally (n)	No/never (n)
7. How often do you attend any religious meetings? (n=649)	85.1% (552)	4.9% (32)	10.0% (65)
8. Do you attend any community/ neighbourhood or social groups such as clubs for older people, lectures or anything like that? (n=561)	41.0% (230)	9.8% (55)	49.2% (276)

The majority of respondents (81.7 per cent) lived within five miles of their nearest child or relative, with a minority (8.7 per cent) reporting distances greater than 16 miles. The majority (71.2 per cent) had children living within a distance of five miles.

Contact with children and other relatives was high. The majority of respondents (88.8 per cent) had regular verbal interactions with relatives and at least weekly contact with children. Slightly more (90.6 per cent) reported that they had contact with friends at least weekly, if not more often. However, 6.3 per cent only had intermittent contact with friends (monthly or less often) with 3.1 per cent indicating that they had no contact at all with friends. Contact with neighbours was also high. Over 98 per cent reported weekly or more frequent contact with neighbours. Relatively few respondents (1.1 per cent) reported no contact with neighbours.

The majority of respondents attended church regularly (85.1 per cent); only 10 per cent of the respondents reported that they did not attend. In relation to attendance at older people's clubs or social groups, the respondents were almost evenly split in their responses. Almost 51 per cent of the respondents reported that they attended these groups on either a regular or occasional basis with the remainder reporting non-attendance.

Overall, the majority of respondents had regular contact with relatives, friends and neighbours. Contact with family was high with the vast majority living within five miles of their nearest relative. The importance of the church in the lives of older people was also evident with 90 per cent regularly or occasionally attending religious services. Community groups were less important in the lives of older people although over half attend such groups.

3.6.2 Social Network Type, Social Isolation and Loneliness

This section describes the profile of respondents in each of the network types, the level of support they receive and their loneliness scores as measured by the SELSA-S.

As can be seen in Table 3.11, the vast majority of respondents (73.2 per cent) were in locally integrated support networks, indicating that they had close relationships with family, friends and neighbours. The lowest percentage (2.3 per cent) of older people were living in a private restricted network type or a locally self-contained network type. Private restricted and locally self-contained network types are associated with social isolation but not necessarily loneliness. Nearly 10 per cent of respondents were in borderline or inconclusive social networks, indicating that their support network may be in a state of flux or shifting from one network type to another due to a change in family circumstance or increasing old age.

Table 3.11: Network type

Network type	Percentage	N
Family-dependent	6.9%	45
Locally integrated	73.2%	476
Locally self-contained	2.3%	15
Wider community-focused	5.4%	35
Private restricted	2.3%	15
Borderline/Inconclusive	9.8%	64
Total	100%	650

A higher percentage of older people living in urban areas (75.5 per cent) than in rural areas (69.7 per cent) were living in locally integrated social networks (Figure 3.4).

A higher percentage of older people from rural areas were living in family-dependent and wider community-focused networks when compared to urban dwellers. However, no statistically significant differences were identified between urban or rural areas in relation to network type.²⁴

24. $p > 0.05$

Figure 3.4: Network type and area of residence

No statistically significant differences were found between males and females in relation to type of social network. Slightly more females (7.6 per cent) than males (6 per cent) were family dependent, whereas slightly more males (75.9 per cent) than females (71.9 per cent) were locally integrated (Figure 3.5).

Figure 3.5: Network type and gender

Each of the five network types, and the profile of older people in each, is described below.

3.6.2.1 Family-dependent Support Network

Wenger (1994) describes older people in this category as having the majority of their support needs met by their family. Overall, this network accounted for 7 per cent of the sample. Predominantly the oldest old were in this network. Of all respondents aged 85 years and over, 20 per cent were in this network compared to 5.6 per cent of respondents aged 65-74 years and 7.2 per cent of those aged 75-84 years. Over 20 per cent of respondents in this network were living in a relative's home. Older people who were widowed or divorced/separated were three times more likely to rely on a family-dependent network than respondents who were married or had never married.

Statistically, people in this network are more likely to be older than respondents in all other networks (apart from private)²⁵, widowed²⁶ and living in a relative's home²⁷ (Figure 3.6). Respondents were also significantly more likely to be in poorer health than those in other networks, with 35 per cent of older people in this network indicating that their health was poor or fair.²⁸ Older people in this network also had, on average, the highest number of children compared to any other social network (mean = 4.83, SD = 2.82). A majority of respondents in this network (81.4 per cent) were also unlikely to be involved in community activities or social groups.

Figure 3.6: Network type and accommodation

25. $F=4.25$, $df=5,639$, $p=0.001$

26. $\chi^2=61.14$, $df=5$, $p=0.001$

27. $\chi^2=45.51$, $df=5$, $p=0.001$

28. $\chi^2=20.83$, $df=5$, $p=0.022$

The minimal contact with social and community networks, and the fact that the majority were widowed are reflected in the older person's experience of social and emotional loneliness. Loneliness scores were highest in both the romantic and social loneliness subscales, indicating moderate levels of loneliness. The lowest level was noted in family loneliness, which is reflected in the fact that older people in this network rely mainly on their family for help, support and friendship.

3.6.2.2 Locally Integrated Support Network

Wenger (1994) describes this network as one where older people have close relationships with family, friends and neighbours. The majority of older people (73.2 per cent) in the survey were identified as being within this social support network. Family, neighbours and friends of older people in this network tended to live within a mile of them. This indicates that levels of social isolation are low.

The majority of respondents in this network were younger (76.5 per cent of all respondents aged 65-74 years were in this network type), reported regular or occasional involvement in social and community groups (60.2 per cent), had an average of 3.5 children and had a higher weekly income than older people in other social networks. A statistically significant difference was found between those who are younger (more likely to be locally integrated) and those who are older who were less likely to be socially integrated.²⁹ Older people who were married were significantly more likely to be within a locally integrated social network than older people who never married or were widowed.³⁰ Respondents in this network had also lived within their community for 40 years, on average, and nearly 80 per cent had children living within five miles of them. The vast majority (92 per cent) attended religious services, with over half frequently attending social groups and meetings.

Older people identified as being within a locally integrated social network had the lowest overall experience of social or emotional loneliness of all network types. The low scores for family and social loneliness indicate that the majority of older people in this network have a close relationship with family, neighbours and friends. The highest score was identified in the romantic subscale indicating that, although the experience of social and family loneliness was minimal, respondents were moderately romantically lonely. Older people who experienced romantic loneliness in this network tended to be widowed (mean romantic loneliness score = 4.11, SD = 1.00) or had never married (mean romantic loneliness score = 4.24, SD = 0.97).

29. $\chi^2=32.96$, $p=0.001$

30. $\chi^2=61.14$, $p=0.001$

3.6.2.3 Local Self-contained Support Network

Wenger (1994) describes older people in this network as having infrequent contact with relatives and limited community involvement. The overall percentage of older people in this category was small, accounting for just over 2 per cent of the sample. Respondents in this category tended to have infrequent contact with relatives (sibling, niece or nephew) or neighbours living close by. The majority identified that their most frequent contact with relatives was only weekly (73.3 per cent) or monthly (26.7 per cent). No respondents in this category indicated that they saw relatives on a more frequent basis (daily or two to three times a week). In relation to contact with friends, 46.9 per cent saw their friends daily or two to three times a week, with a third indicating their most frequent contact as being weekly, and 13.3 per cent only having contact with friends on a monthly basis. The majority of respondents in this sample had no children (60 per cent) and were never married (40 per cent). Respondents in this social network had on average lived in their community for over 45 years. Only half attended religious meetings or services and the majority (61.5 per cent) did not attend any community or social groups, with only 38.5 per cent 'occasionally' attending.

Statistically, older people in this group were less likely to have children³¹ and more likely never to have married³² than older people in other network types. This indicates that their social networks are small.

The experience of romantic loneliness was significantly higher in this network than older people in both locally integrated support networks and wider community focused support networks³³, indicating that they would like to have had a closer personal relationship with a friend or romantic partner. However, the experience of social and family loneliness was low and not significantly different from other social networks. The overall profile of older people in this network identifies them as socially isolated but not necessarily socially lonely.

3.6.2.4 Wider Community-focused Support Network

Wenger (1994) describes older people in this type of network as having an absence of children and relatives living locally; however, there is engagement in community and voluntary organisations. Overall 5.4 per cent of the sample was identified as being wider community-focused. Older people in this network did not have close relatives (including siblings) living nearby. The majority (71.4 per cent) of respondents' relatives and children lived at a distance of greater than 50 miles. However, contact with friends and neighbours was very frequent. The majority of older people in this network (80 per

31. $F=10.14$, $df=5,644$, $p=0.001$

32. $\chi^2=13.43$, $p=0.020$

33. $F=6.72$, $df=5,629$, $p=0.001$

cent) saw friends either daily or two to three times a week, with 57.2 per cent having regular contact with neighbours. On average, respondents had lived at their current address for about 30 years, which was less than other networks. They were also significantly more likely to have lived abroad than older people in other networks.³⁴ Respondents in this network tended to report good or excellent health (88.6 per cent), and were more likely to be married (50 per cent), with 38.2 per cent widowed. The majority, prior to retirement, reported that they had been in non-manual or professional/managerial occupations (70.6 per cent). Over 85 per cent saw their relatives or children monthly or less often.

Although older people in this network were at a greater distance from relatives, respondents reported a low experience of social and family loneliness, with low to moderate levels of romantic loneliness. There is good social integration, especially with friends, and social isolation is low. However, Wenger (1994) reports that, in times of ill-health or crisis, isolation and loneliness may become a problem for older people living within this social network.

3.6.2.5 Private Restricted Support Network

Wenger (1994) describes this network as one characterised by a lack of local relatives and very little contact with neighbours or community involvement. The prevalence of older people in this network was low, accounting for only 2.3 per cent of the total sample. A third of respondents in this network reported having poor health, with the majority (57 per cent) having never married. The majority (60 per cent) did not attend religious services and all (100 per cent) in this network reported that they did not attend any social or community groups. A third reported that their nearest relative lived over 50 miles away, while 20 per cent had no relatives or children. Contact with friends was minimal, with over a quarter indicating that they had no friends or never saw friends. Although a third indicated that they saw relatives either daily or two to three times a week, the majority (53.3 per cent) had no contact with neighbours or saw them less often than monthly. Overall, older people in this network had little or no contact with neighbours or community groups.

This profile is reflected in reports of loneliness in this group of older people. Across all concepts of social and emotional loneliness, people in this social network scored significantly higher in loneliness scores than those in other networks. The highest score (mean = 4.2) related to moderate to high levels of romantic loneliness, indicating the absence of a close personal relationship with either a romantic partner or friend. Moderately high loneliness scores were also identified in relation to the experience of family loneliness and social loneliness. Although in a minority, older people in this social

34. $\chi^2=35.60$, $p=0.006$

network are more vulnerable to loneliness and social isolation than those in any other social network type.

3.6.2.6 Borderline Networks

Generally network types are stable, although changes can occur due to an alteration in the circumstances of the older person, such as increasing age and poor health (Wenger, 1994). Approximately 10 per cent of the sample was identified as belonging to borderline or inconclusive social networks. Over a quarter of older people aged 85 and over were in a borderline/inconclusive network. The majority of older people (57.5 per cent) in a borderline/inconclusive network appeared to be moving between locally integrated, locally self-contained and family-dependent networks. Wenger (1994) points out that even though network types are relatively stable, increasing age and ill-health can lead to a change in social network. However, not all network changes may be due to a crisis or ill-health. Wenger (1994) shows that older people may move from an isolated private restricted network to a wider community-focused network following a positive change in life-circumstances such as relief from caring responsibilities or recovery from long-term illness.

Table 3.12: Network type and loneliness

Characteristics	Social loneliness Mean (SD)	Family loneliness Mean (SD)	Romantic loneliness Mean (SD)
Family-dependent	3.26 (1.47)	2.12 (0.76)	3.65 (1.11)
Locally integrated	1.94 (0.67)	1.81 (0.59)	3.03 (1.30)
Local self-contained	2.60 (1.46)	2.68 (0.81)	4.23 (1.59)
Wider community -focused	1.98 (0.48)	2.20 (0.64)	3.18 (1.23)
Private restricted	3.75 (1.81)	3.60 (1.61)	4.21 (1.43)
Inconclusive	2.34 (1.23)	1.97 (0.75)	3.47 (1.16)
ANOVA	F = 30.56 df = 5,634 p = 0.001	F = 25.15 df = 5,631 p = 0.001	F = 11.45 df = 5,629 p = 0.001

3.6.2.7 Summary of Social Networks

Overall, the vast majority of the sample were living in strong locally integrated social networks, in which support was provided by family, neighbours and friends. However, a significant minority of older people were living in networks where they were socially isolated and lonely. This was evident in the family-dependent, local self-contained and private networks. Older people in family-dependent networks have low levels of family loneliness, although their dependence on their family for contact and support appears to be resulting in higher levels of social and romantic loneliness. Older people in this network reported limited contact with friends or neighbours.

The local self-contained network identified older people who had minimal contact with family, friends or neighbours. Although not directly asked, people in this network are more likely to be living alone. Although socially isolated, levels of social loneliness are low; however, Wenger (1994) points out that in times of ill-health or loss of independence, loneliness may become an issue.

Although in a minority, older people living in private networks were both lonely and socially isolated. Contact with neighbours was minimal and levels of loneliness were higher than in any other network. This network is characterised by an absence of close relationships. Of all the networks identified, older people within this network have become most isolated from family, friends and neighbours.

It was also evident that 10 per cent of older people were in borderline or inconclusive networks. The majority of respondents in this network were the oldest old, indicating that their network type may be changing due to ill-health or increasing dependency.

3.7 Activities to Alleviate and Prevent Loneliness and Social Isolation

The interactions and social contacts that older people maintain can be critical to reducing or preventing loneliness and social isolation. The respondents were asked to identify three activities that enabled them to alleviate or prevent loneliness and social isolation. All of the respondents identified one activity. The responses were grouped according to similar themes. It was evident that the majority of the activities reported related to four specific areas: family and friends; church-related activities; organised clubs and activities; and personal hobbies and activities.

3.7.1 Family and Friends

The activities associated with family and friends involved either caring or visiting, including caring for other relatives, babysitting and visiting with family and friends.

3.7.2 Church-related Activities

Church-related activities included attending religious services, often daily. Other levels of participating in church activities included assisting with services in the role of eucharistic ministers or singing in church choirs. Other levels of church activities included assisting with the cleaning and flower-arranging.

3.7.3 Organised Clubs and Activities

These activities included participation in organised older people's clubs and groups, for example, ARAs and Senior Citizen Clubs. Participation with other clubs reported included playing and/or watching GAA and football. Finally, popular activities also included card-playing and bingo.

3.7.4 Personal Hobbies and Activities

The range of personal hobbies and activities included walking, watching television, reading, gardening, playing golf and visiting the pub. This category was more likely to include activities that were undertaken at home and did not have to involve interactions with other people (with the exception of visiting the pub). For most of the reported activities, a reasonable level of good health, eyesight and hearing are important requisites. It is apparent that older people who are participating in activities in each of the previous groups may have opportunities to prevent or reduce their levels of loneliness and social isolation. For individuals who may only have personal hobbies and activities or a limited range of activities, their levels of interaction and social contact may be less.

3.8 Summary

A cross-sectional national telephone survey of 683 respondents aged 65 years and older was undertaken to determine the prevalence of loneliness amongst older people in Ireland and to examine loneliness associated with a number of factors. The results indicated that the levels of social and family loneliness reported by the sample were

low. The highest level of loneliness reported overall was in relation to romantic loneliness. The results from the survey also indicated that the majority of older people are not socially isolated. However, where loneliness did exist, a number of factors were associated with the experience of loneliness in older people.

Respondents who were more likely to report statistically significant high levels of loneliness were: the oldest old; female; either single or widowed; educated to a primary level of education only; and in the lower social classification. Statistically significant high levels of loneliness were also more likely to be reported by individuals who lived in either rented accommodation or with relatives in rural areas. Poor self-rated health and lack of transport also impacted significantly on the reported higher levels of loneliness.

Overall, significant differences were found between social network and type of loneliness. Older people in family-dependent and private restricted networks had significantly higher social loneliness scores than all other social networks. The experience of family loneliness was significantly higher in older people within local self-contained and private networks. Moderate to high levels of romantic loneliness were found across all networks but were significantly higher in family-dependent, local self-contained and private networks.

Although the majority of older people in this survey are not lonely or socially isolated, there is variability in the types of loneliness experienced and, for a number of older people, loneliness and isolation is a real problem. This is mainly in relation to romantic loneliness, which scored higher than either social or family loneliness. One reason for this is widowhood which results in an older person not having emotional support and care from a close friend or romantic partner. It is important to note that women mainly experienced widowhood.

3.9 Conclusions

1. The social networks of older people in this study were identified through the use of the Network Assessment Instrument (Wenger, 1994). This allows practitioners to assess effectively older people at risk of isolation and to plan interventions that will alleviate or prevent the risk of loneliness and social isolation. It is recommended that the Network Assessment Instrument be made available to groups and individuals who come into contact with older people in helping identify those at risk of loneliness and social isolation at individual and community levels.

2. Emotional loneliness, especially romantic loneliness, was significant, indicating that older people would like a closer emotional relationship with another person. These needs often go unrecognised in older people. It is important to recognise this aspect of older people's lives through publication of these findings and further consultation with older people on their emotional needs.
3. The oldest old experience higher levels of social and romantic loneliness than their younger counterparts. Therefore this group should be specifically targeted by outreach programmes, such as home visits, befriending clubs, active retirement groups and the provision of transport to enable older people to attend clubs and societies if they wish.

Chapter Four

The Experience of Loneliness and Social Isolation

Chapter Four

The Experience of Loneliness and Social Isolation

4.1 Introduction

This chapter reports findings from the in-depth interviews undertaken with older people. Interviews were undertaken with 34 people aged 65 years and over in order to explore the experience of loneliness and social isolation among older people in Ireland. In addition, one focus group interview was conducted with a group of nine older people. The interviews were conducted with people living in two health board areas. The average age of participants in the individual interviews was 78 years, with ages ranging from 66-99 years. The characteristics of the samples are outlined in the following section. Unless otherwise indicated, the findings reported represent the views of both community and long-stay-care-dwelling older people.

4.2 Demographics

4.2.1 Interviews

The highest proportion of those interviewed lived alone (67.7 per cent, $n=25$) compared to 32.4 per cent ($n=9$) who lived either with a carer/spouse or in a nursing home. Most of the people interviewed lived in an urban setting (55.9 per cent, $n=19$) compared to 44.1 per cent ($n=15$) living in a rural setting. Only one participant did not have access to a telephone: the remainder all had access, including participants who lived in nursing home accommodation. Most participants were female (79.4 per cent, $n=27$). With regard to marital status, 61.8 per cent ($n=21$) of participants were widowed, 14.7 per cent ($n=5$) were married and 23.6 per cent ($n=8$) were either single or separated. In terms of educational attainment, the highest proportion of the sample were educated to trade/technical college level (38.2 per cent, $n=13$), 29.4 per cent ($n=10$) were educated

to primary level and 23.5 per cent (n=8) had left education after secondary school. The sample included six participants who were 'housebound' – that is participants who were unable to get out of their house without significant assistance. Three of the participants lived in three different nursing homes, one in a rural area and two in urban areas.

4.2.2 Focus Group Interview

A total of nine participants took part in the focus group interview, six females and three males. The ages of the participants ranged from 69-87 years. All participants lived in a rural area and some of the group were involved in the community project established in the area by PHNs and GPs to promote integrated community activities and socialising among older people.

4.3 Findings

The findings from the interviews and focus group are presented in four main categories that, when combined, describe the experience of loneliness and isolation from the perspective of the older person. The four categories are personal context, social interaction, loneliness and isolation.

107

4.3.1 Category One: Personal Context, Circumstances and Philosophy

This category acknowledges that loneliness and social isolation are complex phenomena that do not exist in a vacuum outside the context of people's lives.

4.3.1.1 Personal Context

Participants were asked about their social networks, their experiences of loneliness and social isolation, and how these related to their own personal contexts. Participants' descriptions of their personal contexts featured aspects of their circumstances, such as health, housing and family life, and examples of the consequences of these are given throughout this report.

4.3.1.2 Personal Circumstances

Personal circumstances considerably affected feelings of loneliness and isolation. The participants in this study reported many changes in their circumstances, both in the

short- and long-term past. Their ability to adapt to these changes was key to the degree of loneliness and isolation encountered and the person's 'fit' with their personal circumstances could support or hinder this adaptation. However, circumstances were diverse as were participants' resources to deal with circumstances, including material, interpersonal and psychological resources (coping skills). Participants' personal histories, such as family history and history of hobbies and religion, are important to the extent that personal history determines personal circumstances, learned coping mechanisms and mediated expectations about quantity and quality of social interaction. An important aspect of personal context was the individual's personal philosophy as described in Section 4.3.1.3.

4.3.1.3 Personal Philosophy

Personal philosophy was closely related to coping mechanisms for loneliness. This category is integral to the participants' descriptions and thus a little more background detail is needed here. There are four aspects to personal philosophy: making the most of one's situation; independence; acceptance; and faith.

Making the Most of One's Situation

Making the most of one's situation was a common theme in participants' descriptions of how they liked to approach life. Participants spoke about there being no point in moaning and were aware that people did not want to spend time with miserable people. Making sure one kept on good terms with people in the social network in order to maintain that social contact was also an important consideration. Participants also indicated an awareness that worrying would do nothing to ease their situation. Comparisons with those worse off were common.

There is a good social life out there for you if you're old if you want it ... You know but I mean there's people there, comes to this club 90 years of age and they're down there dancing ... So you know if you want it it's there but if you want to sit in front of the fire and watch the television all day, turn into a vegetable you can, but some people can't help doing that but I can't see me ever doing that.

Independence

Most participants stressed the importance to them of maintaining independence. Independence was related to maintaining a sense of purpose but accounts also suggest

that participants were proud of their self-reliance. Some participants took this to the extent of concealing illness or sadness from those around them.

[Name] brought me out twice and I see the other girls. I can see them when I want to see them, it's up to myself and they come down to see me. I could see them every day if I wanted to but I don't like that. I prefer to be able to do my own thing - very independent.

Acceptance

Acceptance of circumstances was a theme that was common to most participants and was cited frequently as a coping mechanism by participants who regularly felt lonely or isolated. Although it is suggested that acceptance may be used as a coping mechanism to deal with lonely or isolated feelings and as such was positive, it may result in participants accepting situations before they have fully explored options that could be effective in addressing issues that have arisen.

I: *Yes. And why wouldn't you like to go there now? [Whist drive]*

R: *Well there'd be too much, eh trouble. And then you have to move you see. If you win, you have to move ... You'd have to move and ... well that wouldn't be ... you'd be holding up the whole thing.*

This widespread acceptance of circumstances suggests an exploration of personal expectations is important in any intervention to promote social interaction.

