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EXAMINATION OF FACTORS AFFECTING THE FEELING OF LONELINESS AMONG THE ELDERLY: IMPLICATIONS FOR INTERVENTION

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Abstract

Alleviating social isolation and loneliness among the elderly is a vital area for both policy and practice. However, the effectiveness of various interventions has been challenged due to lack of evidence. Twenty-four institutionalised geriatric residents from an institution in Manila were recruited. Using a non-experimental research design, participants completed questionnaires to measure their feeling of loneliness. Findings revealed that blurring of vision was the most common physical agony. While in terms of common emotional agony, feeling of irritability has been identified. No notable mental agony has been revealed by the present study. Findings support earlier studies that emphasise the social isolation and loneliness encountered among this age group. Results are intended to serve as a framework for intervention.

Key words*:* elderly, loneliness, geriatric residents

Introduction

Loneliness is a prevalent experience across one's lifespan. Available studies conducted in developed countries indicate that as many as 40 per cent of adults over 65 years of age report being lonely at least sometimes. Approximately 5–15 per cent of adults of this age report feeling lonely frequently, but that figure increases to about 50 per cent of adults 80 years and older. Chronic feelings of loneliness are experienced by 15-30 per cent of the general population (Hawkley, 2015).

More research should concentrate on this since it is a global issue. In one study it has been observed that loneliness concerns the subjective evaluation that the number of relationships is smaller than the

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individual considers desirable or that the intimacy that the individual wishes for has not been realised. The aim of this study was to assess variations in levels of late-life loneliness and its determinants across Europe. Using logistic models, researchers tested several types of explanations for country differences: differences in demographic characteristics, wealth and health, and social networks. Older adults in the southern and central European countries were generally lonelier than their peers in the northern and western European countries. In the southern and central European countries, loneliness was largely attributable to not being married, economic deprivation, and poor health. Frequent contacts with parents and adult children, social participation, and providing support to family members were important in preventing and alleviating loneliness in almost all countries. To combat loneliness among older adults, the findings suggest both (a) generic approaches aimed at improving social embeddedness and (b) country-tailored approaches aimed at improving health and wealth (Fokkema, De Jong Gierveld, & Dykstra, 2012).

Earlier studies have revealed that Old age and loneliness are linked in the stereotyped picture of old people and is one of the most widespread myths about this age group (Tornstam, 1994). More so that in an earlier study (Kaasa, 1998) it has been revealed that it is important not to contribute to the gloomy perception of old people as lonely and unhappy, but nevertheless one must not underestimate the serious consequences of extreme loneliness among the elderly.

Loneliness may be defined in several different ways, often related to the cause of the loneliness. One connotation is positive, as in solitude, deliberately chosen to be alone. Peplau (1982) explored 12 definitions of loneliness and found that all have three elements in common: Firstly, loneliness is a result of deficiencies in a person's social relations. Secondly, it is a subjective feeling, not synonymous with isolation. It is possible to feel lonely together with many people or to be alone without feeling lonely. Thirdly, the feeling is negative and unpleasant.

More recently, it has been observed that older people moved into and out of frequent loneliness over time, although there was a general increase in loneliness with age. Loneliness at baseline, depression increment and recent widowhood were significant predictors of loneliness in all three multivariable models. Widowhood, depression, mobility problems and mobility reduction predicted loneliness uniquely in the model for women; while low level of social contacts and social contact reduction predicted loneliness uniquely in the model for men (Dahlberg, Andersson, McKee, & Lennartsson, 2015).

Findings show that loneliness was significantly associated with cardiovascular disease, diabetes, and migraine. In addition, high perceived stress, physical inactivity, daily smoking, and poor sleep mediated the association between loneliness and adverse health conditions. Moreover, findings demonstrate several

gender differences in the association between loneliness and various adverse conditions and the indirect mechanisms affecting these associations.

It is important to ascertain the factors that contribute to the feeling of loneliness among the elderly because these can be used as a basis for future interventions. For instance, it was assessed whether the use of internet could be an effective method for elderly people to cope with the loneliness. In the screening study based on the relationship model, a total of 569 elderly individuals were included. The obtained results showed higher levels of loneliness in elderly people living alone, compared to the elderly using the internet, such as the use of social networks. Higher education levels was found to be related to increased internet use and decreased loneliness. In general, it could be stated that use of internet has an important place among methods used in dealing with loneliness of mature and adult individuals (Sar, Göktürk, Tura, & Kazaz, 2012).

