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The Experience of Loneliness in Seniors: A Qualitative Descriptive Study

by

Stacy Landa

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The undersigned certify that they have read, and recommend to the Faculty of Graduate Studies for acceptance, a thesis entitled "The Experience of Loneliness in Seniors: A Qualitative Descriptive Study" submitted by Stacy Landa in partial fulfilment of the requirements of the degree of Master of Nursing.

Supervisor, Dr. Sandra P. Hirst, Faculty of Nursing

Dr. Shelley Raffin Bouchal, Faculty of Nursing

Dr. Peter Donahue, Faculty of Social Work

Dr. Carole-Lynne Le Nevenec, Faculty of Nursing

Dr. Pamela Miller, Faculty of Social Work

April 20/07
Date

Abstract

For Registered Nurses and other health care professionals to provide the best possible care for seniors who are lonely, it is necessary to understand the experience of loneliness in seniors. However, little is known on this topic in seniors. To develop an understanding of loneliness in seniors, a qualitative descriptive study was conducted with eight seniors, 65 years of age and older, who presently or had recently experienced loneliness. Two audio-recorded interviews were conducted with each participant, which were then transcribed and analysed. The findings yielded five themes that describe the loneliness experience: 1) The trigger, 2) Feelings of aloneness, 3) Lost, an unpleasant experience, 4) The influence of loneliness on the self, and 5) Coping with the loneliness. With this knowledge of the experience of loneliness in seniors, Registered Nurses and other health care professionals can better assist seniors to achieve their highest possible quality of life.

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Dedication

I could not have completed this project without the support and encouragement of my husband and parents. Therefore, I would like to dedicate this thesis to them and my beautiful daughter.

Table of Contents

List of Tables

CHAPTER ONE: THE BEGINNING OF THE JOURNEY.

Loneliness is not a new phenomenon; it is one that has been experienced by most individuals at some point in their lives. As individuals age, they may face many challenges that cause them to be vulnerable to feelings of loneliness. Some of these challenges include having to relocate from one's home for any number of reasons, as well as coping with the numerous losses associated with aging: the loss of health, of friends, and of loved ones. Alberta statistics indicate by the year 2016, the number of older adults in this province is predicted to reach 505 800, an increase of 165,300 from the year 2005 (Government of Alberta, 2006). Currently, females outnumber males in the senior population, and as a married aging female, the risk of becoming a widow steadily increases because females have a longer life expectancy and are often younger than their spouses (Government of Alberta). Age, widowhood, and gender have all been identified as correlates of loneliness in seniors (Holmen, Ericsson, & Winblad, 2000; Tijhuis, de Jong Gierveld, Feskens, & Kromhout, 1999). In addition to these correlates, loneliness in seniors has been linked to health concerns including hearing loss (Chen, 1994), dementia (Holmen et al., 2000), depression (Krohn, & Bergman-Evans, 2000; Prince, Harwood, Blizard, Thomas, & Mann, 1997), and suicide (Kennedy & Tanenbaum, 2000).

Furthermore, being lonely has been identified as a major fear of aging by seniors (Beyene, Becker, & Mayen, 2002), which indicates loneliness and the fear of it has an impact on their psychological health. A Gallup poll cited in Kennedy and Tanenbaum (2000) indicated that in 1996, Canada's suicide rate was the highest in those aged 75 years and older, and that seniors identified loneliness as a major reason for considering suicide. However, seniors do not often seek treatment for loneliness according to Donaldson and Watson (1996). The fact that seniors decline to seek assistance to manage their loneliness supports the need for increased awareness and understanding of the experience by Registered Nurses because nurses are typically a first point of contact in Health Services for the senior population.

Registered Nurses work with seniors in a variety of settings: hospitals, care centres, and the community. They have a goal of providing quality care for their clients, and an element of this care involves understanding their clients' experiences. With an

increased awareness and a clearer comprehension of the loneliness experienced by older adults, Registered Nurses can provide quality care for those who are experiencing loneliness. Furthermore, greater knowledge of this phenomenon could contribute to a better understanding of the relationships among loneliness, physical health, and psychological health in this population. The purpose of this study was to explore and describe the experience of loneliness for seniors living in a community setting, which would contribute to a better understanding of it.