Faith

Running throughout all the personal philosophies described was a strong religious ethos. Not all participants were practising a religion, but religious values were implicit in many accounts, as for example the emphasis on 'counting your blessings' and accepting life. Participants differed on how explicitly they linked these philosophies to religion.

I think minding my faith. I always believe that nothing happens by accident. So whatever has happened to me was meant to be and fine, I go on with the flow. Really, you know, because I feel that, well the Scripture tells us that the widows are looked after and I feel that if it wasn't meant to be, it wouldn't be.

4.3.1.4 Summary for Category One

While describing their experiences of social interactions, loneliness or isolation, participants used examples of their personal histories, personal circumstances and personal philosophies. Personal circumstances were important, both in being associated with the level of social interaction and in the ability to employ coping mechanisms. Adaptation to personal circumstances or inability to adapt were themes highlighted in participants' explanations of their circumstances.

Personal philosophies included making the most of one's situation, maintaining independence, acceptance of personal circumstances and faith. All participants alluded to a personal philosophy or a code, which they used as both a coping mechanism for loneliness and isolation, and which mediated their 'benchmark' as to what was an acceptable amount of social interaction. It was clear that the diversity of contexts and ability to cope with these would give any single intervention for loneliness and isolation a limited effect on a large scale. The strong emphasis on acceptance as a form of adaptation suggested that older people may impose limits on their demands and engagement with their social grouping.

4.3.2 Category Two: Social Interaction

This category identified the kind of social networks the participants were part of and the aspects of their circumstances or personality that act as a barrier to social interaction. The barriers to social interaction that were identified can be seen as factors contributing to loneliness and social isolation rather than directly causing either of these conditions.

The social networks that participants described were varied and clearly not all participants have the same social networks. Social networks comprised two main themes, namely people-related social networks and activity/organisational-related social networks.

4.3.2.1 People-related Social Networks

People-related social networks involve companions, family, home help, friends, neighbours, visitors and others. These were important for the initiation and maintenance of social interaction.

Companions, Family and Friends

Companionship appears to relate to a particular type of relationship that does not require effort to maintain. Participants explained that a companion was often, although not necessarily, a partner, family member, close friend or home help. A companion is someone who has been around long enough to reassure the individual that small disputes can be overcome without damage to the relationship. The participants also seemed to describe mutuality in these relationships in that they serve a purpose for each person involved and this avoidance of one-way dependency seems important. The other key aspect to companionship is that it provided a partner to go out with, making going out to new places and meeting people less daunting.

I wouldn't dream of getting up here [town] of a night. "Oh if [husband said] I'm just going to pop down ... ", "Ah [I'd say] I'll come for the drive with you", you know. It was constant all the time.

People appreciated visits from their friends and family, but they also looked forward to visits from nurses or home helps for the company as well as the help they were providing.

I would think a lot of elderly people alone like me look forward to the company as much as the help they were getting you know.

A clear theme that emerged from participants was that social networks were needed to develop friendships and that this required active engagement on the part of the older person. Some participants were actively looking for a companion, particularly a companion of the opposite sex.

I ... miss the company of a ... husband or a partner, but I mean it's so long ago since I had any company of a male partner that I must have [got] used to it. Maybe you need company to meet good company?

Participants indicated that families play a key role in providing a social network. Some participants had strained relationships with their family or friends, which was a source of great unhappiness and limited the social network and resource. Some participants suggested that they had lost the ability or the desire to converse and if they did go out they would choose times or places when they did not have to talk to people. This was described by a number of participants and related to avoidance of confrontation.

Many participants were living with the reality that most of their family (or certain key members) had died, causing sadness and grief but also a loss of companionship. The following quote highlights participants' difficulty in talking about the taboo subject of death following a bereavement.

But some people I meet, I can't even talk to them ... Eh I, I don't know, it's not that I don't like them ... Eh you know, "Hello, how are you", and then I run out of conversation. I can't be talking anymore.

Home Help, Neighbours and Others

Accounts indicated that the home help service was of major importance to the participants in the study. This importance cannot be overstressed.³⁵ Many participants looked on these individuals as their special friends rather than being paid staff from an organisation.

She [home help] doesn't have to but if she's in the district she will drop in on you ... Like if she's around, she will ... and if you ... then again if you need her, she's on the other end of the phone ... So if you need her for anything at all.

The flexibility and responsiveness of individual home helps were key to their great success in promoting the social networks of the participants. Certain participants felt they would have liked more hours from their home help, but most felt themselves fortunate to have their particular home help and access to the service.

Neighbours fulfilled a number of functions in the participants' networks, from being a person to contact in an emergency, to someone with whom they would have regular cups of tea and conversation, or people with whom the older person had little contact apart from a greeting if they chanced to meet. Participants suggested that other older neighbours are better neighbours as there was more in common to talk about and younger neighbours were rarely at home. Generally, even participants who had very little contact with their neighbours derived a comfort from the fact they knew they were there (even if some distance away in some of the rural areas) and being able to see activity was reassuring.

I think it's essential. If you want someone, your neighbour's the first one you call isn't it.

35. It should be noted that 20 of the interview sample were recruited through the PHN service and as a result were more likely to have access to services such as home helps.

A number of other individuals were noted by participants as people they see on an irregular basis. These included a physiotherapist, occupational therapist, nurses and doctors. These individuals were noted specifically for their expertise in helping with specific physical problems. For instance, one participant stated that her physiotherapist enabled her to walk and stressed the importance this had on her social interaction and independence.

The importance of the postman and people who help with house maintenance was highlighted. The postman provided regular contact and specific mention of the prospect of postmen not visiting was made. In the case of maintenance work, this promoted a feeling of security and was thus linked with the prevention of feelings of isolation. Several participants mentioned the help of a warden. They said that the presence of a warden meant there was always someone to call in an emergency.³⁶

4.3.2.2 Activity/Organisational-related Social Networks

Activity/organisational-related social networks, including socialising and enjoyable activities, were described as important factors in maintaining social interaction and incorporated items such as religious activities and the importance of 'getting out of the house'.

Religious Activities

While not all participants indicated a religious affiliation, networks made through church or other religious meetings were very important to the majority of participants. For some individuals, religious practice and attending the church was a daily routine. Often, if a barrier to going to Mass existed, it was a source of great sadness for participants.

The biggest thing in my life would be for someone to take me to Mass.

Not only was going to Mass and other church meetings a mechanism for seeing old friends, it also enabled older people to meet new friends and to engage with services backed by religious organisations. Participants also felt their faith was an important coping mechanism in dealing with loneliness and isolation. Other meetings arranged within the church, especially fundraising, gave participants what they termed a sense of purpose. For some people going to Mass at the weekend provided a welcome break to a weekend otherwise devoid of company.³⁷

36. Emergencies or times of crisis were closely linked with feelings of isolation.

37. Weekends were highlighted as lonely times.

Organisations and Community Centres

A wide range of organisations were mentioned by participants. These included Meals on Wheels, ARAs, an arthritis group, a women's equality group, Friends of the Elderly, ALONE, St Vincent de Paul and housing committees in some blocks of flats. Attendance at day hospital was also stressed. However, the importance of community centres was particularly emphasised.

The [community centre] is very important, to us all. People say what would we do if we hadn't got it ... I wouldn't want to think about it.

The overwhelming view was that community centres were a great way to meet people in similar circumstances. For many participants the major benefit was that their community centre was in town and, as it provided transport to and from their homes, it enabled participants to go shopping if they could walk independently. Another aspect of community centres that was highlighted by participants was the provision of meals which were much appreciated and which also provided a social forum. Choice and flexibility were indicated as incentives to continue going to community centres, for example, some flexibility about what time they were picked up and dropped off and how they spent their time. Despite this, some people still found the day very long.³⁸ In many cases the opportunity to participate in the activities provided in centres was secondary to the fact that participants were interacting with other people.

Getting Out

All participants, even those who had not been out of the house for some time, indicated that they liked to 'get out and about'.³⁹ Several people interviewed had not been out for a year or more; these included the housebound immobile and those who lived in nursing homes. They had clear ideas about where they would like to go, and this was often related to personal history, for example, a visit to the seafront, to visit a grave, to Mass and many would have liked to do their own shopping. All participants, regardless of whether they were able to get out or not, said that it would be a good mechanism to alleviate loneliness and isolation. There was not necessarily a need for great social contact on outings, the change of scenery seemed to be more important to many. This theme is important because participants felt it kept them 'in circulation' which meant they would be missed if they had a problem and could not get out. The following quote sums up how important getting out is to many participants:

38. A long list of activities was given when participants were asked what they liked to do at the community centre. These are detailed in the 'enjoyable activities' section.

39. This theme links very closely with barriers, especially inadequate transport and is discussed later in this chapter.

There is a way of contacting people. Now if I'm seen around the church and I was missing for a while they'd think "God we haven't seen her for a while" you know. Now I'm not saying I do it every day but most of the time I do ... I go out – I put myself about. Because I'd hate to be a house hatchet and be very lonely. I'd hate that because that's one way of getting house reliant, and getting lonely. If [you] ... stay in and not go out you'll get yourself that used to the house that you won't want to go out.

A crucial aspect of getting out is being able to go at one's own pace. The following quote sums this up.

I just don't want anybody standing to attention to me ... I don't want my daughters breathing over my shoulder saying, "Well you should be finished now Mum". ... I like to do my own thing and they let me go and do my own shopping here and there and wherever I want to go and then have a cup of tea ... I want to do me own wee bits and pieces and I want to be able to stand and talk to whoever I like ... And, mind you, when I meet someone from bygone days, we can reminisce over the years a lot.

115

Enjoyable Activities

In relation to activities, participants indicated that they wanted choice and that when engaging in activities they wanted to be able to use their skills and have strengths emphasised. The range of activities the participants described as enjoyable was extensive and important examples included music (singing and dancing), computing, exercise (including walking, swimming, tai chi and yoga), and competitive activities such as quizzes, darts, bowling and bingo. Bingo had negative connotations for many participants (not confined to the younger old) who found the bingo stereotype offensive and did not wish to be associated with it; others loved it. Some were involved in more artistic endeavours such as flower arranging, knitting, crochet, art, crafts, creative writing, drama groups and book clubs.

Novel examples of organised activities included a history group writing a book of their stories that will be published, and activities involving intergenerational integration. Some participants went to the theatre, exhibitions and the cinema, arranged through organisations. Many participants stated that they enjoyed being involved in fundraising

activities as this gave them a particular sense of purpose. Some participants saved all year to participate in holidays and trips. While participation in activities was described as important, some participants said that they were not skilled at art or at computers but enjoyed meeting and mixing with other people. Some participants described very full social lives during the week, taking part in numerous activities and clubs. Despite this some of these participants still felt very lonely at weekends, particularly if they had no family.

There were some participants who did not enjoy socialising and meeting new people and went out of their way to avoid this; they wanted to restrict their social circle to family and more trusted friends.

4.3.2.3 Barriers to Social Interaction

Barriers to social interaction are presented within the four themes. These are psychological, environmental, physical and interpersonal. The presence of multiple barriers seemed to be significant in diminishing the amount of an individual's social interaction.

Psychological Barriers

Barriers that were classified as psychological included the effort required for social interaction, lack of interest and lack of motivation.

Effort Required for Social Interaction

Participants did not explicitly mention the effort involved as a barrier to social interaction. However, it was clear from the descriptions that there was considerable effort involved in maintaining social networks.

So then eh, the wake-up call came ... the thought came into my mind that you must help yourselves ... You know, you can't sit behind the door saying rosaries and begging the Lord to send somebody in to visit you.

In terms of the effort required, participants described a range of difficulties including not being able to admit they needed company to not being able to cope with crowds or groups of people. For some participants these feelings occurred after a period of absence from their networks, for example, following illness or hospital admission as indicated in the following excerpt:

I don't know [Friend] said to me "Would you not go back to bingo" ... I said no. I don't think, I think I have committed a terrible crime and that I can't face anybody now. That's it.

This theme also described being out of the habit of being with other people and the effort needed to regain social engagement.

Lack of Interest or Motivation

Lack of interest in others also appeared to be a barrier to social interaction, although having extremely limited social networks was not a source of unhappiness for all:

I love it ... [being on my own] ... just I read all night if I want to ... I'm not interested in people, I'm interested in reading.

A feeling of being unwanted was expressed by some participants who were subsequently less inclined to seek out company as they were unsure of a welcome.

One neighbour I would stay a night with her, then I would go into my [daughter] and stay another night ... and just go from here to there and sometimes maybe you might not be wanted. And that makes you feel bad. But that's just the way it is.

Lack of energy or motivation to interact with others was also indicated as a barrier to seeking social interaction. In the excerpt below the participant felt they had little in common with the people they might meet at the community centre and felt the effort required would not be worthwhile.

I have been asked, to be honest about it, I have been asked to go down to the old folks parties ... to the community centre. Eh, I have been asked a lot by a lot of people but I suppose it's a bad attitude to take, but I just can't be bothered.

One participant highlighted the fact that having no hobbies or interests is a barrier to social interaction, in that individuals are without a motivating factor or sense of purpose for getting together with other people or going out.

But I think boredom is worse than the loneliness. And I haven't got anything to take the boredom off. I've got no hobbies ... Something like going to theatre, pictures or anything like that, I'd have no interest in at all.

Environmental Barriers

These barriers included the weather and the amenities available within the local community. As with enablers to social interaction, the lack of adequate transport and lack of knowledge of existing services were considered very important.

Weather

Weather, particularly winter weather and dark evenings, was described as a barrier to participants' interaction as expressed in the quote below.

You see them [your neighbours] more in the summer than you would the winter ... The evenings are dark in the winter and people are in from four o'clock – in the real winter, you know say November, December.

Transport

Lack of transport was frequently identified as a barrier to social interaction. Several important issues arose. Participants who were immobile found it impossible to use standard bus services and this was expressed in both rural and urban interviews. However, in relation to rural areas participants felt there were insufficient people, especially older people, in need of the services to make the bus service cost-effective. This minority were thus unable to travel locally and engage in any kind of social interaction or 'getting out', an important factor in social interaction. This was most apparent if participants did not have family nearby who could take them out by car. In terms of transport, flexibility was the key to participants' transport needs, with many describing themselves as being too frail to be out of their homes for very long stretches of time. Some participants had limited financial resources to use taxis with disabled access, and this form of transport was affordable only for shorter journeys. Taxis were not an affordable form of transport for longer distances, such as travel into the city for a hospital appointment. The loss of a driving licence is a serious issue for an older person. A minority of participants described lack of transport as their sole reason for feeling lonely and isolated. However, those participants were totally reliant on transport and where it was not available it prevented all opportunity for the participants' social interaction.

I can't get on a bus. I could get on a bus if they pulled in level with the footpath, but they don't.

We were at a meeting in ... [community centre] back about four or five months ago now, all of us. It was a meeting full of people. That's the difficult thing about the transport, having bus passes and no buses ... So what a TD said there, he said there were enough old people in the vicinity. But there are two or three old people out there and they don't even [have to] come in here [centre], they would have people like their daughters living in the house with them and sons and they have no call for the bus.

Opportunities, Services Provided and Personal Interest

The services provided for older people were only utilised if participants were interested in and motivated to use the service offered; otherwise they did not perceive the effort involved as being worthwhile. While some participants welcomed the chance to meet a large number of people, others preferred smaller groups or one-on-one interaction. Therefore the absence of a service preferred by the particular older people is a barrier to social interaction. This theme is associated with choice and individuality in that participants demonstrated that one service or organisation could not be all things to all people. What participants desired was personal choice in terms of social interaction/activity. This is difficult to clarify, as the majority of older people were unable to specify the precise activities they would like.

When ... older people have parties on at the town [community centre] ... I didn't go to any for years now ... I don't know. They hadn't anyone of my own age ... All these young ones. Didn't care about going ... I wouldn't care now either as much ... I like company but I don't like going out to big crowds.

Location

Busy roads were also a disincentive to going out and thus socially interacting with others. In rural areas the lack of footpaths exacerbated this. In urban areas uneven footpaths also caused a barrier.

And I used to walk all the time, you see, to the village but I'm not able to do it now. You see the – the paths are so uneven.

Some participants described being overlooked by services when assumptions had been made about their needs without their input.

No priests, no nuns, no nothing. Now there are two nuns in the parish who are supposed to call in to the elderly people, but if you're able to walk at all ... [they don't call]. They never think that your mind might be lonely.

Several people stated that living far from town was a problem and this was particularly related to transport and weather. However, some also liked the seclusion of the countryside.

Lack of Information

Unmet information needs were described explicitly and implicitly by participants who were unaware of local services or clubs. Had these participants known about the clubs they might still have chosen not to be involved, but it was clear that there was a lack of information among some participants, which is undoubtedly a barrier to the take up of such services.

We get a hell of a lot of pamphlets in through my door. The postman puts them in and some of them apply to me, some of them don't. I will never use pizza or [take-away] from the Indian [restaurant] and it's endless, totally endless. But what I never ever get in the door is a pamphlet telling me what is available in my town.

Physical Barriers

While participants indicated that general good health was the most important factor in social interaction, they specifically indicated a number of physical problems as barriers to social interaction. These included the psychological effects of hearing loss and vision problems, mobility and acute and chronic ill-health.

It's a terrible thing [hearing problem] to be sitting in company and you can't chat, like at the moment I can chat to you, but if someone over there was chatting at the same time I don't know what he has said, so it's a hell of an inconvenience.

Fear of falling was a strong disincentive to many participants to going out. Many people needed help and so had to rely on another person if they were to get out.

I was out yesterday. I wouldn't walk down the road now if I hadn't someone to hang on to ... or something to hang on to ... I'm pretty wobbly. I go to the left most of the time.

If I were younger I wouldn't miss the film [name of film] for anything... But I'm not able to go because I have a bit of waterworks trouble. And, ah I'm just not able to do it.

Interpersonal Barriers

Interpersonal barriers describe barriers to communication and include sensitivity to, and concern for, the busy lives and space of others, a lack of shared interests, limited social networks and limited contact.

Concern for the Busy Lives of Others

Participants often stated of family and relatives that 'they've got their own lives' and that they were conscious of being a nuisance. An awareness of how busy friends, neighbours and family were inevitably had a negative effect on the amount and quality of social interaction. This was exacerbated further when the family lived at a distance or lived outside Ireland. For some of the older old participants, the reality was that their sons and daughters were also getting older and sometimes not enjoying good health.

I don't have a lot of visitors. My family, one boy lives up on [names road], but emm, he works down in [another county]. Now he has to leave his house at a quarter to seven every morning ... And he's not home until half past eight at night or maybe twenty to nine.... So I really don't expect to have an evening call from him... And then the girls are working. So I've only two children ... two daughters-in-law. But I mean, they must live their own lives. But I would like to see them occasionally.

Not wanting to bother people was a theme closely linked to independence and also to an acceptance of one's circumstances – both aspects of personal philosophy. Participants were aware that they needed help but consciously decided not to interact socially rather than to bother someone.

And on my own ... who can you call, you know, I'd no one to call. So at those times there's nobody maybe to pick up the phone ... But maybe that's my fault I don't like asking people, you know.

Not Having Shared Interests

Participants indicated how shared interests were important to enable social interaction. Conversely not having shared interests or something in common, such as grandchildren, made social interaction difficult or caused participants to be aware of certain deficiencies in their own lives. In addition, some felt that they had little in common with new younger neighbours.

This district has changed ... you see they are a lot of newcomers, you know young people with families. It's grand to see them and all the rest of it but ... I wouldn't have anything in common with them.

4.3.2.4 Summary for Category Two

This category described the type of relationships and social life of the participants and aspects that may act as barriers to social interaction. The barriers to social interaction that were identified can be seen as factors contributing to loneliness and social isolation rather than as a direct cause of either of these.

People-related social networks included networks that involved companionship, family, home help, friends, neighbours, visitors and other individuals. Activity/organisational-related social networks included socialising and enjoyable activities, which were described as important factors in maintaining social interaction and incorporated items such as religious activities, and the importance of 'getting out' of the house.

Initiatives that allowed for the diversity of circumstances of the participants and emphasised their abilities were particularly successful. Support that was flexible and promoted individual choice and independence was well received. Religious organisations had an importance to many participants. Participants with companions stressed the importance of this person in preventing lonely or isolated feelings. The older people themselves provided a great resource in that they made efforts to visit people who they thought might be lonely. Visitors with a practical significance, such as people who maintain good housing conditions or a physiotherapist who promotes mobility, had far-reaching if indirect effects on loneliness and social isolation.

Barriers were described by participants and were presented within the four themes of psychological, environmental, physical and interpersonal. Where participants experience only one barrier, it might or might not prevent social interaction. However, participants commonly described a compounding effect of barriers. Some participants were disinclined to go out and interact with other people. While this was a very positive choice for some, for others it perpetuated and further limited social interaction. Environmental barriers to social interaction generated the maximum amount of data. Transport deficiencies and lack of knowledge of existing services were considered very significant barriers.

While participants indicated that general good health was the most important factor in promoting social interaction, the opposite was also true, with participants explaining that their poor health caused a decline in social interaction. Participants specifically indicated a number of physiological conditions, which ranged from vision and hearing problems to mobility and bladder control.

A number of interpersonal barriers to social interaction were identified which interfered with relationships and communications. These included a recognition on the part of older people that people are busy, and older people may consciously step back so as not to intrude on the lives of others. Participants indicated how limited social networks meant their social circle got smaller and thus more limited. Some participants reported limiting their social interaction out of a feeling of personal deficiency or because of circumstance.

4.3.3 Category Three: Isolation

This category included participants' descriptions of the experience of isolation, features associated with isolation and coping mechanisms employed by participants. Isolation, in contrast to loneliness, was described by participants as having some positive aspects to it. There were fewer emotional terms and more practical terms attached to the feelings of isolation. For instance, participants concentrated on isolation causing vulnerability or threat to the person or personal possessions. Some practicalities associated with isolation have been described as barriers to social interaction rather than causes of isolation.

4.3.3.1 The Experience of Isolation

Several participants stated that they liked their own company or that they had grown used to their own company and would not like to fit in around anyone else. Findings indicated that the quantity of social interaction desired by participants differed greatly. Some participants had hobbies that were solitary, such as reading. Many participants said that at least for some of the time they appreciated having time on their own.

I mean if you've people all the time, you kind of get ... I get kind of tired ... Frustrated.

There were two negative aspects to isolation as described by participants: feeling vulnerable and feeling lonely. Participants spoke mostly about the vulnerability in relation to isolation: this appertains to the practical nature of not having someone there in a crisis or potential crisis. Several participants said that isolation could lead to feeling lonely. The following quote sums up participants' descriptions of vulnerability and isolation.