Loneliness is a common source of suffering in older persons. We demonstrated that it is also a risk factor for poor health outcomes including death and multiple measures of functional decline. It persisted after accounting for a large number of confounders including illness severity and depression. With the increasingly large number of Americans aging and the high costs associated with disability ($26 billion annually for those who lose their ability to live independently over the course of a year), it is necessary to identify and, if possible, modify the factors that place elderly persons at risk for functional decline and death (Perissinotto, Cenzer, & Covinsky, 2012).

Loneliness has previously been related to various aspects of cognition, including cognitive decline and the onset of dementia in the elderly. There are several differences between prior studies and the present study, however, so it is useful to explain this discrepancy (Cacioppo & Cacioppo, 2013).

With the host of life events, it does not come as a surprise that the elderly are very much prone to experience agony. The researchers have categorised these into three: physical, emotional and mental. In line with this, the present study sought to identify the agonies and its levels being experienced by the elderly. The discussion of abandonment in this study highlighted the causes why they are living in a solitary life. The study has also attempted to identify the various underlying factors of their abandonment and reasons for their agony.

Given that the elderly population is on the rise, it is of paramount importance to examine the burdens of the elderly people, be it physical, mental or emotional. This study would offer useful insights for further understanding of the real situation during old age which can be useful in designing holistic programmes to address their needs.

Methodology

Objectives

In view of the earlier studies narrated above, this study sought to identify the level of agonies of the elderly in terms of: physical, emotional and mental; to characterise the cause of abandonment; and, lastly, to relate the causes of abandonment with the physical, emotional and mental.

Materials and Methods

The present study is a descriptive, exploratory study with a qualitative approach. This type of study allows the description and exploration of aspects of a given situation, and allows the researcher to enhance the experience on the subject, helping to find the necessary elements required to contact a given population in order to get the desired results. Additionally, for the purpose of this study, researchers have immersed themselves in the geriatric residence through voluntary work and community service.

Setting of the Study

The respondents are the elderly being looked after by the Salvation Army, an institutionalised organisation that helps less fortunate people, the homeless, outcast, and orphans from the poverty stricken location of Tondo, Manila. The Salvation Army is a religious organisation which is distinctive from government services. The Army's doctrine follows that of the mainstream Christian beliefs and its articles of faith emphasises religious doctrines. Its objectives are 'the advancement of the Christian religion of education, the relief of poverty, and other charitable acts which are beneficial to society. It was founded in 1865 by William Booth. The Salvation Army in the Philippines was established through the initiative of Filipinos during 1933-1937. In June 1937 Colonel and Mrs Alfred Lindvall officially inaugurated Salvation Army in the Philippines. The researchers coordinated with the Manila Tondo Corps branch located in Manila, where their Community Health Resource and HIV/AIDS centre are also situated. The Golden Acres of Salvation Army were founded in 1980. And finally, in 1990, sponsorship grants such as feeding programme and financial assistance have been offered.

Survey Instrument

Researchers used a self-made questionnaire which measured the level of agony in terms of physical, emotional and mental aspects brought about by living in an institutionalised geriatric residence. The questionnaire also aimed to identify the causes of their abandonment. The instrument has been validated and interviews were conducted to have a clearer understanding of their feelings and experiences

Sampling Technique

Participants have been selected through purposive sampling based on the characteristics they exhibit. These elderly are living a solitary life.

Results, Interpretation and Discussion

While social isolation and loneliness are seen as common problems of old age, it is important to understand how this can be taken into account from a number of factors such as age, gender, number of years living in the geriatric institution and reasons for living in a geriatric institution.

Firstly, in order to ascertain the profile of the respondents, the study explored the age group of the elderly. Out of 24 respondents, 13 of them are between the ages of 52-69. This accounts for 54.17 per cent of the participants.

Table 1. *Profile of the Respondents According to Age*

Age group	F	%
44-56	7	29.17
57-69	13	54.17
70-82	3	12.50
83 and above	1	4.17
Total	24	100.00

One study has observed that advanced age and possession of post-basic education were independently *protective* of loneliness (Victor, Scambler, Bowling, & Bond, 2005). Aside from the age group, gender was also taken into account. Most of the respondents were female (91.67%) in contrast to male respondents which accounts to 8.33%.

Table 2. *Profile of the Respondents According to Gender*

Gender	F	%
Female	22	91.67
Male	2	8.33
Total	24	100.00

While gender is an interesting factor to be considered, apparently, whereas men are more likely to find an intimate attachment in marriage, women also find protection from emotional loneliness in other close ties. The marital-history differences in social loneliness are largely mediated by social embeddedness characteristics, partly in different ways for men and women. Involvement in activities outside the home serves as the context for sociability for men, whereas parenthood plays a more important role in women's social engagements (Dykstra & de Jong Gierveld, 2004).