Review of the literature

Prior to commencing a study on loneliness in seniors, it is necessary to examine the current state of knowledge on this topic. The first section of the literature review explores the theoretical views on the experience of loneliness, and the second segment will discuss changes related to normal aging and theories on aging with regards to loneliness. The third section will review theories on aging, and the fourth segment will synthesizes and analyses the literature on loneliness not specific to seniors. The fifth section reviews the literature on loneliness specific to seniors. The sixth section identifies the gaps and inconsistencies in the literature, and the final section describes the relevance of this topic for Registered Nurses.

Theoretical perspectives on the experience of loneliness.

There are various theoretical perspectives on the loneliness experience and this section will review some of those identified by Fromm-Reichman (1960), Moustakas (1961), Rogers (1970) Weiss (1973, 1982), and Peplau and Perlman (1982a & 1982b). These perspectives have been classified into either the interactionalist, psychodynamic, cognitive, existentialist or phenomenological groups. According to Weiss (1982) and Stokes (1989), loneliness is a phenomenon that can be described better than it can be defined. One of the earliest descriptions of loneliness was in 1953 by Sullivan (as cited by Peplau & Perlman, 1982b), who stated that loneliness was an experience motivated by the desire for interpersonal intimacy with other humans. Fromm-Reichman (1960) agreed with Sullivan's description, however added that loneliness is a psychotic state that causes helplessness and an emotional paralysis in individuals who suffer from it. Fromm-Reichmann and Sullivan's views are considered to be part of the psychodynamic

perspective (Peplau & Perlman, 1982). This perspective focuses on infant and childhood interpersonal relationships, how they shape personality, and influence coping abilities (Donaldson & Watson, 1996).

Bulka (1984) claimed loneliness develops when individuals are unsatisfied with their relationships with others. Peplau and Perlman (1982a) agreed with Bulka's views, but added that loneliness is the result of perceived deficits in a qualitative or quantitative form of relationships, causing feelings of emotional anguish. They suggested that individuals' views on their social abilities might contribute to feelings of loneliness (Peplau & Perlman, 1982a). The perspectives of Peplau and Perlman centered on people's reactions to loneliness and are classified as cognitive theory (Donald & Watson).

Weiss (1973) initially described loneliness as being experienced in the form of social or emotional isolation. Loneliness as social isolation results from actual or perceived inadequate social relationships, and loneliness as emotional isolation results from an insufficient or nonexistent attachment figure. Attachment figures are individuals to whom people feel linked emotionally and perceptually because the attachment figures provide security. Although, attachment figures are not always a confidant or an individual with whom a person has an intimate relationship (Weiss, 1989). Weiss (1973) and Peplau and Perlman (1982a) agreed that attachment plays an important role in whether individuals feel lonely throughout their life span. If attachment figures are insufficient or nonexistent, loneliness develops as a state of emotional isolation (Weiss, 1973). Furthermore, Weiss (1989) believed there are elements that influence how individuals develop and maintain relationships. These are: the presence or absence of attachment figures, the types of people with whom one develops attachment relationships, and the consequences of those attachments throughout the lifespan. Perlman (1989) agreed with Weiss that attachments play a role in the loneliness experience. However, Perlman believed the difficulties people encounter in adulthood are a result of disrupted attachments the same individuals had in their childhood, which contributes to interpersonal and emotional difficulties, such as loneliness. Additionally, Perlman indicated that situational characteristics could play a key role in the loneliness

experience, such as, a hospitalization. Yet, situational characteristics are often overlooked with the focus remaining on the influence of attachments.