Yes, all the falls, eight stitches there. All along my face there I fell against the sideboard down there actually. I ended up in [Name] Hospital. I got those when I fell across the hearth my head was up against that. Because there's no use in my body, when I fall I'm down I'm down, and [Husband] isn't able to help me.

4.3.3.2 Factors Associated with Isolation

A range of factors associated with older people feeling isolated were identified: insufficient company, poor relationships, and isolated times.

Insufficient Company

One of the reasons participants gave for feeling isolated was that they simply did not see many people. Several participants described receiving very few telephone calls or visitors. As described earlier, the amount of social interaction that people find acceptable varied and it was possible that there was a greater need for visitors when participants could not use the important coping mechanism of 'getting out'. Some participants who were unhappy with their levels of social interaction reported feeling dejected.

And, maybe by night-time I haven't seen a sinner all day.

Several participants associated not seeing their family with isolation. Various reasons were given for not seeing family members, such as living at a distance or abroad, relatives being unwell, being too busy and because of family disputes. The latter is related to the theme of 'poor relationships'. All participants had experience of the loss of a family member or close friend through death, indicating that for participants their social circle was constantly narrowing and this was a source of feelings of isolation.

Poor Relationships

Participants referred to experiences of 'falling out' with or feeling let down by friends or family. Participants felt very isolated when involved in family disputes, which had a compounding effect on the participants as, not only do they have a narrower social network, but they also felt very hurt about the dispute and this may have had a negative effect on mood and desire to seek interaction.

Another aspect of this theme is instances where participants felt they were being patronised or being given 'token' time for interaction. Several participants gave accounts of people coming in to visit but not sitting down, not listening or not seeming to care.

They were brought up in an atmosphere of sharing, loving, helping. We did all those things ... We loved doing them ... And I don't know where they got the, the example to be so self-contained and not to bother about their mother. But if they don't do it out of respect or love, I don't want it done by, by them at all.

Isolated Times

Participants identified certain times, which were associated with feelings of isolation. Generally speaking, participants related feeling isolated when they thought of a crisis that had occurred or of a potential crisis. Potential crises included a break-in, the thought of falling and not being able to get help, or needing work done on the house and not having the resources to do it. Clearly, this was more of a worry to those participants who had limited mobility.

I'm at my most isolated when I'm in the shower. You see that's why I've stressed washing facilities, supervised washing facilities. Somebody within call, I don't mean someone with me in the bathroom. Someone around. If I fell in my bathroom I would probably lie there maybe for days. Sometimes I bolt my doors on the inside and they wouldn't be able to get in anyway. Eventually they would have to break in. I've got over that now with this thingy [personal alarm]. I'm sure that a lot of old people would feel like that, the fear of falling. I think most old people feel like that.

The most extreme of these crisis situations was a flood. One participant explained she was soaked in her bed because the water tank burst in the loft space. The immediate feeling of helplessness and having no one to call to help her was a feeling she described as isolation.

Death was an important theme throughout the findings and it was also associated with isolation. People described awareness that others did not know how to talk to them when they were recently bereaved; this led to participants staying away from people so as not to make them feel awkward, or friends and neighbours staying away from participants.

Ah well, I suppose it's like that. You sit sometimes in your chair, you feel ... what I could have been doing with my husband now, we could have been walking, swimming, going to the theatre, going away for a weekend, going away on a holiday together.

Several participants pointed out that isolation could be felt during social interaction if the participant felt that he/she could not relate to the conversation or if the conversation in some way excluded the participant so he/she felt unable to join in.

4.3.3.3 Coping Mechanisms

Many of the coping mechanisms identified related to the loneliness category; however some coping mechanisms are different for isolation. For example, social interaction sought here is more functional – to let someone who can help you know something is wrong. Coping mechanisms related more strongly to isolation than loneliness and were associated with preventing a crisis or having someone to call in the event of a crisis. As a result the major coping mechanisms described by participants for isolation as opposed to loneliness were having security systems, having a telephone or mobile phone and having a personal alarm. Participants said they felt much less vulnerable and less isolated by having such devices.

There are plenty of people ... If I press the button somebody will come. You know these things [alarm] are here and that makes you feel more secure, doesn't it?

It was also suggested that having one special person to rely on prevented feelings of isolation. This is closely related to the strong desire for companionship described earlier.

Well you could and you would be relying now ... I tell you for example, you would be relying kind of on your, say on your nieces and not them all maybe only one out of the whole lot of them. All lovely people and when you meet them and couldn't do enough for you when you meet them but one sincere one, that you know could be there for you if you needed her now ... The others are great but well of course they're working too, they're working so many days a week and I could understand that.

4.3.3.4 Summary for Category Three

This category as described by participants included the experience of social isolation, the factors associated with social isolation and the coping mechanisms employed by participants to prevent or allay social isolation.

Participants described the experience of social isolation as having some positive and negative aspects to it. Positive aspects included the enjoyment of time spent alone. Negative aspects included feeling lonely and feeling vulnerable to personal injury or damage to personal property.

The features associated with social isolation were insufficient company, poor relationships and isolated times. Clearly participants differed in terms of what they perceived as an acceptable amount of company. The theme 'poor relationships' was a complicated one in relation to feelings of isolation, but in all cases negative life circumstances impacted on these feelings. Isolated times were related to times of crisis or potential crisis where participants feared for their physical or material well-being.

Coping mechanisms seemed to be practical in nature, which reflects the expression of isolated times being when a person needs or could potentially need help and were apparently amenable to coping mechanisms that promoted security.

4.3.4 Category Four: Loneliness

This category includes four aspects: the differentiation between loneliness and isolation; the experience of loneliness; coping mechanisms; and lonely times.

4.3.4.1 Differentiation between Loneliness and Isolation

Participants often found it difficult to differentiate loneliness from isolation. Often when asked about isolation the participant answered using the term 'loneliness' and vice versa. In order to clarify this, participants were asked directly if they perceived a difference between loneliness and social isolation. Some of the differences identified are illustrated in the following extracts.

Loneliness is a different thing. I mean to feel lonely ... isolation ... now I suppose you could combine the two together you know, I mean, I suppose one does relate to the other if you're very, very lonely you feel isolated.

I don't feel isolated, I would be lonely for people who have gone.

I think they're the one and the same thing [loneliness and isolation] ... No they're not. They're two different ... I think ... how would I explain isolation? Emm, away back now when I was back in the North, I used to visit to visit this old lady and she lived quite far out ... Now I'd call her isolated. Now ... she wasn't lonely.

The data suggests loneliness was closely related to isolation in that when the level of isolation was at odds or inconsistent with the individual's expectations and aspirations (aspects of personal philosophy) for the level of social contact they would have liked, then this seems to lead to loneliness. Isolation was not always problematic. Indeed certain individuals indicated that they were entirely comfortable when they were in their own company. The data suggested either state can occur alongside, or independently from, the other.

4.3.4.2 The Experience of Loneliness

The experience of loneliness as described by the participants was varied, ranging from fleeting mild feelings to ever-present feelings causing suicidal thoughts. One very clear feature of these explanations was that loneliness was a continuum of negative feelings from slightly negative to extremely negative and no positive aspects were identified by participants. Another key feature was that participants found loneliness a difficult subject to talk about. Firstly, perhaps, because it was a subject linked to painful experiences and, secondly, because participants seemed to struggle to find words to

express their feelings. Experiences of loneliness included feeling a void, negative emotions and acceptance.

Feeling a Void

Participants referred to loneliness directly as a void or indirectly as boredom; not knowing what to do; having too few things to worry about; an awareness of an empty home; feeling no-one cares; and life having no meaning.

Often where participants were struggling to describe loneliness they made the comparison between their current circumstances and those when they were younger or those experienced by their peers. Their descriptions were indicative of people coming to the realisation that there was something missing in their lives.

There's a void there because when [husband] was alive, Lord rest his soul, like we always planned what we'd do on the bank holidays. Everyone didn't go away the way they do now ... Not in those days. But you always planned, and you knew what was ... what you were going to do, or who you were going to invite or who you were going to meet when you got there.

Boredom was identified as a key theme in relation to loneliness. The predominance of this theme reflected the most frequently mentioned coping mechanism, 'keeping busy'.

But I mean nowadays, I mean eh, I can't complain myself but ... come about half ten onwards ... bored stiff so what do you do? You go back to bed.

Participants described 'not knowing what to do' to get out of the lonely situation they were in. Participants also referred to not having enough to worry about when describing the experience of loneliness. The quotes below seemed to infer that having something to worry about might be preferable to the loneliness or an absence of things that concerned them.

I: *You know those times when it is that you do maybe feel lonely, can you explain it?*

R: *The only way I can explain it is that you start feeling sorry for yourself and that's the worst type of loneliness you get, because you've nothing to feel sorry about, that's the trouble. If you had trouble it would be a different matter.*

Apart from that there's not much else for me to do. Then if you Hoover during the day, there is no one there to dirty it for you and if you take a cup of tea, then there is only the one cup and you'd be hoping that there would be more cups to wash.

Many participants explained that loneliness could cause one to talk to oneself. An awareness of something missing was ever present in participants' descriptions of loneliness. In the excerpt below personal worth was suggested as the missing factor.

I: *That would be like loneliness would be?*

R: *It's an indescribable feeling of worthlessness. You've nothing to offer.*

I: *Nobody needs you?*

R: *You could say nobody needs you. That is the most awful feeling in the world. Nobody needs you. Why? Because you're worthless. Now it's not that but that's how you feel about it. That might not be the case but it is how it feels.*

Participants described a certain predictability associated with loneliness which was experienced when participants knew they would have a long period with no social contact.

Because [name] ... should come at the weekend, that's my home help, she comes on a Tuesday, Thursday and Friday, but she has to have some time off I realise that and she didn't come at the weekend so I was feeling more ... Saturday a horrible ... Sunday's the worst time. I go to ... up to the church there to Mass on a Saturday night. And then that's it then ...'til [home help] comes on Tuesday ... That's why I don't like the weekend.

Negative Emotions

Several negative emotions in relation to the experience of loneliness were also described, including pain, depression, feeling worn down, broken-hearted and fearful for the future. Although loneliness was not perhaps the sole cause of emotional suffering, it

seems that these emotions were not so easy to separate from the feeling of loneliness experienced through life crises, such as the death of a loved one or family breakdown. The following two quotes showed how these negative emotions were related to loneliness. A minority of participants expressed these more extreme feelings and in most of these cases the feelings were linked with another crisis in personal circumstances.

I: *Just really looking at a particular time in your life, when you did feel lonely and what that felt like?*

R: *Well I don't think I could describe that. It was just ... I mean to lose your partner, it was absolutely devastating and just missing him is absolutely ... You couldn't explain the pain in your heart.*

It was loneliness and I wanted my brother so much, that I just didn't care whether I died - I wanted to die, literally wanted to die ... I was careless, I didn't care what happened to me, I was walking out, whether ... it wasn't intentionally, but I wasn't taking a bit of care to the traffic.

Importantly, participants highlighted the nature of loneliness as a self-fulfilling experience in that feeling lonely made one less inclined to go out. The following quote highlights how loneliness could be self-perpetuating and could have serious effects on individuals' mental health.

R: *Well you see, I went through a period of loneliness. That's why I wanted to talk to you ...*

I: *Would you tell me about that?*

R: *That was when [husband] was in hospital. And the family all gone you see and ... I was just alone in the house ... for ... a year. A year and a half.*

I: *Right.*

R: *And eh, it was misery, pure misery. And the thing ... the way it affected me was that I gave up wanting to do anything ... Even if somebody said "I'll bring you out. I'll bring you to the theatre on Tuesday." ... I wouldn't want to go.*

I: *No?*

R: *I got into a ... eh, I think it was depression.*

Acceptance

When discussing loneliness the majority of participants suggested they had come to accept their personal circumstances. Acceptance could be seen as adaptation to changed life circumstances, but it could also be negative if participants accepted circumstances they were unhappy with before exploring other coping mechanisms which could improve lifestyle. The degree of acceptance was closely linked to personal philosophy and life circumstances.

I: *Have you ever felt lonely at any time in your life?*

R: *Lonely and sad, all the time. But there's nothing you can do about it ... you can do nothing about it. What can you do about it?*

I: *I suppose in a way why we're doing this research is maybe if people could tell us maybe what makes them feel lonely?*

R: *What difference would it make though ... What difference would it make now to us? You can't help us can you?*

4.3.4.3 Coping Mechanisms

Coping mechanisms used by older people to deal with loneliness included filling the day, social interaction and 'turning your mind'.

Filling the Day

This theme linked very closely to the experience of loneliness as a void as these activities are what participants described as things to fill the day or fill the void. The majority of these coping mechanisms relied on the individual having the resources to

enable them to take part in the activity. Often participants described coping mechanisms they used in the past but were no longer able to use (through loss of vision or mobility), and these individuals seemed to suffer more acutely from feelings of loneliness.

One way of filling the day employed by several participants was to stay in bed longer in the morning and go to bed earlier at night. Some participants said they had problems sleeping and took sleeping tablets for this.

Eh, ... it gets me at night. That's probably why sometimes I go to bed earlier... I mean if [daughter] is here now, it doesn't bother me too much because there's somebody either going to come or somebody going to go or ... em, waiting for something ... If, if I'm just here on my own, I'll probably get fed up with the television (mumbles intonating TV), "You know what's the point" ... Now, those times you feel a bit down ... So I just go to bed and sleep it off and get up in the morning and I know I've got some work to do in the morning.

Media, including radio, television, the newspaper and books, were the most commonly employed strategies and all participants had either a radio or a television and many had both. Many liked music and radio talk shows. Many participants who lived alone kept a radio in the bedroom, which they would listen to if they felt lonely.

R: *Yes I do, I like the radio too.*

I: *Which station would you listen to?*

R: *Oh the ... [local radio station] of course.*

I: *Is there anything specific about that radio station that you like?*

R: *Ay [Radio Presenter], and people like that, they're like old friends. Just like the television. You get used to names and people like that. They're just like old friends coming into the house and talking.*

The newspaper functioned as a way of keeping in touch but, for some, reading the paper was more to do with preventing feelings of isolation than filling the day. Closely linked with reading the newspaper was the completion of crosswords. Many felt that in addition to filling time it kept their minds active. Reading books also passed large periods of time for the participants and gave them interesting things to talk about. There was a sense that television was good because it distracted people from the feelings of loneliness, but after watching a film the loneliness was still there.

Housework, cooking and sewing were important pastimes. Independence with housework was important, not only because it filled the day with activities, but also because feeling independent seemed to be important to general well-being and also because having to do chores gave participants a sense of purpose. Many participants talked about hanging on to their independence with light household chores despite having a home help. Also for many having a clean house promoted a sense of well-being and a feeling that they were coping.

R: *But maybe as for loneliness, I think when I've been used all along, keeping myself busy. You know, because ... I just can't emm, ... I keep myself occupied all the time.*

I: *Yes. So a day, a usual day would be ...*

R: *Keep the house running and ... keep the house running. Don't do too much. And a bit of gardening.*

Taking exercise was another way that mobile participants felt they filled their day. Many immobile participants also felt they missed this coping mechanism greatly.

Not all coping mechanisms were without risks to health and participants reported smoking and drinking as coping mechanisms. Several participants employed these pastimes and they referred to them as a 'crutch' or 'something to do'.

The evening time would get to me. Eh, I might as well, ... eh I might as well finish with it. When [wife] first did die, ... I would go down in the afternoon and buy myself a drop of beer and a bottle of whiskey, come up here and try to kind of drown my sorrows I suppose it would be ... It didn't work.

Social Interaction

Seeking interaction seemed a more fulfilling way to allay feelings of loneliness and was a different mechanism to filling the day by watching television, for example. Participants said they felt happy to spend evenings on their own if a portion of the day was taken up with social interaction. For others, any time alone was lonely. This highlights the fact that different individuals have different expectations about the amount of interaction they require.

Shopping was an important form of social interaction, which, over and above necessary shopping, was employed as a way of dealing with loneliness. Brief conversations with shop assistants also seemed to serve as beneficial social interaction. Getting out of the house not only filled the day, it gave a purpose and focus for the day, and loss of these activities was associated with loneliness for the participants. Going to church also increased the possibility of social interaction with friends and acquaintances, and enabled the use of other coping mechanisms, such as faith. However, going out and seeking social interaction was not an option for some of the participants due to mobility difficulties. Some reported that they lacked this opportunity and felt it added to their loneliness. For them the only option was the telephone, which was considered a good means to deal with loneliness. However, one participant indicated that there was no one she could call on the telephone.

In relation to those recently bereaved, many participants stated that talking to others in similar circumstances was very comforting.

But I come here and I love this club, it's great out and if I don't feel ... if I feel anyway down which I have been there for the last few months I can pick up the phone and [name] will sit with me for ... and listen to me for an hour.

Pets were considered important in preventing loneliness for several reasons. Some participants said pet ownership made them go out and this gave them focus and increased social interaction. Pet owners felt they had a 'relationship' with their pets and having a pet promoted feelings of safety.

And I've a little dog, I love my little dog ... My dog, ... [name]. He's tremendous company. We should have gone into that. All people should be encouraged to keep a pet, a pet dog. I can talk to [name] and we understand one another. [Name] runs around and looks up at me and I know

exactly what he wants. There's some sort of mental communication there. If he asks for a drink of water, he wants to go outside, he wants a bite to eat, I know what he wants.

Finally, participants stated that they avoided certain social situations that they felt might cause feelings of loneliness or isolation. For instance, participants would avoid going out with a group of people who might talk about things they could not relate to.

'Turning Your Mind'

This refers to coping mechanisms that involve the psychological activity of thinking about things other than their own circumstances. This was a phrase used by one participant who described putting the situation in perspective or reframing the problems.

One of the things participants said made them feel better about their loneliness was 'seeing people worse off'. Participants said that this would 'shake them out of it' and help them to put their own situation in perspective.

Reminiscing was also employed as a psychological strategy but this seemed especially effective when done with another person who shared those memories, and certain participants said they would spend time 'in their memories', evoking memories which made them laugh or feel contented. However, for some, specific memories caused grief and sadness.

Participants who followed a religion said that when they felt very lonely they would rely on their faith to get them by. There were many facets to this coping mechanism such as the comfort they derived from saying prayers, faith that things happen for a reason and the fact that faith had been a continuous thread throughout the participants' lives. Some participants had no particular religious beliefs and did not use or miss using this coping mechanism.

I think minding my faith is important. I always believe that nothing happens by accident. So whatever has happened to me was meant to be and fine, I go on with the flow. Really, you know, because I feel that, well the Scripture tells us that the widows are looked after and I feel that if it wasn't meant to be, it wouldn't be.

4.3.4.4 Lonely Times

Participants identified times that they found particularly lonely. The most common time that participants described as feeling lonely was after the death of a partner, friend or family member.

*Yes, I'll tell you what makes me lonely. See now, I'm 84 ...
and a lot of my friends are going to heaven.*

It is important to note that while some participants found certain times (winter, for example) to be particularly lonely, other participants found this time the least lonely. This highlights the links between the person's personal philosophies and the meaning ascribed to certain times. Some felt that at night-time, social interaction was harder to come by because they were frightened to go out in the darkness and they also got fewer visitors. Other reasons were that television was not interesting at night or that historically they associated the evening with company.

Perhaps because some data was collected before Christmas, several participants said that this time of the year was particularly lonely. Some remembered previous Christmas times that had been shared with absent people. This theme was also linked to 'comparing yourself', as people said they felt others had families or a more fulfilling Christmas than they had themselves and this made them sad. Another feature of holidays and weekends was the lack of services available and this contributed to feeling lonely at these times.

Several participants said the time when they retired was very lonely. One participant had prepared for this by planning his retirement. Others said eventually they found activities to fill the gap that retirement left but that finding the contacts was not easy.

4.3.4.5 Summary for Category Four

The experience of loneliness comprised four aspects: the difference between loneliness and isolation; the experience of isolation; coping mechanisms; and lonely times. The study sought to identify distinctions in the participants' explanations of loneliness and social isolation. One uniting factor among participants was that loneliness was hard to describe. Descriptions of the experience had three aspects: a void, negative emotions and acceptance.

Lonely times, as described by participants, were at night-time, weekends, winter, Christmas, retirement and, commonly, the death of a loved one. Coping mechanisms fell into three themes: filling the day, social interaction and 'turning your mind'. Individuals' ability to use these coping mechanisms varied.

4.4 Summary

The four categories reported in this chapter described participants' experiences and understanding of loneliness and social isolation.

It is important to acknowledge that individuals' experiences occur within a life context. The category 'personal context' incorporated factors such as personal history and philosophy, and these factors mediated both the amount of social interaction possible and the ability to utilise many of the coping mechanisms described by participants. Participants indicated that they often did not want particular assistance, but that they simply wanted obstacles to be taken out of their paths so that they could have equal access and be independent. Maintaining independence enabled a sense of purpose, which was very important to participants in preventing loneliness and isolation. Adaptation to and acceptance of personal circumstances were aspects of this category which may limit older people's expectations and engagement in social interaction.

The category 'social interaction' described the social networks of older people and indicated the importance of family and an ever-diminishing circle of friends in this respect. Participants valued the opportunity to get out of their homes, not just for focused meetings, but to engage as part of the general social milieu through shopping, walking or travelling. Specific opportunities to engage with other like-minded people who had shared backgrounds or interests, in community centres, church groups etc. were highly valued.

In describing barriers to social interaction a number of factors were identified, most especially that opportunities for social interaction are severely limited by the lack of transport and other environmental issues. Where participants experienced only one barrier, it might or might not impact negatively on social interaction. However, participants commonly described a compounding effect of barriers, with no counteracting enablers such as a helpful neighbour or friend.

Older people wished to be independent and in control of their social interaction and engagement in activities but their environments and the access to flexible services necessary to achieve this were not always available. Access to flexible transport was considered very important. In addition, it seems that participants consciously limited their 'invasion' into the lives of others, including significant others, so as not to infringe on their busy lives. This is a self-imposed limit to social interaction that to some degree could be addressed with more flexible services such as transport.

In the category describing isolation, participants did not always report isolation as problematic and some felt very comfortable with their own company. The experience of isolation included factors associated with isolation and coping mechanisms employed to prevent or ease feelings of isolation. Negative aspects of isolation were feeling lonely and feeling vulnerable to injury to person or damage to personal belongings. Factors associated with isolation were insufficient company, poor relationships and lonely times. While some participants felt they had nobody upon whom to call in an emergency, participants generally felt they could call on their family if they needed help. However, if for any reason a person did not feel they could call their family, this caused a sadness which the participants described as feeling isolated.

Generally, feelings of isolation could be experienced at times when it was harder to attain or maintain social interaction, such as night-time, winter or in an emergency. The period following the death of a loved one was also indicated as a time when participants could feel very isolated. This occurred in two ways: through the loss of someone dear and because the grieving process could cause feelings of isolation.