The current study has also looked into the number of years the participants have been living in the geriatric institution. It was revealed that most of them (50%) have been living there for more than 11 years.

Table 3. *Profile of Respondents According to Number of Years of Living in the Geriatric Institution*

Number of Years	F	%
1 to 3	3	12.50
4 to 6	1	4.17
7 to 10	8	33.33
More than 11	12	50.00
Total	24	100.00

Future researches could compare these findings with their own study. Other factors could be taken into account. In an earlier study, for instance, it was observed that he migration patterns of the elderly are placed in a developmental perspective. For those who migrate, three kinds of moves tend to occur among the aging in a modern society: one when they retire, a second when they experience moderate forms of disability, and a third when they have major forms of chronic disability. Litwak's formulations on the extended family provide the context for these patterns, whereas Longino provides much of the migration data (Litwak & Longino, 1987).

Meanwhile it was observed that 41.66 per cent of the respondents are unemployed so they have chosen to stay at the geriatric institution.

Table 4. *Profile of Respondents According to Reasons for Living in the Geriatric Institution*

Reasons	F	%
Unemployed	10	41.66
Widowed	8	33.33
No relatives to stay with	6	25.00
Total	24	100.00

Filipinos might have a different attitude on this. For instance, A cross-cultural study (İmamoĞlu & İmamoĞlu, 1992) has revealed that compared to Swedes, Turks had more frequent social contacts but reported feeling lonelier and more negative about aging and their lives. Relative to Swedes, Turkish respondents were less favourable toward institutional living but became more favourable with age and urbanisation. Unlike in Sweden, in Turkey an institution becomes an acceptable last resort for those who have fewer social contacts and feel lonelier and more negative about aging and their lives.

This table shows the score and verbal interpretation used in the study. The scores were grouped into five intervals: 0.00 – 1.49; 1.50 – 2.49; 2.50 – 3.49; 3.50 – 4.49; 4.50 – 5.00 with their respective verbal interpretations.

Table 5. *Score and Verbal Interpretations Used*

Score	Verbal Interpretation
0.00 - 1.49	Never
1.50 - 2.49	Sometimes
2.50 - 3.49	Often
3.50 - 4.49	More often
4.50 - 5.00	Always

Table 6 showcases the physical agony of the elderly. For this study 16 physical agonies were considered. An overall score (M = 2.16, SD = 1.38) has been reflected on this table. As can be seen from Table 6, blurring of vision is the most common physical agony among the participants (M = 3.23, SD = 1.31) while fever (M = 1.31, SD = 0.48) is revealed to be the least of their concern. However, there are other physical agonies that might not have been reported by the participants themselves such as Alzheimer's disease and Parkinson's disease (Relojo, 2015).

Table 6. *Physical Agony of the Elderly*

Physical Agony	M	SD	Verbal Interpretation
1. Blurring of vision	3.23	1.31	Often
2. Dizziness	2.33	1.03	Seldom
3. Headache	1.94	0.68	Seldom
4. Breathing difficulty	2.21	1.13	Seldom
5. Painful urination/bowel movement	1.75	1.00	Seldom
6. Bleeding (any body parts)	1.29	1.07	Never
7. Cough/colds/sore throat	2.10	1.17	Seldom
8. Chest pain	1.94	1.18	Seldom
9. Abdominal pain	1.83	1.07	Seldom
10. Weakness	2.56	1.15	Often
11. Muscle/joint pain	2.67	1.03	Often
12. Fever	1.31	0.48	Never
13. Nervousness	2.19	1.38	Seldom
14. Hearing difficulty	2.85	1.31	Often
OVERALL	2.16	0.55	Seldom

Table 7 enumerates the emotional agony of the elderly. For this study 14 emotional agonies were considered. An overall score (M = 1.93, SD = 0.39) has been reflected on this table.

Table 7. *Emotional Agony of the Elderly*

Emotional Agony	M	SD	Verbal Interpretation
1. Feeling alone	2.35	1.14	Seldom
2. Feeling isolated	2.24	0.70	Seldom
3. Feeling unhappy	2.14	0.53	Seldom
4. Feeling irritated	2.67	1.37	Often
5. Fear of death	1.72	0.83	Seldom
6. Unexplained feeling of anger	2.32	1.20	Seldom
7. Feeling bored	1.57	0.76	Seldom
8. Feeling bad about oneself	1.36	0.63	Never
9. Feeling down	1.57	0.76	Seldom
10. Feeling sorry	1.61	0.98	Seldom
11. Feeling of emotional pain	2.29	1.40	Seldom
12. Feeling miserable	1.67	0.78	Seldom
13. Feeling incomplete	1.83	0.39	Seldom
14. Feeling unappreciated and unloved	1.69	0.39	Seldom
OVERALL	1.93	0.39	Seldom

Further to the findings from Table 6, it was revealed in Table 7 that the most common emotional agony of the elderly is feeling alone (M = 2.35, SD = 1.14) while the least common emotional agony is feeling bad about oneself (M = 1.36, SD = 0.63)

Lastly, the mental agony experienced by the elderly has been explored. It was revealed that too much worrying (M = 2.29, SD = 1.23) emerged as the greatest mental agony, while feeling dumb and stupid was the least mental agony among participants.