Coping mechanisms for isolation, where they differed from those for loneliness, were practical in nature. Having security systems, personal alarm systems and telephones were all important coping mechanisms to prevent feeling isolated. Participants seemed to feel that these systems worked very well, which differed from coping mechanisms for loneliness where, despite adopting these mechanisms, participants could still feel lonely.

The final category 'loneliness' included participants' descriptions of the differentiation between loneliness and isolation, the experience of loneliness and the coping mechanisms employed to prevent or ameliorate loneliness. Participants' descriptions of the differences between isolation and loneliness varied greatly and demonstrated a shared difficulty in finding words to distinguish between the experiences. Many used the terms interchangeably. For participants, loneliness is closely related to isolation in that, when the level of social interaction is inconsistent with an individual's expectation, this can lead to feelings of loneliness. Data suggests that the states of loneliness and isolation can occur alongside or independent of one other. Loneliness was described as

being a void of emotions, a physical void or an interpersonal void. There were some negative emotions related to loneliness such as feeling worn down and fearful for the future; a minority of participants experienced these as more severe aspects of loneliness.

Coping mechanisms were closely related to the experience of loneliness as a void as they involved filling the day or keeping busy. Participants also employed psychological coping mechanisms. When personal circumstances prevented participants employing other coping mechanisms, psychological coping mechanisms were the only other recourse. Psychological coping mechanisms could lead to acceptance of circumstances, which could be seen as positive adaptation but also could lead to acceptance of circumstances before strategies had been tried to improve lifestyle.

In conclusion, all participants had experienced loneliness at some stage in their lives and loneliness was always perceived as a negative state. By way of contrast, social isolation, while it can lead to older people feeling vulnerable and/or lonely, was not always viewed negatively. Where social isolation was problematic it was amenable to practical solutions as proposed by participants. The single most important factor proposed by participants for the alleviation of loneliness was enhancement of social interaction opportunities.

4.5 Conclusions

Given the qualitative nature of the foregoing findings, insights rather than recommendations are presented. It is important to note that the participants did not constitute a representative sample, as was the case in the quantitative aspect of this study. The endeavour in the qualitative research component was not to identify a cause and effect relationship between factors and loneliness and isolation, but to provide a greater understanding of the experience of older people in relation to these issues. This deeper understanding is useful in forming strategies for older people in combination with other research in the area, the survey data presented in this report and in understanding why initiatives for the alleviation of loneliness and social isolation may or may not succeed. The following insights as identified by the older people in the interviews in this study are presented with this *caveat*.

1. Social interaction opportunities are important. Significantly, companionship was vitally important to many participants. The development of interventions that enable opportunities to promote and maintain friendships and companionship is desirable. In addition, it is also desirable to promote a sense of community 'involvement' for older

people through community networks involving personal callers/befriending and the provision of activity centres or the extension of existing community groups to include activities involving older people.

2. Independence was important to participants as it maintained a sense of purpose in their lives. Promotion of and maintenance of mobility was vital to continued independence.
3. An acceptance and adjustment to changing and limiting circumstances was identified. Participants did not want to impose on others and this could be reflected in a reluctance to accept help. This emphasis on acceptance of circumstances by participants makes exploration of personal expectations important for any intervention to promote social interaction.
4. There appeared to be low expectations about lifestyle. Given that the experience of loneliness may perpetuate low expectations, there may be difficulties with the uptake of services for older lonely people. Participants' access to information about what services were available differed and this would seem important to address as it would impact on an individual's expectations.
5. The 'acceptance' of circumstance by older people warrants further examination and may point to the need to raise self-awareness and expectations among older age groups if they are to avoid some aspects of loneliness and social isolation.
6. Participants have diverse physical abilities and psychological coping mechanisms, and consequently participants require choice. Interventions should be individually planned and flexible. For example, flexible transport arrangements are needed by older people. 'Getting out and about' was considered very important by almost all participants, and people's different needs and abilities in this respect were diverse.
7. While some barriers to social interaction are more amenable to intervention than others, the presence of multiple barriers can have a compounding effect on participants' ability to interact socially and consequently on their experience of social isolation and loneliness. When considering an individual's needs, multiple facets of the individual, their social network and their environment need to be assessed.
8. The importance of social networks in preventing or alleviating loneliness suggests that the extent of social networks should be audited and targeted at local levels to have maximum impact.

9. Feelings of isolation can be alleviated by facilitating access for older people to housing repairs, house alarms, personal alarms and telephones.

The reader must bear in mind the context of the non-random nature of the sample and the inability to generalise from qualitative findings. Where qualitative findings are supported by survey data, they are included in the recommendations in Chapter Six.

Chapter Five

The Extent of Loneliness among Older People and Effective Measures to Deal with Loneliness

Chapter Five

The Extent of Loneliness among Older People and Effective Measures to Deal with Loneliness

5.1 Introduction

Four focus groups were conducted with key stakeholders involved in the planning and delivery of services for older people. The focus groups included members of both voluntary and statutory organisations, and were made up of participants working in

older people. In contrast, the findings from the previous chapters come from over 700 older people themselves. As such the conclusions should be considered alongside those contained in the other chapters.

5.2.1 Stakeholders' Perceptions of the Extent of Loneliness among Older People in Their Areas

Both planners and providers stated that they know of, or would come into contact with, older people who are lonely, and although there would appear to be an increase in loneliness, the number of older people who are lonely is still small. In one area, a survey was conducted recently which suggested that the prevalence of loneliness was lower than planners had expected it to be. In contrast, however, it was reported that the Senior Help Line has an increase in calls related to loneliness of approximately 80 per cent per annum. One clergyman noted that loneliness has become more acute, mainly because families have become fragmented. Participants stressed that being socially isolated does not necessarily mean that someone is lonely and that social isolation and loneliness are not the same thing. In addition, participants identified a number of factors involved in loneliness among older people. These points are outlined in more detail in the following sections.

5.2.1.1 Social Isolation Is Not the Same as Loneliness

It was suggested that being socially isolated is not the same as being lonely; some people are isolated but not lonely. Some choose to be alone, want to be alone and do not want others 'crowding' them. Others, although living in isolated areas, have a good community network. Some people have good networks and are still lonely, because they cannot cope with living on their own. People living in urban areas may also be lonely, especially where communities are less well established or where the population is transient.

5.2.1.2 Factors Involved in Loneliness

Loneliness Arising out of Acute Scenarios

Participants suggested that people may feel lonely because of acute scenarios arising from the fact that they live alone, such as in the case of bereavement, separation, illness and retirement. Older people may be coping well with living alone, keeping active, getting out and about, and maintaining links with the community, until they become sick. It was suggested that all people experience loneliness at some time in their lives.

I think all people can at some stage feel lonely, experience loneliness. But I do believe ... that the biggest jolt a person can get in their lives is the day they retire. Because for 40 years perhaps they have been associated with their friends at work and they come to retirement and they say, gee this is great, I can play golf every day now. But that's not on at all, because you can't play golf every day. I feel sorry at times for the people who are living alone, their partner has perhaps departed, died and they can be very lonely, particularly women, we have a lot in our groups. It can be very lonely sitting at home twiddling your thumbs looking at the four walls.

All that type of thing it has all changed but ... we try to be independent for as long as we can and then suddenly our independence disappears, be it through a bit of sickness or whatever and what happens as well is, you know a couple that had reared maybe nine or ten of a family or that they all done well and everything else. They come to see them but suddenly one of them dies and while they have their family maybe living within ten or twelve-mile radius and them all married and their grandchildren and everything they're still living on their own and it's an awful jolt to them. A house that was full of people now they're suddenly on their own.

Some People May Be More Prone to Loneliness

Participants suggested certain personalities may be more prone to being lonely than others. For example, some people may be a little eccentric or introverted and therefore find it difficult to mix with others. Other risk factors may include never marrying or having children, or being poor. One provider suggested that the loneliest people they came into contact with were those who had not married or where family supports had broken down. Participants also suggested that people who have returned from abroad or are from another culture may be more likely to experience loneliness because they don't have the same social networks or because of language difficulties. It was stated that being lonely does not just affect older people, some young people are lonely but the situation can become more acute as they get older.

*As you age, you become more of what you were earlier.
Some people are lonely throughout their lives and maybe
they have a personality that they can't get on with somebody*

or maybe that they're just melancholy by nature or whatever it is. ... I don't think loneliness goes with old age, again I think the notion that we're portraying old age as a lonely life and that all old people are lonely, it's the victimisation again and it's ageist, I think that. So I think it's maybe to do with lifelong patterns or predispositions.

Loneliness and Poor Family Relationships

Planners and providers also emphasised that someone can live with family and feel lonely if relationships are not good. Participants noted that loss of family contacts may relate to loneliness, for example, where families have become fragmented, have moved away or are caught up in a busy lifestyle, or where family disputes occur. It was suggested that, very often, older people see their peers dying and relatives moving away. It was also suggested that people are more likely to feel lonely at the weekend, particularly on Sunday, which is typically a family day.

Certain people whose peer group all died, relatives died, moved away, lost contact with family, maybe maiden aunts and so on, their nieces and nephews, busy with their own lives, do call now and again, but would not feel as close... although I have some nieces who are incredibly dedicated.

But an awful lot of people that you would talk to say that Sunday is a very lonely day. It is one of the loneliest days of the week because going back maybe 15, 20 years, it was the day the whole family sat around to the dinner together, so they find that it's the loneliest day or after five o'clock in the evening. But I mean there's only a certain amount that the day centres can do. The idea of a drop-in centre that everybody is integrated into a community setting, young and old, you have the generational crossover, you have everything.

Loss of Community Networks

Participants also noted the reduction in day-to-day callers within communities, for example, the postman, milkman, bread man, grocery delivery man; all of which can add to social isolation.

The postman years ago went around on the bicycle and he had time for taking the cup of tea and a chat and he could listen to their grievances or their complaints or what was wrong with them. The same with every other thing everything went so slow 30 or 35 years ago that everybody had time to say hello to everybody else, but nowadays we haven't and that's part of the problem. You know, times have sort of passed by these people. Everybody is so independent as well. Even going to Mass, there was a time them people all would have met their neighbours at Mass and they'd have words with them and they'd talk about what was happening in the locality and nowadays people go to Mass in the car and they're ... they go late and they get away as quick as they can.

Loneliness and Loss of Function

Providers suggested that loss of function and mobility, which comes with ageing, may be related to loneliness and depression, as it limits social contacts, particularly where older people become housebound. It was also suggested that general negative attitudes towards older people, paternalism and inflexible approaches may further alienate older people.

I think a lot of it is tied up again with the fact that the physical health of the person is such that they can't get out and about and have that bit of interaction even if it was only down at the local shop and things like that. But most of the people would be single or where one spouse had died and they're quite elderly and infirm, maybe with arthritis, curtailed, can't get out and about, and then they're very cut off and lonely ... if they could have a volunteer visitor of some sort, I think it would make a huge impact on their lives.

Loneliness and Fear

It was suggested that fear may be a big factor in loneliness as it may cause older people to become withdrawn. It was suggested that the increase in crime, increased reporting of crime and withdrawal of rural Gardaí all contribute to increased fear amongst older people.

Loneliness in Residential Accommodation

Both planners and providers noted that people living in residential institutions or nursing homes tend to become isolated. If they come from a village, neighbours tend not to visit them in the nursing home and entry for visitors tends to be restricted.

I was going to say that some of the loneliest people could be those who are in our residential institutions or in private nursing homes. They're one of a number and they don't get the individual, I don't know if you call it, love, that they need. They just don't get any sense that they're being treated as unique individuals. So our programmes have very much been targeted at keeping people at home, which is where they say they would like to be. And the assumption is that if that's where they choose to be and we help them stay there then that will improve their outlook on life and loneliness could be part of it.

5.2.2 Measures that Stakeholders Perceive to Be in Place to Deal with Loneliness and the Effectiveness of These Measures

One point mentioned by planners, and which is evident from the descriptions of interventions provided in focus groups, is that there is considerable variation between and within jurisdictions in relation to interventions established to address issues faced by older people, including loneliness.

Interventions which had been established were provided by both voluntary and statutory organisations, through statutory funding, grant aid and fundraising activities. Six different types of interventions were identified by participants:

- group activities
- visiting and befriending interventions
- day centres and social centres
- interventions aimed at enabling people to stay in their homes for as long as possible
- interventions aimed at providing alternative, suitable accommodation
- rural transport initiatives.

Participants also emphasised the need to involve older people in the planning and delivery of services for older people.

5.2.2.1 Group Activities

Group activities included Active Retirement Associations (ARAs), which are groups organised by older people who establish a range of local activities for older people. The Federation of Active Retirement Associations (FARA) provides support to local people interested in forming these groups. ARAs are involved in organising holidays, a wide range of social activities, creative and learning opportunities and community work. A range of retirement, senior citizens', social and parish clubs were also identified by planners and providers, and it was suggested that clubs tend to be focused around keeping older people active through participation in various organised activities. Some clubs also provide classes, such as nutrition and yoga classes. However, it was suggested in one provider focus group that clubs are not suitable for every older person. Some people may not mix very well in a group situation, while others may feel that particular clubs are not for them. In response to the perception in one area that clubs were dominated by women, a men's club was established. It was also suggested that some older people may be reluctant to join in group activities.

I think social clubs are great, I think all of these things are absolutely fabulous, but it's not to forget the person in all of this. Because they can go to all this, but it's like the old thing, we can work from nine to five, those of us who do work from nine to five and we go home after that, but people are left. Similarly if they go to clubs and it's grand, but they go home after that and they're left. It's a difficult one, but it's not to forget the person. I'm not saying anything negative about any of the services, or provision of services, it's just the individual should be the key focus, rather than the service.

It's about personality, isn't it? If a person, when they reach 65 or whatever, has been involved in clubs all their life, whether it's the local GAA club, it's something. Clubs are something that they will lean towards because it's something they're comfortable with. And if they were involved in an individual sport or activity, that's what they tend to lean towards as well. And it's about providing them with choice and people can be intimidated by large numbers and feel that it's not for them, so it's about creating a choice and if they

have a choice well then you know they can decide which is more suitable for them.

A range of social and other activities organised for older people was also identified, some of which are provided through clubs and others through voluntary organisations. These include yoga, bridge, painting, walking, various training and advice sessions, and trips to the theatre or cinema. One scheme funded by a voluntary organisation is 'Lunch date' where an older person can invite another older person for lunch without incurring the expense for lunch or for the transport required.

5.2.2.2 Visiting and Befriending Interventions

A range of visiting and befriending interventions were identified by planners and providers. In both regions sampled, visitation programmes are provided by employees or volunteers from different charities, with isolated lonely older people being referred to them by health care professionals, social workers, clergymen or members of the public. In one area, the role of community wardens includes visiting (or 'keeping an eye on') older people in their areas. Providers discussed in detail the importance of visiting older people:

... while our main duties would be traffic duties, litter, dog licence sort of enforcement elements, we have a role in keeping a watch out for the elderly and the vulnerable and, for instance ... a funeral in an area or a removal or whatever, we might be in that area and when all the people would be away, we might sort of keep an eye on the houses and that. It's kind of we are reassuring people that we're moving about and keeping an eye, watching out for suspicious vehicles or persons ... we would concentrate on a hard core of people that are very independent, some of them very advanced in years, and they still want to keep their independence and some of them still not in contact very much with the PHN or home helps.

I think they need a little bit of company, just somebody to call and visit and I find that a lot of women, I think, they have the death of a partner and there's a loss there and they have a loss when they lose the ability to go out every day and then maybe they have to stay in more and they get a bit angry or they're not able, they're not as good as they used to be all their lives. So I think somebody visiting, either

someone from the community, say voluntary bodies, if they have the names of all the people in their area that would visit from time to time, it might help. Those that don't need medical help. And I find that even living with somebody they can be isolated and lonely as well, say if they were bedbound, a person can be very lonely because they have nobody coming in from outside. Another person with different stories and ideas to talk to. And that's a loss they have.

In both regions, an initiative was established to get older people to tell their stories, which is reported to be working well. In addition, several schemes have been established to get younger people to interact more with older people, some through Transition Year programmes.

Planners in both health board areas identified befriending services that had been established by a voluntary agency or with grant-funding. These services were organised on a local basis and involve volunteers spending time with an older person on a regular basis. There was general agreement that this is a valuable intervention that has worked well. There was concern, however, that the grant-funding for one of these schemes has since dried up.

I think one of the greatest successes that we had in the last four or five years was the fact that we got a small amount of money through European funding to set up a befriending scheme and we did it in the [name] area. Now that money is dried up at the moment. But that was a great success and there was a great need there. Now where people would be very lonely and where there would be a lack of neighbours, we as [role], throughout the county, would endeavour to match somebody up with a young person or neighbour or whatever who would make a commitment to visit at least once a week or something like that or make a commitment of taking them for their shopping or whatever they need to do or taking them to church on Sunday. This scheme was a bit formal in that people were actually interviewed and there was a coordinator to coordinate the pilot and they also received a small remittance if they had to travel, so there was an incentive there, an encouragement, but by and large it would be something that we would try to encourage.

It was suggested that other visitors (service providers) to older people may not have time to stay and chat or that they may need another reason to call on an older person. The need for someone calling in on an older person to build a rapport with them was also emphasised.

There's also the emotional kind of stuff and the building up of trust with people, for example, you mightn't be let in once or twice and you stay talking outside the door and eventually there's a trust built up and you're allowed in. And after a while the emotions come, they share their emotions, the sadness and that loneliness and the crying and all of that. Sometimes we overlook that. For that trust to be built up and for that emotion to come, it's a massive release for people. And they will tell you that in [name] down the road how good the release that was. Sometimes, I'm not saying always, I can't generalise, that we provide porridge or a bucket of water or we provide a heater and we do that, but there's a whole other emotional thing that we don't cater for sometimes. And that takes time and it takes that trust and I don't think it should be forgotten because I think it's a great healer.

5.2.2.3 Day Centres and Social Centres

Both planners and providers spoke about the success of day centres for all of those who avail of them. The models adopted in all areas include transport to and from the day centre, and provide a range of services and social outlets for older people. However, it was also suggested that the inflexible approach to transportation which results in older people being collected from their homes early in the morning and returning home after dark (in the winter) sometimes prevents older people taking up the service. It was also suggested that some older people may be deterred by the perceived stigma of having a minibus call to the house to collect them. It was suggested that drop-in centres can provide a more flexible and appealing approach for some older people. In one area, the day centre is a social centre rather than a centre for the provision of services and also includes evening activities. Another point raised was that day services tend only to be provided during the week and that a weekend service would be beneficial.

There are very few drop-in centres around, where people wouldn't feel the onus that they are committed to say a Monday or a Thursday or one day a week, that people felt that when they were up to it and it was a nice day they could

have a potter on down, maybe get a bit of shopping in, collect the pension and then maybe drop in, without this you know ...

I know one lady of mine was very, very reluctant to attend a day centre, then it transpired that in actual fact she was quite keen to go to the day centre, but her husband was mortified at the thought of this minibus with all sorts of writing on the side arriving at the door and the neighbours seeing this. So then in the end, when we had a chat, and discussed that it would be very beneficial for his wife to attend. He then said yes, but he was going to pay for a taxi there and back, rather than have the minibus call.

I would come into contact with a lot of older people and I would see them deriving great benefit from the day centres, but I worry about the people who have opted out and don't attend the day centres, like elderly bachelors living in very, very lonely isolated areas who may see nobody from day to day and it's only maybe somebody like myself as they see me as being non-judgemental and maybe no tags or labels attached to me and they just ring up and you find a lot of older people admitting that they actually suffer depression and loneliness, particularly people whose children have moved away to the city, maybe even Dublin. Okay they ring them now and again, but that's all the contact that some of them have. And like you said a lot of the post offices are even closing in the area and postmen might be the only person they would see from one day to the next. So those are the people I would be very worried about. How are we ever going to reach them?

5.2.2.4 Interventions Aimed at Enabling Older People to Stay in Their Homes

A particular theme in both sets of focus groups was the need for planners and providers to do whatever is necessary to enable older people to remain at home for as long as possible. This was on the basis that older people prefer to be in their own homes and if the supports are not provided they will end up being admitted to an acute hospital or a nursing home. As previously identified, the perception of planners and providers was that older people are more likely to be lonely in residential care.

We would be very much in favour ... further development of social models, resource centre type of services in [place], for example, getting out of the residential business entirely because of the physical facility we have to deal with and getting much more into that, so we would be very strong in our feelings about the desirability of doing that and the value of it

Somebody mentioned just a minute ago, it also gives an opportunity as well for people to maintain social links, but to actually tap into the services as well, so we actually stop crisis admission to hospital or whatever it might be.

To come back to your question [name], in terms of the emphasis from the health board and that side, really the emphasis is through retaining people at home for as long as possible and to give them the choice to remain at home. So everything then comes into the equation, into the picture, socialisation, day care, whatever it is, to retain that person in their own community, where they're familiar with the surroundings.

It was suggested that a lot could be done to support older people to stay in their homes, for example, the provision of a home help, meals on wheels, home support service and home care assistance. Some participants stated that part of their role was to keep older people living at home, and to do, or to arrange, whatever they could to enable them to stay at home. Such activities ranged from arranging health care related services, such as chiropody and occupational therapy, to home support services and household repairs. In one area, a community survey had been undertaken to identify household repairs required to prevent older people living alone from having to leave their homes. Other sources of support identified for older people living alone included the Senior Help Line, television and local radio.

5.2.2.5 Interventions Aimed at Providing Alternative, Suitable Accommodation

A range of interventions was identified which are aimed at providing alternative, suitable accommodation for older people living alone. These included a 'granny flat' to enable older people to live close to relatives and community, or sheltered housing where older people can live independently but can call someone should they be required. Providers and planners described these interventions as successful. A 'Boarding Out a

Granny' scheme has been established in one area, where an older person is taken into the home of a volunteer, and this is reported to be working well.

5.2.2.6 Rural Transport Initiatives

One of the most frequently mentioned needs among older people is the need for rural transport. It was suggested that, although older people are eligible for free public transport, public transport is virtually non-existent in rural areas. One small-scale rural transport scheme introduced in one area and funded by the Department of the Environment was reported to have made a dramatic improvement to the lives of older people living in that locality.

A useful initiative that's cropped up in [area] ... to provide a rural transport service ... highly significant in terms of people living in rural isolation being able to access public transport ... and to go to the local shop, post office, town, village, whatever it might be, just to be out and about if nothing else ... I heard various people at the official launch of the service and they had experience of it over the preceding six months and they just said it made a dramatic difference to their lives. They were free again, because they were reliant on a family member, a neighbour or horror of horrors going out on the roadside and thumbing a lift or hoping that somebody passing would take pity on them, which was the ultimate indignity.

5.2.2.7 Involving Older People in the Planning and Delivery of Services

A theme running through all focus groups was the need to respect and value older people in the provision and planning of services. It was suggested that older people need to be involved in the development and delivery of services where possible. Some participants spoke about the need to empower older people and to respect their independence. Participants emphasised the need for interventions to be appropriate to the needs of each individual.

I think there is one element we need to look at and that's respect for the dignity of the person you're providing the service for. Because we do get money or people do get money to provide services, the goal is we get the service, we get the building, but maybe the dignity of the person is not being respected in the way it should.

On the other hand though I've worked in the community, speaking as a community worker and a lot of those people that someone might refer to as vulnerable do not want you. And you must respect that. If you're working in an area for any length of time there are very few people you won't know about, but they don't want your service and I think everybody has that right. ... We have to respect each individual and I fully agree ... that each person is an individual in their own right and as we age we become twice as much as what we were in our youth. So if you were lonely and you want to remain so, you will. I think we have to respect that when people talk about a vulnerable older person.

It was suggested that older people should be involved in needs assessment and, on an individual level, should be asked what their needs are rather than making assumptions. It was suggested that some older people may be reluctant to avail of services, perhaps because they have always been very independent. They may not feel ready to avail of services or they may be reluctant to get involved. The point was made that many older people are still very active and are in a position to make a significant contribution to service provision. It was also suggested that men may be more difficult to engage in organised activities than women.

5.2.3 Other Measures Stakeholders Would Wish to See in Place

Focus group participants were asked to identify gaps in service provision and other measures that they would like to see in place to tackle loneliness and social isolation among older people. With regard to providers, the item most frequently mentioned was information for older people. Participants spoke about the importance of information on entitlements, local resources, and available health care, health promotion and social services. It was suggested that this information should be made readily available to all older people and one medium suggested for this was to include a specific section in the local directories currently delivered to all homes. An information officer is employed by one of the regions included in the study but this role is not specifically directed towards older people.

With regard to planners, the most frequently mentioned gap in service provision was in relation to the coordination of services available for older people. It was suggested that more needs to be done to integrate all health and social services (both statutory and voluntary) for older people to address the current fragmented, patchy and *ad hoc* nature of service provision. Further, it was suggested that there should be one person

designated to have overall responsibility for older people within each health board region. One planner pointed out that there are already structures for a regional officer with responsibility for the unemployed and for people with disabilities, and something similar should be done for older people. In focus groups with planners and providers, it was suggested that there should be a nurse in each region with overall responsibility for older people. On a similar note, a particular theme with providers was the need for services to be better organised. They spoke about the difficulty of organising home help and home-care staff because staff are only given an hour or two a day and are poorly paid for the work that they do. Also mentioned were the limitations imposed on what home-help staff are allowed to do. It was also suggested that meals on wheels services could be better organised and targeted more accurately towards those who need them.

The next most mentioned gap in service provision was in relation to transport. Participants emphasised the importance of adequate and flexible transport to enable older people to participate as fully as possible in social activities, particularly in rural areas.

Providers spoke about the shortage of volunteers to visit older people and to do small jobs for them. It was suggested that there is a particular difficulty in terms of selecting and screening volunteers, and it was suggested that a volunteer bureau should be established.

In terms of service provision, the issue of equity and difficulty accessing services was identified. Further services or more widely available services required included home help and home support, laundry services, meals on wheels, general support to stay at home and chiropody services. In addition, participants in particular areas identified a need for a day hospital, for day services that are locally-based, for sheltered housing, for services to be extended to provide weekend cover and for services that would allow for early intervention when issues arise so that admission to hospital could be avoided. Participants also noted the need for more education programmes for older people and education programmes to raise public awareness of the responsibilities that everyone has for older relatives.

5.3 Summary

Key stakeholders involved in the planning and delivery of voluntary and statutory services for older people reported coming into contact with, or knowing of, older people in their areas who are lonely. Loneliness among older people may be increasing but the number of older people who are lonely is still small. Being socially isolated does not necessarily mean being lonely.

A range of factors contributing to loneliness were identified, including: not marrying, having no children, personality type, being lonely as a young person, poverty, not having lived locally and language difficulties. Loneliness may also occur as a result of sudden bereavement, separation, illness and retirement. Social isolation was related to loss of family contact or family disputes, reduction in day-to-day callers, fear due to increases in crime, loss of functioning and mobility, and negative attitudes towards older people.

A range of existing measures were identified that work well. These include group activities, visiting and befriending interventions, interventions aimed at keeping people in their homes for as long as possible, day centres and social centres, interventions aimed at providing alternative, suitable accommodation, and rural transport initiatives.

Stakeholders highlighted the patchy and *ad hoc* nature of service provision between and within regions. Particular measures that stakeholders would like to see in place included better information on entitlements, resources and services, better integration and organisation of all statutory and voluntary provision coordinated by an officer with specific responsibility for older people, better rural transport, a volunteer bureau, improved equity and access to services, more day hospital and day services which are locally based, more sheltered housing and the extension of services to weekends. Stakeholders also identified the need for additional chiropody services, home help and home support, laundry services, meals on wheels and general support to stay at home. There was a particular emphasis on enabling older people to stay at home for as long as possible, or where this is not possible, providing the most suitable accommodation for them, avoiding institutional care where possible.

5.4 Conclusions

Although the number of older people who are lonely is still small, loneliness may be on the increase and may be becoming more acute in nature. This is related to a reduction in community and family networks and is also related to specific acute events in people's lives. Although anyone can become lonely, certain risk factors associated with loneliness can be identified which could be used to detect older people who are at particular risk of becoming lonely. A number of specific interventions have been established which have proven useful in addressing loneliness and social isolation. However, the *ad hoc* and patchy nature of provision means that not every older person can avail of these services. Better coordination of services at regional level and the availability of services out of hours are also required. The availability of information and transport is of particular importance in ensuring that older people know of resources

available within their area and can avail of these. Transport is also important in ensuring that older people can participate in community networks.

As set out at the beginning of this chapter, the findings presented here should be considered alongside those contained in the other chapters. The following recommendations are made on the basis of the findings of the four focus groups with key stakeholders.

1. An index of risk factors should be developed to enable service providers to identify older people who are at particular risk of becoming lonely.
2. One person should be appointed at regional level with designated responsibility for the coordination of services for older people and to address the current fragmented nature of service provision.
3. Access to existing services should be widened to all older people within regions, and services should be identified where weekend and out-of-hour provision would be beneficial.
4. Rural transport schemes are critical in order to provide older people with reasonable access to key resources within their area. Rural transport schemes should be developed across all regions.
5. Currently the information available to older people is limited. Work is required to identify the type of information required by older people and the most effective mechanism to distribute this information. The appointment of an information officer for older people at regional level should be considered.
6. Home support and home repair services should be enhanced to enable older people to stay in their homes for as long as they wish to do so.
7. Visiting and befriending services can help to alleviate loneliness for older people who cannot leave their homes. Further visiting and befriending initiatives should be established.
8. Access to alternative accommodation should be improved for older people who can no longer live alone but who do not wish to take up residential care accommodation.

9. Group activities are important for older people to enable them to meet other people and to remain active. A flexible approach should be adopted in terms of the range of activities provided and the nature of their provision to ensure that all older people can avail of them if they so wish.
10. Day centres and drop-in centres are important to older people in terms of meeting other people, engaging in activities and availing of services provided. A flexible approach is required, particularly in relation to transport to and from such centres, to encourage older people to avail of these services.
11. A volunteer bureau should be established at regional level to facilitate the recruitment and selection of volunteers for service provision, including services for older people.

Chapter Six

Discussion

Chapter Six

Discussion

6.1 Introduction

At the beginning of the twenty first century, life expectancy at birth has increased substantially for Irish men and women, and older people in Ireland are living longer. While Irish people have generally high levels of social contact, increasingly many older people are living alone or with a partner. A large body of international and Irish research indicates that loneliness and social isolation are part of the experience of old age.

The aim of this study was to document the prevalence and the experience of loneliness and social isolation among older people in Ireland. The study employed a range of

of much of the social intercourse among older people. Nevertheless, the international and national literature indicates that social isolation can be part of the experience of being old, and, while it may be understood as an objective state by social researchers, older people may experience it subjectively. A range of factors are associated with social isolation, including the range and quality of social networks, while a significant consequence of social isolation is loneliness.

Loneliness is a complex, multidimensional phenomenon and its two principal variants are social and emotional loneliness. The literature indicates that the experience of loneliness impacts on individuals across the lifespan. Its prevalence has been explored in groups ranging from teenagers to the oldest old, and research results indicate that loneliness is prevalent throughout the entire population. However, international empirical research shows that, despite there being a widely held stereotype associating old age with loneliness and with social isolation, the prevalence of loneliness reported by older adults ranges from just 5 to 15 per cent of the population (Pinquart and Sorensen, 2001).

Loneliness has been associated with several factors relating either to older people's circumstances or to their personal characteristics (Kileen, 1998) such as age, social and economic circumstances, living arrangements and social networks, family function and the quality of social relationships. Older people's personal characteristics including their physical and mental health, and their cognitive integrity, self-esteem and pre-morbid personality are also associated with loneliness. The literature suggests loneliness also has consequences for older people including altered physical and mental health. Numerous strategies for preventing and alleviating loneliness have been advocated and these may be categorised as either social/community-level or individual-level approaches. Since loneliness is a complex individual human experience that can occur in the presence of social contacts, the benefits of social/community-level strategies may not, in and of themselves, be sufficient to prevent or alleviate loneliness. Furthermore, since loneliness can occur in the presence of social contacts, social intercourse will not, in and of itself, prevent or alleviate loneliness. The fact that loneliness is ultimately a subjective experience suggests that individual-level strategies must feature in any attempts at prevention or alleviation.

6.2 Study Participants

Three types of participants were included in this research. The first part of this study was a national telephone survey of people aged 65 years and over, selected through

random digit dialling of telephone households in the Republic of Ireland. A number of population characteristics of older people were also measured in the telephone survey, including age, gender, marital status, residence, educational level, occupation and family-related issues. In the second part of the study, in-depth interviews were conducted with a purposive sample of 34 older people and one focus group of nine older people. Data gathered from the in-depth interviews and the focus group generated findings that described the experience of loneliness and isolation from the perspective of older people themselves. The third part of the study involved four focus group interviews with a total of 39 stakeholders involved in the planning and delivery of services for older people.

6.2.1 Profile of the Sample of Older People Involved

A cross-sectional sample of 683 older people, that the telephone survey yielded, completed the SELSA-S and the Network Assessment Instrument. When compared with CSO national demographic figures for Ireland (CSO, 2002), the sample was largely representative of the total population of older Irish people in terms of age, gender and marital status.⁴⁰ However, the study sample contained smaller proportions of women in the 75-79 years group and 85+ years group than are found in the population as a whole. In addition, single men were slightly under-represented for the same population.

Of those who were widowed, 80.7 per cent were women, a finding that may be explained by the increased life expectancy of females in Ireland. The mean length of time widowed was reported as 15.3 years, suggesting that many older people were living long after the death of a spouse (DOHC, 2001). The HeSSOP report (Garavan *et al.*, 2001), which had a similar sample size (n=937) to the present study, reported that 28 per cent of older people lived alone, with women making up two thirds of those living alone and over 50 per cent of these women being aged 70 or over. Of the participants involved in in-depth interviews, 61.8 per cent (n=21) were widowed, 14.7 per cent (n=5) were married and 23.6 per cent (n=8) were either single or separated.

In general, family networks remain strong in Ireland, representing the basis of much of the social contact that people experience. Over 60 per cent of the respondents in the telephone survey had three or more children and over 80 per cent had at least one child who was alive. Whether these immediate family members were the basis of much of the social contact that the sample experienced is unclear. However, the majority of the sample had both a spouse and at least one other family member as a potential source of social intercourse. Most of those interviewed lived alone (67.7 per cent, n=25), six participants were 'housebound' and three participants lived in nursing homes. Interview data also highlighted the importance of family in providing a social network.

40. Recent CSO demographic figures for Ireland show that persons aged 65 years and over represent 11.2 per cent of the total estimated population (CSO, 2002).

The survey sample comprised an approximately two thirds urban and one third rural mix, with the majority of respondents (91.4 per cent) living in a property that they owned and few (5.2 per cent) living with a relative. Of those older people involved in the in-depth interviews, just over half lived in an urban setting (55.9 per cent, $n=19$).

In conclusion, the sample recruited for this study is broadly representative of older people (people aged 65 years or over) living in the Republic of Ireland. The sample largely comprised older men and women living with a spouse in their own homes and older widowed women living in their own homes. The profile of the survey sample mirrors published demographic data concerning the social circumstances of older people in Ireland, which indicates that upwards of 30 per cent of older people live alone (Fahey and Murray, 1994). While these same published demographics indicate that a quarter of older people live in a household made up of an older couple, of the present sample, half lived with a spouse. Living with a spouse in later life can result in improved social networks (Kim and Baik, 2002).

6.2.2 Education, Income and Access to Transport

Educational level and socio-economic status are reported to be negatively associated with loneliness (Wang *et al.*, 2001; Kim, 1999; Dugan and Kivett, 1994). Among the survey sample, the oldest old (85 years and over) were significantly more likely to have completed primary education only (63.3 per cent); a little over half (50.9 per cent) of the youngest old (65-74 years) reported that they had attained a secondary level of school education and more than one tenth (11.9 per cent) had attained a university-level education. The highest proportion of those involved in in-depth interviews were educated to trade/technical college level (38.2 per cent, $n=13$), 29.4 per cent ($n=10$) were educated to primary level and 23.5 per cent ($n=8$) left education after secondary school.

Older people are counted among that proportion of the population at highest risk of poverty and social exclusion, on the basis that they are not in a position to earn a wage income (Department of Social and Family Affairs, 2003). The social classification of the present sample was based on their last or current occupation; just over 10 per cent of the sample was currently working (7.6 per cent of males and 2.9 per cent of females). Reported weekly incomes show that 61.6 per cent of the female respondents reported weekly incomes of up to €200 and almost twice as many of the male respondents reported weekly incomes of between €201 and €400. CSO figures for the 1999-2000 Household Budget Survey (CSO, 2000) showed that upwards of 40 per cent of pensioners resided in households with the lowest incomes and that State transfers (Old Age and Retirement and Widows' Pensions) were increasingly becoming the most important sources of income for older people. Evidence from the present study indicates

that the sample was representative of lower income households; almost two thirds (61.6 per cent) of women in the sample were classified as being in receipt of a low income.

Irish people have generally high levels of social contact, and family networks remain strong within Ireland. Good social contacts, including good transport and communication systems, are important factors in facilitating social contact (NCE, 1994); visits to the post office or bank can be a very important source of social contact. By the same token, lack of access to either a car or public transport can reduce or prevent visits to family and friends or travel to shops. Distance to services and accessibility to transport are important prerequisites for gaining access to services, even for short journeys. Survey respondents were asked about their current access to transport and to estimate their travelling distances (in miles) to specified amenities, including the bank and post office. While 43.8 per cent reported that they had access to a car, 17 per cent reported that they had access to public transport only, and over one tenth (11.7 per cent) had no access to any mode of transport. Those without access to any mode of transport were more likely to be rural dwellers. The majority (87.8 per cent) of respondents reported that they travelled a distance of less than five miles to services such as the post office and bank.

In conclusion, differences were found between groups of older people in relation to education, income and access to transport. These factors can be used as indicators of the risk of social exclusion, where provision has not been made to address the potential barriers to social interaction that arise. The findings suggest that the older old, older women and older people living in rural areas are most at risk in this regard.

6.2.3 Health, Care and Access to Services

Over a third of the respondents rated their general health as very good or excellent, with a further 42 per cent reporting their general health as good. There were few differences between males and females in this regard. While few reported poor hearing, a fifth of the males and over a quarter of the females rated their vision as fair or poor. Contrary to the profile of older people caring for an infirm spouse, the sample comprised married couples with few caring for a spouse, with just 5.7 per cent of respondents reporting that they currently cared for another individual and only 4.6 per cent caring for a dependent spouse.

Older people's basic needs in the area of mobility including daily life activities (such as shopping and attending health care facilities), walking, leisure and mobility may be restricted by fears related to the use of public transport and by altered health or decreased stamina (O'Leary *et al.*, 2004). In exploring the views of older people about

the health and social services available to them in two health authority regions in Ireland, the HeSSOP report (Garavan *et al.*, 2001) also explored aspects of their social contacts and support. The authors reported that of the sample of 937 older people, 23 per cent experienced limitations on everyday independence due to mobility problems. The present study found significant differences between urban and rural dwellers with regard to access to banks and the local post office; urban dwellers were more likely than their counterparts to travel distances of less than one mile. Without access to transport, even short distances can prevent access to essential services where older people have reduced mobility.

In conclusion, the findings suggest that most older people are generally in good health, but poor eyesight affects a considerable number, particularly older women. Poor hearing and limited mobility can also be a problem for older people. These health problems can significantly limit older people's independence and their ability to interact socially, and are further compounded by inadequate access to transport and to local services.

6.3 Social Networks, Social Interaction and Social Isolation

Establishing social contact with others through a range of social networks is generally assumed to be a natural human need and, conversely, a lack of social contact is a threat to psychological well-being. Social contact has both quantitative and qualitative dimensions, and it is the content and quality of social interactions, more than their quantity and range, which appear to be important to psychological well-being. As people get older their social networks can become reduced and they are at higher risk of social isolation (Fahey and Murray, 1994). As an objective state, based on the absence of contact with other people and integration with other members of society (Wenger and Burholt, 2003), social isolation can be quantified. Furthermore, patterns of social isolation in individuals can be identified (Wenger and Burholt, 2003).

The Network Assessment Instrument (Wenger, 1994; Wenger and Burholt, 2002) was used in the telephone survey to explore the social networks of the sample of older people surveyed. The Instrument enables the identification of five types of support network and identifies how individual older people are linked to other groups in society, as well as the core group of people upon whom they rely for advice, help and support.

The results of the survey demonstrated that the majority of respondents (73.2 per cent) were in the locally integrated support network category, indicating that older people in

Ireland have a large network of family, friends and neighbours. For the majority of respondents (81.7 per cent), their nearest relative lived within a distance of five miles; children were more likely to live within a distance of five miles than a sibling. In addition, the majority had regular verbal interactions with relatives, friends or neighbours. The majority attended church regularly (85.1 per cent) and half attended community clubs or social groups on either a regular or an occasional basis. Data from the Living in Ireland Survey (Layte *et al.*, 1999) indicated similar findings, demonstrating that older Irish people are less likely to live alone and that older Irish men and women have high levels of contact with neighbours, friends and family. The frequency of social contact among those older people living alone was also reported to be high for the Living in Ireland Survey; over 94 per cent talked with a neighbour or had contact with friends and relatives, at least once or twice a week (Layte *et al.*, 1999). Garavan *et al.* (2001) reported that the majority of older people in Ireland are interested in maintaining social contact with family and friends, with many expressing an interest in becoming a member of a social club or group. Many older people believe that 'getting out in the community and socialising' was critical to their mental health (Garavan *et al.*, 2001).

170 While the network types were generally stable, upwards of 10 per cent of respondents in this study were placed in a borderline or inconclusive category, indicating that their support network may be in a state of flux or may be shifting from one network type to another due to a change in their social/family circumstances. Respondents identified as being borderline appeared to be moving between locally integrated, locally self-contained networks and family-dependent networks. A quarter of all the older people aged 85 years and over were identified as being in an inconclusive or borderline category, suggesting that increasing age may lead to a change in social network.

Social networks were also explored in the in-depth interviews with older people. The quality and quantity of older people's social networks and social support can moderate the experience of loneliness; and participation in social activities can result in significantly larger social networks and reduced feelings of loneliness among older people (Moorer and Suurmeijer, 2001). While family networks have formed the central element of older people's social networks in Ireland, non-family social networks are also important (Fahey and Murray, 1994). The 'social interaction' category described the types of relationships and social life of the participants, and it comprised the two factors of social networks and barriers to social interaction. It was clear that while participants had diverse social networks, they could encounter barriers to accessing them. Where there were multiple barriers, this had a negative and compromising effect on participants' ability to interact socially.

The expectations of support associated with certain types of relationship and the individual's evaluation of their available network of social relationships have been shown to be associated with loneliness (Lauder *et al.*, 2004). International research indicates that loneliness is associated with a range of descriptive variables, including living arrangements, social networks, and the quality of social relationships. For example, living alone in older old age and having a poor social network are correlated with both social and emotional loneliness (Holmén *et al.*, 2000). While many of the interview participants enjoyed a diverse social network, several had very narrow social networks, so that their capacity for social interaction was vulnerable to factors such as illness, immobility or other factors outside of the individual's control. Like the wider sample from the national survey, some of the participants attended social centres and made sure they were on good terms with as many people as possible.

Information on patterns of sociability – the frequency of people's social contact with different types of people – can illuminate both social interaction and participation and social exclusion (Layte *et al.*, 1999). Patterns of sociability relate to the sorts of activity that people engage in within their communities, and such activities are, in turn, related to individual preferences; some older people participate in cultural activities, while others prefer activities related to sport and recreation (Moorer and Suurmeijer, 2001). Among the present sample of older Irish people, attending church was a prominent activity, as was attendance at older persons' clubs or social groups.

In the wide range of social activities available to interview participants, personal preferences and choice were very important. A case in point was bingo, on which participants were divided as to whether this activity was the most enjoyable social activity or whether it was tantamount to an insult to even suggest it to them as a social outlet. While increasing older people's involvement in social activities can promote their well-being and autonomy (Brenner and Shelley, 1998), it would seem that older people's autonomy is best promoted by giving them choice in the sort of social activities that they engage in.

Patterns of social interaction may be associated with physical location, with rural older people having less daily interaction than those living in urban areas; because of the relative weakness of public transport and the relative low density of housing, when compared with urban areas, living in a rural area may exacerbate social isolation (Layte *et al.*, 1999). However, in the present study, no significant difference in social network type was identified between urban and rural dwellers. A larger percentage of older urban dwellers lived in areas that were a part of a locally integrated support network when compared to older rural dwellers.

The results from the survey indicate that the majority of respondents were not socially isolated. Data from the Network Assessment Instrument supports other research indicating that family networks remain strong within Ireland, representing the basis of much of the social contact that people experience (NCE, 1994). The locally integrated support network accounted for the majority of respondents in the study, with almost three quarters (73.2 per cent) of the sample belonging to this network category. The profile of the sample fits closely with that of the typology description (Wenger, 1994); the majority (76.5 per cent) was in the younger old category (65-74 years), they had close relationships with family, friends and neighbours in the community, and they had a higher income. Respondents in the locally integrated support network category had also lived within their community for on average 40 years, and nearly 80 per cent had children living within five miles of them. The vast majority (92 per cent) were also involved in religious services or meetings, with over half frequently attending social groups and meetings.