Table 8. *Mental Agony of the Elderly*

Mental Agony	M	SD	Verbal Interpretation
1. Memory loss	2.00	0.74	Seldom
2. Too much thinking	2.20	0.77	Seldom
3. Too much worrying	2.29	1.23	Seldom
4. Being unreasonable	1.81	1.05	Seldom
5. Unable to sleep due to thinking	2.20	1.15	Seldom
6. Confusion	1.31	0.48	Never
7. Feeling dumb and stupid	1.00	0	Never
OVERALL	1.42	0.50	Seldom

This is a relevant finding that needs to be considered for the future directions of research. For instance, it was observed that depression is very frequently observed in clinical practice especially in elderly individuals. Its prevalence is always underestimated and it is often undertreated resulting in a lot of suffering. It is one of the important conditions resulting in reduced quality of living of diabetic subjects (Kaulgud et al., 2007)

Table 9 summarises the finding on this study where it was revealed that physical agony, emotional agony and mental agony are moderately experienced by elderly in a geriatric institution.

Table 9. ***Summary of the Agony of the Elderly***

Agony	M	SD	Verbal Interpretation
Physical	2.16	0.55	Sometimes
Emotional	1.93	0.39	Sometimes
Mental	1.42	0.5	Sometimes
OVERALL	1.84	0.22	Sometimes

Based on the results of this study an education and consultation should be done as soon as possible to remove the negative stigma of the institutional life from the geriatric residents. Also, in order to minimise the maladjustment to facility life of residents, a new programme and interventions for the new residents are needed. These finding will help to widen the understanding of the living conditions among institutionalised residents in the Philippines.

Conclusion

In general, the elderly exhibit conflicting feelings about their daily lives in the geriatric residence. While they refer to positive aspects as the good relationship between residents and the possibility of getting involved with activities of daily living, they also describe a feeling of isolation and loneliness, especially when talking about their relatives.

Living at institutionalised residences is deemed as a hiatus from life lived so far. For many elderly, coming to these institutions makes their home, their family, and their friends to become just a story to be told, a life event which becomes alive only in their memories. Hence, with all the fragility and limitations inherent in the life cycle, they still need to find strength to start a new life in their new home, where they meet new friends, and simply live on their lives without their family.

The result of this study has underscored the fact that the environment that will receive this population needs to be prepared so that there is a humanised caring environment and also this place should have a proposal to offer opportunities to health promotion of the elderly and not just provide food and medicine.

Earlier studies have demonstrated the serious consequences of loneliness in the form of more medical consultations (Ellaway, Wood, & Macintyre, 1999), suicides (Rubenowitz, Waern, Wilhelmson, & Allebeck, 2001) and depressions (Prince, Harwood, Blizard, Thomas, & Mann, 1997). An interventional study has demonstrated that an intervention programme, focusing on the CCC-design (availability of a confident, social comparison and personal control) resulted in less feeling of loneliness, less feeling of meaninglessness, more social contacts, higher self-esteem, greater ability to trust and lower blood pressure (Andersson,1984). Analysing the predictors of loneliness may be an instrument to reach the right target group to reduce loneliness. Creating meeting-places to establish new networks may be an important measure to help new widows and widowers as a target group. It could be useful to proceed with further studies combining qualitative and quantitative surveys to study the effect of actions to reduce loneliness among the

elderly. At this point, we need commitment to creating policies and strategies to ensure quality of care in institutionalised geriatric residents, so as to guarantee quality of life to those who rely on these services. Additional factors could also be considered such as adversity quotient and spiritual quotient (Relojo, Pilao, & dela Rosa, 2015).

Limitations and Future Directions

Findings in qualitative studies are always context bound. This study was conducted within a Filipino setting and the findings cannot be automatically transferred to other contexts. Our participants were older people of Filipino descent, so the findings may not be representative for older persons of different ethnic and cultural backgrounds. It is also a limitation of this study that we did not investigate how other groups, such as next of kin, younger people and health care workers, understand loneliness. Finally, this study did not address how lonely older people may be assisted in dealing with loneliness in an appropriate way.

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