172

Data from this study supports other findings that older Irish people are less likely than their counterparts in other countries to live alone and are likely to live among kin (Layte *et al.*, 1999; Fahey and Murray, 1994). The profile of the integrated support network component of the sample also supports other findings that social networks, including non-family social networks, also form an important part of the social networks of older people (Fahey and Murray, 1994) and that most older people in Ireland wish to maintain social contact with relatives and friends (Garavan *et al.*, 2001). The quality of the social network is more strongly associated with loneliness than its quantity; contacts with friends and neighbours show stronger associations with loneliness, when compared to contacts with family members (Pinquart and Sorensen, 2001). Older people in Ireland enjoy large active kinship networks; most have large numbers of children, grandchildren and siblings who live in Ireland and with whom they have regular contact (Fahey and Murray, 1994) and this would seem to be the case for the present sample.

Discrete if rather obvious characteristic patterns were found in relation to the composition and patterns of sociability within the various support network categories, and these patterns convey something of the profile of each distinct support network. For example, almost three quarters (73 per cent) of those in the local family-dependent support network were living in their own homes and those who were widowed or divorced/separated were more likely to rely on this network. Respondents in the local self-contained support network tended to have infrequent contact with relatives or neighbours living close by, the majority had no children, and their lifestyle was generally focused on and around their household. Respondents in the wider community-focused support network were more likely to be married; when compared with other network types, they tended to report good or excellent health and the majority (70.6 per cent)

had been in non-manual or professional/managerial occupations prior to retirement. Over 85 per cent of this network group saw their relatives or children monthly or less often and, for the majority (71.4 per cent), their relatives or children lived at a distance greater than 50 miles. Respondents in the private restricted support network tended to keep to themselves, have few friends or community contacts and valued their independence. The majority of those in this network type (60 per cent) did not attend religious meetings and all reported that they did not attend social or community groups. The majority (57 per cent) never married and more than a third worked abroad and returned to live in Ireland. A third of this group reported having poor health.

Many of the interview participants who reported that they did not attend social centres said that they did not like crowds or were shy. Personal characteristics of older people, such as pre-morbid personality, are associated with loneliness (Lauder *et al.*, 2004), and specific individual psychological and personality differences, including depression, hostility, pessimism, social withdrawal, alienation, shyness and low positive affect, have been shown to be associated with loneliness (Ernst and Cacioppo, 1999). Aside from personal characteristics, the external factors that facilitate good social contact include good transport and communication systems (NCE, 1994); transport is one of the factors that can impact on the quality of life of older people (Whelan and Vaughan, 1982; Horkan and Woods, 1986; Garavan *et al.*, 2001). Some interview participants not attending social centres had concerns about transport. Gaps in services were a particular concern and the issues of transport and information would seem to be fundamental to the uptake of services.

The prevalence of the private restricted social network category, and its association with minimal social contacts and a limited social network, was small among respondents, accounting for only 2.3 per cent of the total sample. Although in a minority in the present sample, older people in this network category appear to have few supports and may be very isolated. It is noteworthy that a third of respondents in this network type reported having poor health, suggesting that older people in this category may become vulnerable in times of ill-health or personal crisis (Wenger, 1994).

The basic source of social support for older adults comes from other people, including other family members, neighbours, volunteers and professionals and, at times, strangers (O'Leary *et al.*, 2004). The fact that the locally integrated support network accounted for the majority (73.2 per cent) of respondents in the study, and the finding that the majority of respondents had regular (daily or two or three times per week) verbal interactions with relatives, friends or neighbours, suggest that, based on objective criteria, the majority of respondents in the sample were not socially isolated.

For interview participants, a very important factor in facilitating social interaction was 'getting out' and participants were consistent in their belief in the importance of this factor, even in the case of those participants who were less social by nature. Despite wishing to have a choice in the range of activities in which to engage, all of the participants said that getting out of the house was important; those who could not get out independently said that this caused feelings of loneliness and isolation. 'Getting out' was also a coping mechanism and it promoted a sense of normality.

The assumption that all older people wish to enlarge their social network may not be true (Moorer and Suurmeijer, 2001) and, for some people, living alone can be a positive experience, especially for those who choose to do so (Holmén *et al.*, 1992). However, older people in Ireland wish to maintain social contact with relatives and friends (Garavan *et al.*, 2001), and living alone has been shown to be associated with loneliness among Irish older people (Horkan and Woods, 1986). Interview participants spoke of isolation, in terms of their personal experience of feeling isolated and the coping mechanisms that they employed to deal with the experience. Social isolation was associated with insufficient company, poor relationships and isolated times. While a separate experience to the feeling of isolation, experiencing poor relationships represented negative life circumstances that impacted on the feelings of isolation. Participants differed in terms of what they perceived as an acceptable amount of company, but those participants who found it difficult to use the coping mechanism of 'getting out' were particularly troubled by the amount of company that they had.

Interview participants described the experience of social isolation as having both positive and negative aspects. Positive aspects included the enjoyment of time spent alone, while negative aspects included feeling lonely and feeling vulnerable to the threat of personal injury or damage to personal property. The participants also experienced isolated times, which were related to times of crisis or potential crisis, when participants feared for their physical or material well-being. Among older people, the experience of social isolation can generate fears of illness, being alone or dying alone and being undiscovered (Horkan and Woods, 1986). Having social networks can increase the likelihood of other social networks.

Although the majority of the sample was identified as not being socially isolated, Wenger (1994) has identified a number of factors that may come into play within each network as people become older and more dependent. In local family-dependent support networks, loneliness and depression may occur when the older person feels they have become a burden on their family. In times of ill-health or with increasing frailty, older people in this network depend on and receive help from family members. However, Wenger (1994) points out that this help usually comes from one person in the

family, and that person is typically a daughter or spouse, although other individual relatives may also be involved. Carers, mostly family members, may also become isolated within their caring role and require personal and practical support in caring for an older relative.

Social isolation and loneliness is low in locally integrated support networks and older people in this network maintain independence in self-care and managing their day-to-day lives. If care is needed, it is generally provided by family, friends and neighbours in the form of high levels of practical help, even where the older person has increasing dependency (Wenger, 1994). Older people in this network may find that their social network shifts (usually to family-dependent) as they become older or experience ill-health.

Older people in local self-contained networks are isolated but not necessarily lonely. Although older people are familiar with their neighbours, they tend to seek help only in times of emergency and may conceal problems until they can no longer cope due to the fact that they value self-reliance (Wenger, 1994). Older people in this network will need the assistance of health and community services when they can no longer meet their needs. Eventually many are admitted to residential care (Wenger, 1994).

Older people in wider community-focused networks experience low levels of loneliness and social isolation. In times of ill-health or dependency, help from family and friends or neighbours is limited, especially if long-term care is needed. However, many in this network plan ahead and may organise private home help or nursing care, including admission to a private nursing home.

Statistically, older people in private restricted networks are more likely to be isolated and lonely than those in any other network. Wenger (1994) identifies older people in this network as those who are migrants who have settled in the community between the ages of 40 and 60. Problems occur with increasing frailty and ill-health as older people in this network resist outside help. The majority of physical and emotional help provided to older people in this network comes from formal health or social services. In many cases emotional needs remain unmet (Wenger, 1994).

In conclusion, the findings suggest that the majority of older people in Ireland are not socially isolated and are part of a locally integrated support network. They have a large network of family, friends and neighbours, live within a short distance of their nearest relative and have regular verbal interactions with relatives, friends or neighbours. They also attend church, community clubs or social groups occasionally or regularly. It is also suggested that social networks, including non-family social networks, form an important part of the social networks of older people and that most older people in Ireland wish to

maintain social contact with relatives and friends. Although it has been suggested in other research that living in a rural location may exacerbate social isolation, this was not supported in the survey element of the research, although poor rural transport was identified as a particular issue in interviews with older people and in focus groups with key stakeholders.

Several factors impacting on social interaction were also identified. For example, the findings suggest that whatever the range of social activities available to older people, personal preferences and choice are very important in relation to which activities older people engage in. Individual personal characteristics and specific individual psychological and personality differences also affect engagement in social interaction.

Although the survey results suggest the prevalence of the private restricted social network category, with its association with minimal social contacts and a limited social network, it accounts for only a very small proportion of older people in Ireland. The fact that people in these networks appear to have few supports, may be very isolated and may be in poor health, highlights their particular vulnerability, especially in times of ill-health or personal crisis. These findings are also reflected in the in-depth interviews where, although many participants enjoyed a diverse social network, several had very narrow social networks and their capacity for social interaction was limited. For these participants, their experience of feeling isolated was real and significant.

6.4 The Prevalence and the Experience of Loneliness

The SELSA-S was used in the national telephone survey. This instrument measures social loneliness and family and romantic loneliness as subscales of emotional loneliness. The questionnaire provided data on the prevalence of loneliness among those sampled and represented a multidimensional rating scale for loneliness (Cramer and Barry, 1999). When combined with demographic data and data from the Network Assessment Instrument, the SELSA-S permitted a closer examination of the nature and experience of loneliness among the study sample and shed light on the factors associated with loneliness.

683 respondents aged 65 years and over completed the SELSA-S questionnaire. The highest level of loneliness reported overall was in relation to romantic loneliness; 50.3 per cent of the respondents reported moderate or very high levels of romantic loneliness. Overall, self-reported levels of social and family loneliness were low.

The highest level of social loneliness was reported by 11.9 per cent of the respondents, 10 per cent reported that they were moderately lonely and less than 2 per cent were very lonely. The highest level of family loneliness was reported by 7.5 per cent of the respondents, with 7.2 per cent reporting feeling moderately lonely. Regarding social and family loneliness, the findings from this study are generally consistent with international research, which demonstrates that the majority of older people are not lonely, with estimates of reported loneliness ranging from 5 to 16 per cent. In terms of the prevalence of loneliness, the findings equate closely with those of Forbes (1996), who reported that only one in ten people experienced serious loneliness in Britain. While slight differences were observed in relation to the mean levels of social and family loneliness, no significant differences were found between the levels of reported loneliness for men and women.

Key stakeholders reported coming into contact with or knowing older people within their areas who are lonely. It is suggested that loneliness among older people may be increasing but the number of older people who are lonely is still small. Participants in the focus groups emphasised that being socially isolated does not necessarily mean being lonely. Living alone, isolation and loneliness are three different experiences and do not necessarily coexist (Townsend, 1973; Horkan and Woods, 1986) and living alone does not necessarily imply being lonely (Power, 1980).

The interview participants who experienced loneliness experienced it in a variety of ways. For some, it was experienced as something different from isolation, for others it was related to the experience of isolation. Loneliness was an experience that all participants had difficulty in describing and three categories of description were identified from the data: 'a void'; 'negative emotions'; and 'acceptance' (of the experience). Others experienced 'lonely times' which included night times, weekends, winter, Christmas, retirement and, commonly, the death of a loved one. Emotional isolation, such as that which results from the death of a spouse, explains a greater amount of loneliness than does social isolation (Dugan and Kivett, 1994) and social isolation is often linked with the deaths of spouse, siblings and same-age friends (Fahey and Murray, 1994).

In conclusion, although romantic/emotional loneliness affects just over half of older people in Ireland, levels of social and family loneliness are low overall. Key stakeholders and older people who were interviewed also suggest that although loneliness exists its prevalence is low.

6.4.1 Loneliness and Social Network Types

The telephone survey assessed social isolation within a five-category typology of social networks and measured the levels of loneliness among those sampled. It aimed to measure comprehensively a number of socio-demographic and health characteristics to determine their influence on reports of loneliness and social isolation. These characteristics included age group, gender, marital status, area of residence (urban or rural), health status and family contact. Through statistical inference, the survey also explored a number of factors associated with loneliness and permitted the profiling of individuals who were more likely to experience loneliness.

The results of the national telephone survey indicate that the majority of older people are not socially isolated. The majority of respondents (73.2 per cent) were in the locally integrated support network category, indicating that older people in Ireland have a large network of family, friends and neighbours. Older people identified as being within a locally integrated social network had the lowest overall experience of social or emotional loneliness. However, individuals in this network had moderate levels of romantic loneliness. Those reporting the highest level of romantic loneliness tended to have never married or to be widowed. Wenger (1994) identifies that the loneliness experienced in this network tends to be emotional and is usually as a result of bereavement and the absence of a close personal relationship. However, it may be difficult to recognise, due to the wide social and family support that individuals receive. This network is the strongest of all the social networks and social isolation is low within the network.

The lowest percentage (2.3 per cent) of older people was identified within the private restricted support network category. Although in a minority, older people in this network category have few supports and can become very isolated. Across all concepts of social and emotional loneliness, older people in this social network scored significantly higher than those in other networks. Of all the social networks, older people in this network are at most risk of loneliness and social isolation (Wenger, 1994).

The oldest old depend on the local family-dependent network for support. The member of the family that provides most of the support is an adult child, usually a daughter (Wenger, 1994). Over 20 per cent of older people in this network were living with relatives and the majority were older widowed people. There is minimal contact with the wider community, including neighbours and friends. Although reports of family loneliness are low, older people in this category may become socially and romantically/emotionally lonely. Wenger (1994) identifies that withdrawal leading to loneliness can occur in older people in this network category due to the burden they

believe they are placing on their family. The development of social loneliness may be due to the fact that neighbours believe care has been taken over by the family and believe that they may be intruding (Wenger, 1994).

Older people in the local self-contained support network category accounted for only 2 per cent of the total sample. Although isolated from family and neighbours, reports of family and social loneliness are low. The majority of people in this network never married and report higher levels of romantic/emotional loneliness than either locally integrated support networks or wider community-focused support networks. Older people in this network value their privacy and may resist offers of help (Wenger, 1994). Social isolation is high within this network.

Overall, just 5.4 per cent of the sample was in the wider community-focused network category. Relatives are usually living at a distance from the respondent. However, there is close contact with local friends and neighbours. There is active involvement in community and voluntary organisations. Although older people in this network were at a greater distance from relatives, respondents reported a low experience of social and family loneliness, with low to moderate levels of romantic loneliness. Older people in this network were significantly more likely to have worked abroad than those in other groups. Wenger (1994) identifies older people in this group as being independent and self-sufficient, and having low social isolation. Loneliness can result, however, as the individual becomes older and frailer.

The quality of social support experienced by older people also relates to their experience of loneliness. Social support comprises notions of structure (the existence and extent of relationships) and function (the extent to which social relationships provide help and companionship) (Kim, 1999). Social support comprises notions of support networks, supportive behaviours and subjective appraisal of support received (Vaux cited by Hupsey, 1998). International research suggests that the quality of older people's social networks and social support may moderate the experience of loneliness. A meaningful social network, defined in terms of 'satisfaction with friend contacts', appears to be a support against loneliness and social isolation (Holmén and Furukawa, 2002). Conversely, living alone in older old age and having a poor social network are correlated with both social and emotional loneliness (Holmén *et al.*, 2000). Social network type, network size, level of satisfaction with network, ethnic attachment and functional status of the network have all been shown to be predictors of loneliness (Kim, 1999).

Moorer and Suurmeijer (2001) report that participation in social activities has been found to result in significantly larger social networks and reduced feelings of loneliness among older people. Along with having a direct effect on an individual's well-being, the

experience or presence of social support can act as a buffer to the detrimental effects of stressful situations (Andersson, 1998). Having a spouse provides an important source of both social and emotional support and marital status is frequently reported as a correlate of loneliness; the absence or loss of a partner has been reported as being associated with increased loneliness among the very old (Tijhuis *et al.*, 1999). Widowhood has been found to be associated with both loneliness and depression in both men and women, and divorced parents are significantly more vulnerable to loneliness and depression (Koropecjy-Cox, 1998). However, Wenger (1994) identified that loneliness following the loss of a spouse or close friend in locally integrated support networks is usually short-term due to the support received from family, friends and neighbours. The level of loneliness has been found to be negatively related to the level of social support network, social support satisfaction and family function, with family function reported as being a significant predictor of loneliness (Kim and Baik, 2002).

In the local self-contained support network, the experience of romantic loneliness was significantly higher than for those in the locally integrated support networks and wider community-focused support networks. However, even though older people in this network are isolated from their community, their overall experience of social and family loneliness was low and not significantly different when compared with the other less isolated support networks. Loneliness may arise as the older person becomes more dependent, although many try to cope alone.

Although living at a greater distance from relatives, respondents in the wider community-focused support network reported low scores of social and family loneliness, and low to moderate levels of romantic/emotional loneliness. However, Wenger (1994) notes that older people in this network are vulnerable to loneliness in times of ill-health or increasing frailty due to the fact that the social network is friendship-based rather than family-based. Older people may become isolated from friends as their health deteriorates.

According to Victor *et al.* (2002), a good supportive family and a partner appear to play a key role in preventing loneliness. Respondents in the private restricted support network reported significantly higher scores in all subscales of social and emotional loneliness than those in the other networks, reflecting the wider profile of this network category in existent reports of loneliness in this group of older people. The highest mean score (4.2) represented a moderate to high level of romantic loneliness, suggesting that the lack of a close personal relationship was a predictor of loneliness. Older people who are married with no children or friends can experience greater loneliness (Hall-Eston and Mullins, 1999), and widowhood and divorce are noted to be risk factors for loneliness (Victor *et al.*, 2002). Within the private restricted network category, moderately high loneliness scores in relation to family loneliness and social

loneliness were also identified. Older people living alone can experience more social and emotional loneliness, when compared with those living together with someone (Holmén *et al.*, 2000). Older people in the private restricted network category are more at risk of loneliness than in any other network category. Due to a lack of family and community relationships, loneliness can be exacerbated by loss of a spouse and poor health.

In conclusion, when loneliness is related to social network categories, those most likely to be lonely are those in the private restricted support network, the local self-contained network and the local family-dependent network. These three social networks account for 11.5 per cent of older people in Ireland and are also associated with high levels of social isolation. Those at least risk of all three types of loneliness are those in the locally integrated social network, which accounts for more than 73 per cent of older people living in Ireland. Older people in different social network types are more likely to experience different types of loneliness.

6.4.2 Factors Involved in Loneliness

Loneliness research among older people points to the impact of a wide spectrum of demographic, personal and social factors (Mullins *et al.*, 1996). In the present study, a number of factors were examined as correlates of loneliness. A number of previous studies have identified differing levels of loneliness and isolation in groups of older people of varying demographic and descriptive characteristics. For example, individuals who are married (Weiss, 1973; Kivett and Scott, 1979; Dugan and Kivett, 1994) and have completed higher levels of education appear to report less loneliness (Wang *et al.*, 2001). Place of residence, for example urban or rural living associated with loss of mobility, and living alone are also related to increased reports of loneliness among older people (de Jong-Gierveld, 1987; Norton and McManus, 1989). Older people's families are important as a social network for them, especially in relation to the contact they have with their children and grandchildren (Dugan and Kivett, 1994). The frequency and extent of contact with relations has been shown to influence the levels of loneliness experienced by older individuals (Mullins and Dugan, 1990; Wenger, 1994). Social relationships, their extent and their quality are associated with loneliness, and both social and emotional loneliness have been shown to be correlates of each other (Green *et al.*, 2001). An individual's physical and mental health status can also influence the extent to which he or she becomes socially isolated and, conversely, physical and mental health can be affected by social isolation and loneliness. Sensory acuity may diminish with old age, leading to limitations in the frequency and quality of social interactions (Saxon and Etton, 1987); diminishing sight and hearing have been found to result in reports of social isolation and loneliness.

A number of population characteristics of older people were measured in the survey. The aim was to identify social predictors that are related to loneliness and social isolation; a number of factors may be predictors of the development of loneliness in older people. In this study, those more likely to report statistically significant high levels of loneliness were the oldest old, single or widowed women, those educated to primary level only and those in the lower social classification. Statistically significant high levels of loneliness were also more likely to be reported by individuals who lived in either rented accommodation or with relatives in rural areas. A perceived poor health status and a lack of transport also impacted significantly on the reported higher levels of loneliness.

Men and women have been found to differ in their levels of isolation and need for social support, with women more concerned with intimacy and men more in need of friendship ties (Allen and Oshagan, 1995). Holmén *et al.* (2000) found that women reported both social and emotional loneliness significantly more than men. While respondents in the present study failed to demonstrate any such gender differences in relation to social and family loneliness, levels of reported romantic loneliness were significantly higher for female respondents when compared to their male counterparts.

Age is also associated with social isolation, with reported correlations between increasing age and increasing social isolation and loneliness (Holmén *et al.*, 1992; Dugan and Kivett, 1994). In this study, the relationship between levels of loneliness in each of the three loneliness subscales and chronological age was examined. Statistically significant differences between the level of loneliness in the youngest old and the oldest old in both social and romantic loneliness were found. However, no statistically significant differences were found in relation to family loneliness. No statistically significant differences were reported in the levels of family loneliness among the three age groups (65-74 years, 75-84 years and 85+ years). However, statistically significant differences were reported in the levels of social loneliness among those in the 65-74 years group when compared to the levels reported in the 75-84 years and 85+ years groups. This compares with some international reports that suggest that loneliness increases with increasing age and that the very old appear to experience more frequent loneliness (Holmén *et al.*, 2000; Tijhuis *et al.*, 1999), with older men reporting more loneliness (Tijhuis *et al.*, 1999).

Socio-economic status and lower income are associated with reports of greater loneliness, as is being part of a racial minority (Dugan and Kivett, 1994; Kim, 1999). The level of income is one of a number of factors that impacts on older people's quality of life (Whelan and Vaughan, 1982; Horkan and Woods, 1986; Garavan *et al.*, 2001). Comparison of the levels of income with the levels of loneliness uncovered statistically significant higher levels of loneliness among those respondents with the lowest reported level of income for the three sub-scales of loneliness.

Marital status is frequently reported as a correlate of loneliness, and the absence or loss of a partner has been reported as being associated with increased loneliness among the very old (Tijhuis *et al.*, 1999). Although not statistically significant, reported levels of social loneliness were slightly higher for single and widowed respondents, and respondents who were single reported higher levels of family loneliness compared to the respondents who were either married or widowed. In addition, statistically significant levels of romantic loneliness were also reported among the group of respondents who were single or widowed compared to the respondents who were married.

The factors that facilitate good social contact include good transport (NCE, 1996), and the accessibility to transport can enhance an older person's capacity to interact with family, friends and their community. Conversely, the absence of transport can potentially reduce an older person's opportunities for interaction, which can in turn contribute to loneliness; access to a meaningful social network can be a support against loneliness and social isolation (Holmén and Furukawa, 2002). Among the present sample, statistically significant higher levels of loneliness in each of the three categories of social, family and romantic loneliness were reported in those who had no access to transport.

In focus groups with key stakeholders, it was suggested that loneliness is likely to occur as a result of sudden bereavement, separation, illness and retirement. This is confirmed in the literature where it is stated that among the most important factors associated with the feeling of loneliness is the loss of spouse, depression of mood and lack of friends (Berg *et al.*, 1981). A range of factors involved in increasing the likelihood of loneliness was identified by the focus group participants, including not marrying, having no children, personality type, being lonely as a young person, poverty, not having lived locally or language difficulties. Social isolation is frequently linked with an increase in the incidence of older people living alone, with long-term decline in family size, retirement, the deaths of spouse, siblings and same-age friends, with disability and illness, and with poverty (Fahey and Murray, 1994). Participants related social isolation to loss of family contact or family disputes, reduction in day-to-day callers, fear due to increases in crime, loss of functioning and mobility, and negative attitudes towards older people.

In conclusion, the statistically significant results indicate that higher levels of social, family and romantic loneliness are influenced by many factors including increasing age, marital status, level of education, social class, income, and type and place of residence. Conversely, the respondents who were least likely to report high levels of loneliness were married, were more likely to be in the higher social classification and had access to transport. This profile also reflects a higher level of education and higher income levels. Respondents who reported low levels of loneliness were more likely to be homeowners, live in urban areas and report good levels of health.

Social loneliness was significantly correlated with increasing age, lack of access to transport, poorer health and living in a rural area. Family loneliness was significantly correlated with increasing age, poorer health, living in an urban area, and not being married. Number of children was also associated with loneliness; the greater the number of children, the lower the levels of family loneliness. Romantic loneliness was significantly correlated with increasing age, poor overall health, being female, having a lower level of education, caring for a relative and not being married.

6.5 Strategies to Reduce or Alleviate Loneliness and Social Isolation

Policies developed to alleviate loneliness should focus on 'the complex combination of factors that influence quality of life rather than respond to individual risk factors' (Victor *et al.*, 2002). The development of loneliness interventions needs to be based on knowledge of and sensitivity to the precipitating factors other than mere chronological age; strategies for alleviating loneliness must be sensitive to factors such as loss of a spouse, infrequent visits from siblings and sensory impairment (Dugan and Kivett, 1994). Effectively preventing or alleviating loneliness must take account of the complexity and individuality of the experience, most especially its precipitating and perpetuating factors and the meaning of the experience to the individual.

Interview participants provided information on the barriers and enablers of social interaction; barriers and enablers included internal and external psychological, environmental, physical and interpersonal factors. The enablers to social interaction included the individual's own desire to communicate, good health (the single most important enabler), opportunities to meet people with a shared interest, background or experience, and support from family members in the provision of transport. Access to flexible transport, length of time living in an area and close proximity to a town centre were also identified as enablers. The absence of these enablers may be construed as barriers to social interaction. Barriers included lack of interest in others, lack of motivation or imagination and the effort required to engage in social interaction. A single barrier may not be sufficient to prevent social interaction. While barriers could exist to diminish the possibility of social interaction, older people could still enjoy a level of social interaction that they found acceptable. While it was not possible to infer from the qualitative data that a certain number of barriers or a lack of enablers results in a level of social interaction that the person finds unacceptable, it is possible to draw the general conclusion that having multiple barriers and few enablers can adversely affect the older person's ability to interact socially. Multiple barriers and/or a lack of enablers

can lead to a level of social interaction the individual older person finds too limited and this limited level of interaction was associated with feelings of loneliness and isolation among the participants.

In conclusion, strategies employed to address social isolation and loneliness need to take account of the complexity and the individuality of the experience, most especially its precipitating and perpetuating factors and the meaning of the experience to the individual. A range of barriers to social interaction was identified by older people themselves and these include internal and external psychological, environmental, physical and interpersonal factors. In the absence of specific enablers, these barriers are likely to contribute to social isolation and possibly loneliness. Specific enablers include the individual older person's own desire to communicate, good health, the opportunity to meet people with a shared interest, background or experience, and support from family members in the provision of transport. Where such enablers do not naturally exist, specific interventions may be useful in addressing barriers. However, more than one barrier may need to be addressed and the autonomy of the individual older person must be respected in identifying appropriate interventions on a case-by-case basis.

6.5.1 Strategies and Coping Mechanisms Adopted by Older People

Identifying those strategies employed by older individuals who, despite experiencing decreased socialisation or physical function, are *not* lonely can help other older people to avoid loneliness (Rane-Szostak and Herth, 1995). Older people appear to have the capacity to adapt to their circumstances in order to ensure that they maintain a good social network. Accordingly, most of the interview participants with no family turned to friends as their most important source of social interaction and vice versa. For many of the participants, their home help was more than a functional visitor and they viewed their home help as a friend and source of social interaction. In addition to those coping mechanisms employed to prevent or alleviate feelings of loneliness, coping mechanisms employed by interviewees to deal with the experience of isolation were of a practical nature, including having personal alarms, telephones, mobile telephones and a certain trusted person on whom to call in an emergency. Thus isolation was experienced less as an emotional experience and more in terms of its practical attributes. While none of the participants could say they had never felt lonely, many participants said that they had never felt isolated or cut off.

During the course of the telephone survey and interviews, respondents were asked about the strategies that they used to reduce their loneliness and social isolation. The strategies identified by respondents to reduce or alleviate loneliness and isolation related to four specific areas:

- family and friends which involved either caring or visiting
- church-related activities
- participation in organised clubs and activities
- personal hobbies.

The personal hobbies reported were likely to be home-based in contrast to the other activities, which were more likely to be engaged in outside of the home and involve interactions with other people. An absence or a limited cohort of family and friends, reduced or infrequent access to transport, limited education and limited income are factors that can impact on the opportunities older people can avail of in relation to undertaking activities to reduce or prevent loneliness and isolation. Individuals who have limited social supports and reside in rural areas may have fewer opportunities to engage in activities in comparison with similar counterparts located in urban areas.

All interview participants described a range of coping mechanisms that they employed to prevent and/or alleviate loneliness and these included individual-level coping mechanisms, such as filling the day, social interaction and 'turning your mind' to other things. Individuals' ability to use these coping mechanisms was closely related to their personal circumstances and their personal philosophy.

Reported levels of loneliness for older people are very real and the factors that increased their loneliness need to be addressed. Isolation and loneliness have been shown to be very much associated with an individual's social network type.

In conclusion, older people themselves identified a range of practical measures that they employed to help them to deal with living alone and to prevent or alleviate feelings of loneliness. These included measures to connect them to the outside world and to ensure their safety and, as a result, most did not feel socially isolated. Keeping in touch with family and friends, social activities and personal hobbies were important to all participants. Keeping busy or active was an important theme in in-depth interviews.

6.5.2 Effective Measures for Preventing and Alleviating Loneliness

The focus groups conducted with key stakeholders sought their views on effective measures for dealing with loneliness. The interventions for preventing and alleviating loneliness proposed by stakeholders incorporated both social/community-level strategies and strategies that stressed the position of the individual older person.

Strategies for alleviating loneliness among older people can involve improving older people's social networks with the aim of increasing the likelihood of social interaction. These can include adult education classes, involvement in community action schemes and locally organised outings (Forbes, 1996). From the perspective of the focus group participants, a range of existing measures was identified that work well in preventing or alleviating loneliness. These included group activities, visiting and befriending interventions, interventions aimed at enabling older people to stay in their homes for as long as possible, interventions aimed at providing alternative, suitable accommodation, day centres, social centres and rural transport initiatives.

Further, in relation to existing interventions, stakeholders highlighted the patchy and *ad hoc* nature of service provision for older people between and within regions. Particular measures that stakeholders would like to see in place included better and more easily accessible information on available entitlements, resources and services, and better integration and organisation of all statutory and voluntary provision coordinated by an officer with specific responsibility for older people. They also advocated the need for better rural transport, a volunteer bureau, improved equity and access to services, more locally-based day hospital and day services, more sheltered housing and the extension of existing services to include weekends. Key stakeholders also identified the need for additional home help and home support, laundry services, meals on wheels, general support to permit older people to remain in their own home, and additional chiropody services. Key stakeholders placed particular emphasis on enabling older people to stay at home for as long as possible, or where this is not possible, providing the most suitable accommodation for them, avoiding institutional care where possible.

In conclusion, focus group participants identified a range of existing measures that work well in preventing or alleviating loneliness. These included group activities, visiting and befriending interventions, interventions aimed at enabling older people to stay in their homes for as long as possible, interventions aimed at providing alternative, suitable accommodation, day centres, social centres and rural transport initiatives. Stakeholders highlighted the need for better coordination and organisation of existing services and the need for some services to be available at the weekend and out of hours. Also highlighted was the need for better and widely available information for older people and adequate and flexible transport.

To conclude, this study has identified the prevalence and experiences of loneliness and social isolation among older people in Ireland. The main findings from the qualitative and quantitative aspects of the study suggest that there is a relatively low level of loneliness among older people in Ireland and this is in keeping with international reports of the same phenomenon. However, quantitative data identified that there are groups of older people who are more likely to experience loneliness. These include the oldest old, single or widowed women, those educated to primary level only, those in the lower social classification and older people living within a private restricted social network. In addition, specific socio-demographic characteristics were identified as risk factors for loneliness. The most important predictors or risk factors for loneliness include increasing age and poor health. Qualitative data findings suggest that older people are at particular risk of feeling lonely following the death of a loved one or after family disagreement. The findings suggest that the majority are not socially isolated, with the vast majority of older people in Ireland supported by family, friends and neighbours. However, individuals in private restricted and local self-contained networks are more likely to be socially isolated than others. Even older people who are not socially isolated may experience problems as they become older and most particularly if an illness or other personal crisis occurs. The range of factors associated with loneliness, as identified in the focus group data include not marrying, having no children, personality type, being lonely as a young person, poverty, not having lived locally and language difficulties. Social isolation was related to loss of family contact or family disputes, fear due to increased crime, mobility problems and negative attitudes towards older people.

In terms of loneliness the findings suggest that social interaction is the way in which these phenomena can be addressed. Several barriers to social interaction were identified in terms of psychological, environmental, physical and inter-personal barriers. These included a lack of knowledge about the services that exist, lack of transport, winter weather and dark nights, busy roads, lack of footpaths (rural) and uneven footpaths (urban). In addition, a range of factors that enable social interaction were also identified and categorised as psychological, environmental, physical and interpersonal enablers. These included living in the same area for a long time, having a telephone (landline or mobile), close proximity to amenities/facilities, good weather and access to transport.

A number of practical responses/interventions that can reduce the prevalence of loneliness and social isolation were identified in this research. These included:

- flexible local transport for older people to enable them to participate in local activities, to meet friends and family, to attend day centres and to engage with local networks. This is especially needed for those living in rural areas
- clubs and associations which enable older people to engage with like-minded people
- active retirement networks which empower older people to establish their own clubs and group activities
- day centres and drop-in centres that provide a mechanism for social interaction and activities that meet the needs of local older people
- visiting and befriending schemes to ensure that housebound older people can engage with other people on a regular basis
- community warden (currently, pilot) schemes that provide surveillance of older people living alone
- widely available information for older people on their entitlements and resources, activities and clubs that are available for older people locally to provide a context for interaction with one another
- home support services including home help, meals on wheels and home repair, that provide support to older people to cope with living alone
- community and sheltered housing schemes which enable older people to live independently but with arms-length support should they require it. Several examples were provided of where these types of schemes exist and work well. However, it is suggested that they are provided on an extremely *ad hoc* basis and that coverage is patchy both between and within regions.

This research identifies older people who are at particular risk of social isolation and loneliness. Interventions need to be targeted specifically at older people falling within these risk groups, for example older people with ill-health, including those with poor vision and poor hearing, and single people aged 85 and over who are not residing in their own homes. Although anyone can become socially isolated or lonely, further work is required to develop a mechanism for risk assessment that can be used by planners and providers to ensure the needs of those at greatest risk are addressed.

The survey highlighted the high proportion of older people, especially older women, living in low-income groups and the literature associates this with social isolation and loneliness. Income levels represent a significant factor in older people's ability to 'get out' and interact socially. Older people from lower social classifications are less likely to have been employed in areas where an additional pension could be accumulated over time and it may be difficult for those people to manage financially on a State-provided pension. Interventions at national policy level are required to address discrepancies in income. In addition, the need to empower older people and to involve them fully in the planning and delivery of interventions is stressed.

The following key recommendations are made on the basis of the research findings and the review of the literature:

1. A mechanism should be developed for service planners and providers to identify older people who are most at risk of being socially isolated or lonely. It is recommended that consideration be given to the use of the Network Assessment Instrument to help identify those older people at risk of loneliness and social isolation.
2. A protocol should be developed for the identification of appropriate interventions for older people who have been assessed to be at particular risk.
3. An officer should be appointed in each health board region with specific responsibility for the provision of community-based services for older people. There should be a particular focus on developing and streamlining interventions that promote older people's independence and address the barriers to social interaction.
4. An audit should be undertaken of the availability of the range of interventions identified in this report to prevent and alleviate social isolation and loneliness. Particular attention should be given to inequities within regions and the findings should be used to develop a strategic plan for each region.
5. Further research should be undertaken in the following areas:
 - (a) psychological well-being – exploring the needs of vulnerable groups such as older people who are depressed and/or suicidal. In this research there was some indication that psychological well-being was a factor in people's responses to loneliness and isolation. This particular group of older people, while presenting challenges in terms of research, require further study

- (b) frail older people – in light of the particular needs of frail older people in the study and the small numbers reflected in the sample, further study of this particular group may also need to be undertaken.

6.6.1 Developing Appropriate Policy Responses: Strategies of Intervention and Good Practice

This section sets out a range of recommended strategies of intervention and good practice in the prevention of loneliness and social isolation among older people. In setting out the strategies of intervention and good practice, the researchers have reprised some of the more salient findings from the study and from the literature, including the findings from previous studies undertaken in Ireland. The strategies of intervention and good practice are presented in two principal categories, namely individual-level interventions and social/community-level interventions.

The literature suggests that, in developing appropriate policy responses to alleviate loneliness, it is important to understand the meaning that older people themselves ascribe to loneliness and the fact that loneliness can be social or emotional in nature. This point was further emphasised in the focus group interviews among the service planners and providers. Programmes aimed at promoting social contacts are useful where loneliness arises out of social isolation. Where loneliness is of an emotional nature, arising out of loss of a spouse for example, programmes aimed at addressing the grief response and attachment loss are more appropriate. Nonetheless, maintaining social contacts over a period of time may also be important for someone who has been recently bereaved.

The literature also identifies national strategies aimed at preventing older people from becoming socially isolated, for example, as a result of living alone or on a low income. Irish Government reports refer to 'equality infrastructure' in this regard. For older people, this may require the allocation of additional resources to promote social inclusion, the provision of supports to enable older people to live independently, the development of additional day care facilities and the provision or enhancement of economic support for voluntary organisations involved in the provision of services for older people.

6.6.1.1 State/Community-level Interventions versus Individual-level Interventions

The literature suggests that understanding the cultural and sociological factors relating to the loneliness experience can provide the basis for interventions aimed at preventing or alleviating loneliness, and that the focus should be on community-level rather than

individual-level strategies of intervention. Yet the experience of loneliness is ultimately subjective in nature, suggesting the need for individual-level interventions. Individual-level interventions tend to be reactive in nature, for example as a response to other problems such as poor health. Such interventions may be too late to prevent loneliness, whereas preventative strategies are more likely to be effective. The development of social capital/relationships for community networks that make for a healthier society is advocated. Older people may experience social isolation but may not be lonely; in such instances, the literature suggests, there is a need to identify the strategies employed by such people as a way of helping others to avoid or deal with loneliness.

6.6.1.2 Strategies of Intervention and Good Practice

The range of community-level and individual-level interventions identified from the literature and from the present study is set out in Table 6.1.

Table 6.1: Strategies of intervention and good practice

Interventions	Supporting evidence	
Individual-level interventions	The literature	The findings of this study
<p>Reducing social isolation and preventing loneliness by seeking or maintaining social interaction.</p>	<p>A meaningful social network appears to be a fundamental support in reducing loneliness and social isolation (Hagberg, 1987). The majority of older people in Ireland were interested in maintaining social contact with family and friends and many expressed an interest in becoming a member of a social club or group (Garavan <i>et al.</i>, 2001). Several individual strategies to deal with social isolation identified in the literature are based around seeking or maintaining social interaction. Older people's ways of coping with loneliness include 'getting out of the house', communicating with friends by telephone or in writing (Horkan and Woods, 1986) and making moderations to lifestyle that reduce the likelihood of social isolation (Wenger and Burholt, 2003).</p>	<p>Interview participants suggested that social interaction is a more fulfilling way to allay feelings of loneliness than engaging in mechanisms to cope with being alone. Further, some participants associated any time alone with being lonely. Participants referred to the importance of getting out of the house. Shopping and going to church were identified as important forms of social interaction. For those who could not get out of the house, the telephone was an important means of communication with others.</p> <p>One of the four types of activity to alleviate and prevent loneliness identified in the survey related to family and friends and involved either caring for or visiting other relatives or friends. Survey participants identified interaction with family and friends as an important means of alleviating or preventing loneliness. These included caring for other relatives, babysitting and visiting with family and friends. Interview participants referred to reading the newspaper to keep in touch, thereby preventing feelings of isolation.</p>

Interventions	Supporting evidence	
Individual-level interventions	The literature	The findings of this study
Coping with loneliness by filling the day through engagement in various activities.	Ways employed by individuals to overcome loneliness include watching television, knitting and listening to the radio (Horkan and Woods, 1986).	Older people who participated in individual interviews talked about activities that they engaged in to occupy the day in order to fill a void, which they related to loneliness. These included staying in bed longer in the morning and going to bed earlier at night, listening to radio, watching television, reading newspapers and books and completing crosswords. They related these activities to keeping their minds active. Housework, cooking and sewing were also identified in interviews as important activities, as a way of remaining and feeling independent, and promoting a sense of well-being. Taking exercise and keeping mobile was also identified. Personal hobbies and activities were one of the four types of activity to alleviate and prevent loneliness identified in the survey. These included walking, watching television, reading, gardening, playing golf and visiting the pub. Most of the activities identified are likely to be undertaken in the home and are not likely to involve interaction with other people. They are also likely to require a reasonable level of good health, eyesight and hearing.

Table 6.1 (contd.): Strategies of intervention and good practice

Table 6.1 (contd.): Strategies of intervention and good practice

Interventions	Supporting evidence	
Individual-level interventions	The literature	The findings of this study
<p>Employing mental strategies to cope with loneliness.</p> <p>Faith (religious belief) as a strategy to cope with loneliness.</p> <p>Pets can provide a source of companionship for older people and thereby prevent and/or alleviate loneliness.</p>	<p>Many older people in Ireland believe that 'getting out in the community and socialising' was critical to their mental health (Garavan <i>et al.</i>, 2001).</p> <p>Praying and visits by the clergy were identified as an important measure in preventing loneliness and social isolation (Horkan and Woods, 1986).</p>	<p>Interview participants referred to several mental strategies that they employed to help them to cope with loneliness. These included relating to people they knew who were worse off than them, helping them to gain better perspective of their own situation, reminiscing and thinking about happy times in the past, and drawing on their religious faith.</p> <p>Faith was identified by interview participants as an important means of coping with loneliness.</p> <p>Several interview participants referred to the role that their pets had in preventing loneliness. Pets provided them with a reason to get out, provided company and promoted feelings of safety.</p>

Interventions	Supporting evidence	
Individual-level interventions	The literature	The findings of this study
Support mechanisms in the case of bereavement, possibly to include a bereavement support group in the local community.	In alleviating the emotional loneliness of the loss of a spouse, what are needed are programmes that focus on attachment loss and provide opportunities for lonely people to meet potential attachment figures (Dugan and Kivett, 1994). Grief issues associated with the loss must first be addressed and resolved, and strategies to secure a replacement attachment figure be explored and the use of a bereavement support group may be beneficial in this regard (Dugan and Kivett, 1994).	Many participants interviewed in the study were living with the reality that most of their family (or certain key members) had died, causing sadness and grief but also a loss of companionship. Some participants had difficulties in talking about the taboo subject of death following bereavement.

Table 6.1 (contd.): Strategies of intervention and good practice

Table 6.1. (contd.): Strategies of intervention and good practice

Interventions	Supporting evidence	
Individual-level interventions	The literature	The findings of this study
Improving older people's social networks, thereby preventing social isolation and loneliness.	<p>A meaningful social network may be fundamental to reducing loneliness and social isolation. Understanding the cultural and sociological factors related to loneliness can provide the basis of interventions aimed at preventing and/or alleviating loneliness, and that the focus should be on community rather than individual-level interventions (Lauder <i>et al.</i>, 2004). Improving older people's social networks can provide older people with opportunities to reach out to others. Older people may experience a reduction in the number of contacts and a reduction in the quality of those contacts. Social and functional losses may prevent social interaction. The development of loneliness interventions needs to be sensitive to factors that lead to the development of loneliness other than mere chronological age, such as loss of a spouse, infrequent visits from siblings and sensory impairment (Dugan and Kivett, 1994). Interventions must be sensitive to these causative factors and should include promoting communication and social contacts with siblings and peers (Dugan and Kivett, 1994).</p>	<p>The older people surveyed highlighted the importance of getting out of the house and engaging in social interaction and social activities. A range of interventions were identified with service planners and policy-makers aimed at maintaining or improving older people's social networks. These included establishing appropriate and accessible transport, organising club or group activities, visitation and befriending services, day centres, social centres and church-related activities.</p>

Interventions	Supporting evidence	
Individual-level interventions	The literature	The findings of this study
<p>Enhancing older people's access to public transport in order to increase older people's mobility and improve their social networks by promoting good public transport policy and practice, to include the development of rural transport schemes.</p>	<p>Several studies in Ireland have indicated that environmental and societal factors including housing, social contact, security, transport and income can impact on the quality of life of older people (Whelan and Vaughan, 1982, 1984; Horkan and Woods, 1986; Garavan <i>et al.</i>, 2001). For many older people in Ireland, their quality of life may be a function of their worry over availability of and accessibility to social care and health services, as well as the quality and cost of those services, and less a function of their income level <i>per se</i> (Layte <i>et al.</i>, 1999). Older people who are dependent on a pension experience reduced independence in areas such as transport. Good transport and communication systems facilitate good social contact (NCE, 1994). Older people's basic needs in the area of mobility include daily life activities, such as shopping, attending health care facilities, walking and leisure. Their mobility may be restricted by fears related to the use of public transport and by altered health or decreased stamina (O'Leary <i>et al.</i>, 2004).</p>	<p>There is a strong emphasis in individual-level interventions on older people getting out and about, interacting with others and engaging in various activities. However, lack of suitable transport is a particular barrier for older people in this regard. Service planners and providers referred to the dramatic difference that rural transport schemes and other more specialised transport services for older people with reduced mobility or function had made to the lives of older people. However, these services are not widely available.</p>

Table 6.1 (contd.): Strategies of intervention and good practice

Table 6.1 (contd.): Strategies of intervention and good practice

Interventions	Supporting evidence	
Individual-level interventions	The literature	The findings of this study
Promoting and organising local day centres and social/community centres.	Targeting loneliness for interventions in a preventative mode may be the most effective way for health care professionals to act. Lauder <i>et al.</i> , (2004) advocate the development of relationships and community networks that make for a healthier society, what they term 'social capital'. There is a need to put 'special supports' in place for vulnerable groups, such as older people, in order to prevent social exclusion and achieve social inclusion (DSFA, 2003).	Service planners and providers highlighted the success of day centres/hospitals in providing a range of services and a social outlet for those who avail of them. However, it was suggested that a more flexible approach to transport to and from centres, as well as the extension of services to weekends, would further enhance this service and the uptake of this type of intervention.
Promoting and organising group social activities for older people.	Older people can experience a high degree of social exclusion, in the form of social isolation, fear of crime, reduced access to basic services and exclusion from civic activities (Scharf cited in Dean, 2003). Among those older people living alone, upwards of half can spend an average of 10 to 14 hours alone during the day (Garavan <i>et al.</i> , 2001).	Organised clubs and activities were one of the four types of activity to alleviate or prevent loneliness identified in the survey. Examples included clubs and groups for older people, participation in GAA and football clubs; playing cards and bingo.

Interventions	Supporting evidence	
Individual-level interventions	The literature	The findings of this study
Promoting and organising group social activities for older people (continued).	The basic source of social support for older adults comes from other people, including other family members, neighbours, volunteers and professionals (O'Leary <i>et al.</i> , 2004). The Health Promotion Strategy for Older People has among its goals the need to 'help maintain the well-being and autonomy of older people by increasing their involvement in social activities' (Brenner and Shelley, 1998). Participation in social activities has been found to result in significantly larger social networks among older people (Moorer and Suurmeijer, 2001). Layte <i>et al.</i> (1999) identified a significant decrease in the proportion of older people in rural areas having daily contact with friends, neighbours and relatives. Rural older people also had lower participation rates in clubs and organisations than their urban counterparts.	Service planners and providers referred to a range of clubs and group activities that had been established to provide a mechanism for social interaction and for older people to keep active. One point stressed, however, is that some older people may not mix well in a group situation or may be reluctant to engage in group activities and, therefore, it should not be assumed that group activities and clubs are appropriate for everyone.

Table 6.1 (contd.): Strategies of intervention and good practice

Table 6.1 (contd.): Strategies of intervention and good practice

Interventions	Supporting evidence	
Individual-level interventions	The literature	The findings of this study
Promoting the development of local visitation and befriending schemes.	<p>While the number of contacts with others may not be the important factor in remedying loneliness, the <i>quality</i> of the contacts with others may be the crucial element (Layte <i>et al.</i>, 1999). These various social support networks, most especially the local family-dependent and the locally integrated, can evolve into care networks when older people's circumstances require care, and they can augment essential social services by providing companionship and emotional support (Wenger and Keating, 2002). The frequency of older people's social contacts are associated with loneliness and functional ability; high frequency of social contacts with family, friends or neighbours are related to lower levels of both emotional loneliness and social loneliness (Bondevik and Skogstad, 1998). Providing functional assistance facilitates the frequent social contacts that, in turn, can prevent or reduce loneliness (Bondevik and Skogstad, 1998).</p>	<p>Service planners and providers referred to the importance of visiting older people who are housebound and highlighted the success of pilot projects providing visitation services for older people. One of the key points raised in this regard was the quality of the interaction with older people and the need for those visiting them to develop meaningful relationships with them.</p>

Interventions	Supporting evidence	
Individual-level interventions	The literature	The findings of this study
<p>Facilitating older people to maintain their church-related activities.</p> <p>Providing alternative, suitable accommodation.</p> <p>Promoting interventions aimed at helping older people to cope with living alone, including support for older people to remain in their own homes.</p>	<p>Some older people regard living alone as a way of maintaining their independence and self-esteem (Brenner and Shelley, 1998). For some people, living alone can be a positive experience, especially for those who choose to do so (Holmén <i>et al.</i>, 1992) and living alone does not necessarily imply loneliness and isolation (Power, 1980). Data from the Living in Ireland Survey revealed that the frequency of social contact among older people living alone was high (Layte <i>et al.</i>, 1999). Living alone is not necessarily synonymous with reported loneliness (Victor <i>et al.</i>, 2002).</p>	<p>Church-related activities were included as one of the four types of activity to alleviate or prevent loneliness identified in the survey. This included attending religious service, acting as Eucharistic Minister, singing, cleaning or flower-arranging.</p> <p>Service planners and providers identified a range of interventions aimed at providing alternative accommodation for older people living alone. These included 'granny flats', community or sheltered accommodation and a 'Boarding Out a Granny' scheme.</p> <p>Service planners and providers identified a range of interventions that enable older people who wish to remain in their own homes to do so. These included home help, meals on wheels, home support service, home care assistance, and household repairs. Health care services, such as chiropody and occupational therapy, were also identified in this regard. Participants suggested the range of home-support and health care services needs to be made more widely available to older people. In addition, the Senior Helpline, television and local radio were identified as important sources of support for older people living alone.</p>

6.6.1.3 Summary of Strategies of Intervention

On the basis of the information provided in the foregoing tables, the following strategies of intervention and good practice in the prevention and alleviation of social isolation and loneliness are proposed.

1. Individuals and agencies with responsibility for developing and implementing social policy in relation to older people should recognise the capacity of individuals themselves to promote social interaction and prevent, alleviate and/or cope with loneliness. Social interactions and individual-level coping mechanisms used by older people to prevent and/or alleviate loneliness should be facilitated, where possible.
2. Individuals and agencies with responsibility for developing and implementing social policy in relation to older people should recognise that chronological age is not in itself a cause of loneliness and social isolation *per se*; factors other than chronological age alone can precipitate loneliness. Professionals involved in statutory and voluntary provision of services for older people should be alert to a range of possible precipitating factors, including the loss of a spouse, infrequent visits from siblings and sensory impairment (Dugan and Kivett, 1994). The possibility of preventing loneliness arising out of these factors can be improved if there is a recognition that older people's needs and experiences are about things other than assistance with functional activities.
3. Individuals and agencies with responsibility for developing and implementing social policy in relation to older people should act to enhance older people's access to public transport in order to improve older people's mobility and facilitate their social networks. This requires the promotion and development of public transport policy and practice that recognises that not all people are car-mobile, and it should include the development and/or maintenance of good rural public transport. This could include the provision of funds to finance taxi services for older people in rural areas where public transport is limited or absent.
4. Individuals and local communities should act to promote the development and organisation of group social activities for older people within their communities, in order to promote better social inclusion of older people. The responsibility for such organised activities lies with the community itself, but also with statutory and voluntary bodies with responsibility for older people. This can involve the organisation and development of local day centres and social/community centres where these do not exist already, and the organisation and development of local visitation and befriending schemes.

5. Individuals and agencies with responsibility for developing and implementing social policy in relation to older people should promote interventions aimed at helping older people to cope with living alone, including support for older people to stay at home. The older person's immediate family network may take responsibility for this. However, where the immediate family network is absent or limited, responsibility rests with voluntary and statutory bodies, including local authorities and health and social service providers. By the same token, where living alone is detrimental to the older person's well-being, these same bodies have a responsibility to act to provide alternative, suitable accommodation.
6. A number of other community-level strategies of intervention may help to prevent and/or alleviate loneliness and social isolation. These could include the provision of information on local services available for older people through a range of media, including local radio and newspapers, and financial and other support for specific groups of vulnerable old, such as the recently bereaved, to promote their social contacts and social integration. In this connection, it is recognised that the clergy have a role by virtue of their pastoral ministry during times of bereavement and other major events in older people's lives.
7. Funding for strategies in the prevention of loneliness and social isolation should be so structured as to take account of the individual older person's right to choose the services that meet their individual needs and the resources that they identify are required.

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Appendices

Appendices

Appendix One: Some Methodological Issues in Researching Loneliness and Social Isolation

Research into ageing in Europe is not a unified field and is fragmented across the disciplines of biology, the social sciences and engineering (European Commission, 2000). Research initiatives in Ireland appear to reflect this fragmentation, with biomedical research working in isolation from social research. Historically, social support research and loneliness research have followed parallel but separate traditions; the former has been conducted within social networks research, while the latter has been conducted within the domain of personal relationships (Andersson, 1998). The concepts of social isolation and loneliness thus arise from distinct disciplines of inquiry, with their distinct epistemological and methodological traditions. Sociology gives rise to research into social networks, social support and social isolation, while much of the research into loneliness tends to be conducted within the fields of individual and social psychology,

Ernst and Cacioppo (1999) point out that research on causal process in loneliness is sparse, and they call for more research to delineate which factors are antecedents and which are consequences of loneliness. However, it is generally not possible to establish cause-effect relationships in social research, and studies that explore relationships among variables associated with loneliness, social networks and social isolation are generally of the nature of correlation designs that attempt to establish associative or functional relationships. While social research has established relationships among social-demographic and socio-economic characteristics of populations, such as age, income and education, and among psychological well-being and socio-economic characteristics, such as depression with social deprivation, the precise nature of relationships between variables related to psychological well-being, personal characteristics and the characteristics of a neighbourhood are less easy to establish (Moorer and Suurmeijer, 2001).

Instrumentation

While it is methodologically difficult to study loneliness, a large body of research has resulted in the development of an array of loneliness scales, many of which attempt to capture the multidimensional nature of loneliness (Holmén *et al.*, 2000). This research has produced some robust quantitative approaches (Victor *et al.*, 2002). Instruments with high degrees of validity and reliability permit the testing of hypothesised relationships with and among a range of variables associated with social networks, social isolation and loneliness. Discussing the uncertainty surrounding the validity of objective measurement of a subjective phenomenon such as loneliness and its correlates, Andersson (1998) remarks, 'If someone claims that he or she feels lonely, to what extent are we prepared to accept that an observed dysfunction is associated with loneliness as such?'

Measuring Loneliness

In exploring loneliness among older people in Ireland, this study has recognised the multidimensional nature of the phenomenon; many research instruments attempt to capture this multidimensional nature of loneliness e.g. social and emotional loneliness, family loneliness (Cramer and Barry, 1999) and degrees or levels of loneliness e.g. low, medium or high (Wang *et al.*, 2001). However, much research proceeds on the basis of a conceptualisation of loneliness as a single entity and, in this regard, there is the assumption that loneliness is the same across circumstances and causes (Holmén *et al.*, 2000). The overriding concern with any instrument purporting to measure loneliness or social isolation rests with its ability to measure the concept; this becomes especially problematical when there may be no obvious or universally agreed definition of the

concept or its constituent constructs. Despite these concerns, the literature contains reports of instrument development and testing that suggest that the phenomena in question are amenable to measurement.

It is also possible to describe the incidence of loneliness and related experiences, such as the sense of being cared for, and to explore qualitatively the loneliness experience for individuals. Empirically, loneliness can be measured as a relative variable (Fahey and Murray, 1994), that is its present state relative to its past state, or it can be measured using an absolute scale of loneliness. However, most studies into loneliness are cross-sectional in design and are therefore not designed to study changes in the experience of loneliness over time (Tijhuis *et al.*, 1999). With cross-sectional studies, cohort effects may result in empirical differences between different age groups, while time trends may not be distinguishable from age effects in longitudinal studies (Tijhuis *et al.*, 1999).

In order to assess adequately the incidence of loneliness among older individuals, it may be necessary to examine the combined effects of variables such as marital status, gender, age and health (de Jong-Gierveld *et al.*, 1989). In addition, assessment of the quality of older people's personal relationships contributes more to the study of the incidence of loneliness than do their characteristics (de Jong-Gierveld *et al.*, 1989).

Describing Social Networks and Social Isolation

As with loneliness, empirical studies of social networks and social isolation among older people are plentiful. It is possible to describe the quantity of social networks in terms of their extent and structure, and to explore the content and quality of social interaction in terms of the effect of social relationships on older people's psychological well-being (Fahey and Murray, 1994). Since the content and quality of social networks are difficult to define and to measure in survey questionnaires, consensus on agreed empirical instruments with which to measure social support is difficult to obtain (Fahey and Murray, 1994). Nevertheless, indicators of the quality of social relationships, such as the effectiveness of social interaction in sustaining feelings of belonging and social fulfilment, can be derived from empirical data. A simple but important measure of social isolation can be obtained by measuring variables related to time spent alone (Garavan *et al.*, 2001).

In empirical research, establishing relationships among variables related to social contacts and social isolation and the experience of loneliness is fraught with difficulties. For example, there is the difficulty of establishing valid and discriminating measures of social support, and it is difficult to isolate variables related to social isolation, such as widowhood or the level of support from a living spouse, as predictors of loneliness (Fahey and Murray, 1994). As Fahey and Murray observe:

The complex interactions between expectations, habit and what is available to older people are very difficult to measure and make it hard to isolate any simple set of factors which could be clearly identified as primary contributors to whatever degree of loneliness is common among older people.

Appendix Two: Profile of the Respondents

Demographic Profile

In total, 683 people aged 65 years and older were interviewed as part of the national telephone survey. The sample was obtained through random digit dialling of telephone households in Ireland and accessing persons aged 65 years and older representing all of the counties in Ireland. To ensure the results obtained were demographically representative, they were compared with national demographic information from Census 2002 (CSO, 2002). Twelve questions gathered data from the respondents specifically related to key socio-demographics, for example, age, gender, marital status, residence, educational level, occupation and family-related issues.⁴¹

The survey respondents comprised 39.1 per cent male and 60.9 per cent female. The age of the respondents ranged from 65-99 years (mean 73.5, SD 7.1). In relation to age, the sample was very similar for men and women in comparison to the general population proportions. There were, however, a smaller proportion of women within the 75-79 years group (16.8 versus 21.2 per cent) and in 85+ years group (8.0 versus 11.1 per cent) in the study than that found in the population.

The marital status of the sample again compared favourably with the population proportions. Single men were slightly under-represented (12.9 versus 20.3 per cent) in comparison to the population aged 65 years and over (Table A1).

41. Denominators vary as not all questions in the survey were answered.

Table A1: Marital status (n=673)

Marital status	Respondents	Mean number of years (SD)
Single	12.6%	47.0 (5.7)
Married	49.6%	41.7 (8.6)
Separated	2.2%	20.6 (10.9)
Widowed	35.3%	15.3 (10.8)
Divorced	0.3%	36 (0.0)
Total	100.0%	

Almost 50 per cent of the respondents were married (49.6 per cent, n=333) and resided with their spouse. The mean number of years the respondents were married was reported as 41.7 years (SD 8.6).

Of those who were widowed (n=237), the majority were women (80.7 per cent, n=188). This factor may be explained by the increased life expectancy of females in Ireland. The mean length of time widowed was reported as 15.3 years.

Figure A1: Profile of respondents' children

The majority of the respondents (80.2 per cent, n=548) had at least one child who was alive. Over 60 per cent (n=414) of the respondents had three or more children (mean 4.1, SD 2.1, range 1-13 children).

All of the respondents had completed some formal education. The respondents' ages were reclassified into groups to identify the highest level of education reported between the age groups. Those aged 85 and over were significantly more likely to have only completed a primary level of education (63.3 per cent), whereas those aged 65-74 years were twice as likely to have attained a secondary level of school education (50.9 per cent).⁴²

Table A2: Educational level by age group

Characteristics	65-74 years (n=411)	75-84 years (n=198)	85+ years (n=49)
Primary school	31.9%	54.5%	63.3%
Secondary school	50.9%	31.8%	30.6%
Trade/technical	4.1%	3.5%	0.0%
University	11.9%	7.6%	6.1%
Other	1.2%	2.5%	0.0%
Total	100.0%	100.0%	100.0%

In addition, a greater number of those aged 65-74 years reported that they had attained a university-level education. The social classification of the respondents was based on their last or current occupation. In total, only 7.6 per cent of males (n=20) and 2.9 per cent of females (n=12) were currently working. Eleven per cent of the male respondents were classified as professional in comparison with only 2 per cent of the female respondents. Over 29 per cent of the female respondents (119 of 408) were classified as unknown, although the majority of these (115 of 119) had reported their last occupation as housewife.

42. $\chi^2=43.9$, $df=8$, $p<0.001$

Table A3: Socio-demographic and economic profile

Characteristics	Male (n=263)	Female (n=408)
Social classification		
Professional	11.0%	2.0%
Managerial	20.2%	16.6%
Non-manual	25.5%	30.9%
Skilled manual	26.6%	6.1%
Semi-skilled manual	9.1%	10.5%
Unskilled manual	7.2%	4.7%
Unknown	0.4%	29.2%
Total	100.0%	100.0%
Weekly income	(n=210)	(n=321)
Up to €200	30.5%	61.6%
€201-€400	61.9%	34.0%
€401 and above	7.6%	4.4%
Total	100.0%	100.0%

The respondents were asked to identify their current weekly income. The reported incomes were classified into three groups. Over 60 per cent of the female respondents (61.6 per cent) reported weekly incomes of up to €200. Almost twice as many of the male respondents reported weekly incomes of between €201 and €400 (61.9 versus 34.0 per cent).

Respondents were asked about their residency and current living arrangements: 60.1 per cent of the respondents defined their area of residency as urban while 39.9 per cent

defined their area of residency as rural. The majority of respondents reported that they had lived in Ireland their entire lives (83.7 per cent, n=561).

The majority of respondents (91.4 per cent) lived in property that they owned, with less than 10 per cent reporting that they lived in rented accommodation or with a relative. The respondents who were homeowners had lived in the same house on average for 40.7 years (SD 17.6).

Table A4: Respondents' living arrangements

Characteristics	All respondents (n=677)
Own home	91.4%
With relatives	5.2%
Rented	3.4%
Total	100.0%

Self-rated Health

The respondents were asked three questions regarding self-rated health. They were asked to rate a number of health status indicators including hearing, eyesight and general health using a five-point Likert scale. More than a third rated their general health as very good or excellent, with little differences between males and females (39.8 and 36.8 per cent respectively).

Only a small minority of the respondents reported their hearing ability as fair or poor. Specifically more women had lower rating for their hearing ability (13.2 per cent, n=54) compared with men (8.4 per cent, n=22). Respondents rated their visual acuity lowest overall. One fifth of the male respondents (20.2 per cent) and over a quarter of the female respondents (26.5 per cent) rated their vision as fair or poor.

Table A5: Self-rated health

Characteristics	Male	Female
Overall health	(n=262)	(n=408)
Very good to excellent	39.8%	36.8%
Good	42.8%	41.2%
Fair to poor	17.4%	22.0%
Hearing	(n=262)	(n=410)
Very good to excellent	43.1%	42.7%
Good	48.5%	44.1%
Fair to poor	8.4%	13.2%
Eyesight	(n=264)	(n=408)
Very good to excellent	37.0%	30.4%
Good	42.8%	43.1%
Fair to poor	20.2%	26.5%

Older people often undertake the role of carer for another individual. The time and responsibilities involved in caring for another person can be immense, especially if support services are not in place. The respondents were asked if they were caring or had previously cared for another person at home. The majority of the respondents (87.4 per cent, n=592) reported that they had never cared for any person. A further 6.9 per cent (n=47) of the respondents reported that they had previously cared for another person, while 5.6 per cent (n=38) reported that they were currently caring for another individual. The profile of the persons who were currently being cared for included dependent spouses (n=27), dependent children (n=6), dependent siblings (n=3) and 'others' (n=2), (grandchild and uncle specifically).

Access to Services

Often lack of access to either a car or public transport can reduce or prevent travel to shops, day centres or visits to family and friends. Respondents were asked three questions to ascertain their current access to transport and to estimate their travelling distances to specified amenities, the bank and post office. These services were selected because for many older people, the weekly visit to the post office can be a very important social interaction.

Of the respondents, 43.8 per cent ($n=298$) reported that they had access to a car, while 17 per cent ($n=116$) reported that they had access to public transport only. A further 11.7 per cent reported that they had no access to any mode of transport. These specific respondents were more likely to be rural- than urban-based ($\chi^2=81.3$, $df=3$, $p<0.001$).

In relation to distances travelled to access the specified services of the post office and bank, the majority of the respondents (87.8 per cent) reported that they travelled a distance of less than five miles. The location of residence and the accessibility to transport are very important requisites, however, even for short journeys. While 11.6 per cent ($n=78$) of the respondents reported travelling distances of up to 15 miles to access their local bank, less than 1 per cent of the respondents reported travelling distances of greater than 15 miles. Significant differences were reported when comparing urban- and rural-based respondents and their access to banks. Urban dwellers were more likely to travel distances of less than one mile (86.8 per cent compared to 13.2 per cent, $\chi^2=195.7$, $df=3$, $p<0.001$).

Similar results were reported by respondents for distances travelled to access their local post office. Again, in a comparison of urban and rural residencies, those who had to travel less than one mile to access their post office were more likely to be urban-based (81.1 per cent compared to 18.9 per cent, $\chi^2=199.2$, $df=2$, $p<0.001$).

Figure A2: Distances travelled to bank

Figure A3: Distances travelled to post office

Terms of Reference

Terms of Reference

The National Council on Ageing and Older People was established on 19th March 1997 in succession to the National Council for the Elderly (January 1990 to March 1997) and the National Council for the Aged (June 1981 to January 1990).

The functions of the Council are as follows:

1. To advise the Minister for Health on all aspects of ageing and the welfare of older people, either at its own initiative or at the request of the Minister and in particular on:
 - a) measures to promote the health of older people;
 - b) measures to promote the social inclusion of older people;
 - c) the implementation of the recommendations contained in policy reports commissioned by the Minister for Health;

2. To assist the development of national and regional policies and strategies designed to produce health gain and social gain for older people by:
 - a) undertaking research on the lifestyle and the needs of older people in Ireland;
 - b) identifying and promoting models of good practice in the care of older people and service delivery to them;
 - c) providing information and advice based on research findings to those involved in the development and/or implementation of policies and services pertaining to the health, well-being and autonomy of older people;
 - d) liaising with statutory, voluntary and professional bodies involved in the development and/or implementation of national and regional policies which have as their object health gain or social gain for older people.
3. To promote the health, welfare and autonomy of older people.
4. To promote a better understanding of ageing and older people in Ireland.
5. To liaise with international bodies which have functions similar to the functions of the Council.

The Council may also advise other Ministers, at their request, on aspects of ageing and the welfare of older people which are within the functions of the Council.

Membership

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Mr Bernard Thompson	Ms Mary O'Neill
Mr Michael Dineen	Cllr Jim Cousins
Fr Peter Finnerty	Dr Ciaran Donegan
Mr Eamon Kane	Mr James Flanagan
Mr Michael Murphy	Dr Michael Loftus
Mr Pat O'Toole	Ms Mary Nally
Ms Pauline Clancy-Seymour	Ms Rosemary Smith
Mr Eddie Wade	Mr John Brady
Ms Kit Carolan	Mr Noel Byrne
Mr John Grant	Dr Davida de la Harpe
Ms Sylvia Meehan	Dr Ruth Loane
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