Loneliness experienced as emotional and social isolation are characterized by different feelings (Weiss, 1982). Loneliness as an emotional isolation is characterised by feelings of restlessness and anxiety. In contrast, loneliness as social isolation is characterised by feelings of boredom, tension, meaninglessness, and intentional exclusion (Weiss, 1982). Individuals may feel lonely in the presence of social relationships, meaning the quality of relationships is an important element in loneliness. On the other hand, a person can be socially isolated without feeling lonely (Weiss, 1982). In a later publication, Weiss (1989) stated that loneliness is separation anxiety without an object, and it is expressed in similar forms in all age groups as distress, tension, and restlessness. Weiss' views fall under the umbrella of interactionalist theory, which originate from Bowlby's attachment theory (Donaldson & Watson, 1996).

According to Fromm-Reichmann (1960) and Rogers (1970), feelings of shame can accompany the loneliness experience, which prevents people from sharing their feelings of it. Lonely individuals are ashamed and fear rejection if others knew their hidden feelings (Rogers). Unfortunately, these feelings of shame inhibit people from sharing or seeking assistance regarding their loneliness, according to Fromm-Reichmann. Bulka (1984) believed feelings of pessimism, despair, emptiness, and hopelessness may also develop because some lonely individuals feel responsible for their personal situation as a result of being incapable of dealing with others.

An alternative view on loneliness was that provided by Moustakas (1961). His views are classified under existential theory (Donaldson & Watson, 1996; Peplau & Perlman, 1982). He believed there are two types of loneliness: existential loneliness and loneliness anxiety. Existential loneliness is an unavoidable part of life that is created by the unknown, ". . . the mystery of a new dawn, the endless stretches of sea and sky, the immense impact of air, and time, and space, and unfathomable workings of the universe" (Moustakas, p. 33). According to Moustakas, everyone experiences existential loneliness because people cannot experience the thoughts or feelings of others. However, the acceptance of loneliness as a part of life can be positive, according to Moustakas. He felt

it could assist individuals to experience life to the fullest and to recognize the beauty in the little things while knowing that their existence will come to an end. Those who fear the unknown or deny their existence as truly being alone experience what Moustakas identified as loneliness anxiety. Loneliness anxiety is a common condition in many societies today and is demonstrated by the need to be around others all the time (Moustakas). The environment people live in, the sense of values and standards people posses, and the need to live safe and controlled lives promotes society's fear of being alone, which contributes to loneliness anxiety.

Moustakas (1961) disagreed with theories that suggest the lack of an attachment figure contributes to feelings of loneliness. He believed that loneliness anxiety is a problem in modern society, suggesting humans are born with the need for intimacy and the need to be cared for, and this continues into adulthood as people develop relationships that are based on these needs. It is when these relationships are not fulfilled that loneliness emerges.

These diverse perspectives on the experience of loneliness have limitations. Weiss (1973, 1982) does not give adequate recognition to people's current situational and social influences that may intensify the loneliness experience. For example, those who are in hospital or confined to bed may be content with their social relationships, but lack the contact they desire with those people. In addition, his theory was based on observations and discussions with adults in a support group who were separated, divorced, or widowed. In comparison, Moustakas' (1961) perspective on loneliness is based on his personal experiences of it, and seniors may view their experiences differently. Fromm-Reichmann's (1960) views of loneliness stem from her work with psychiatric patients and those in group therapy, which suggests it perhaps does not apply to the general population. This is similar to Roger's (1970) theory. His views on loneliness are derived from a phenomenological perspective and were developed from listening to lonely individuals describe their experiences in therapy groups. This is problematic because those who participate in focus groups may not always feel comfortable enough to share certain details or feelings about their experiences.

This section has reviewed theoretical perspectives on the experience of loneliness. While a theoretical understanding of loneliness is important, theoretical writers do not apply their work to seniors. It may be possible that the experience of loneliness for seniors has similarities with these theoretical frameworks, but it may differ. Additional knowledge on the experience of loneliness from the perspective of seniors is necessary to develop a greater understanding of the experiences of loneliness among this population.

Aging and the older adult.

As people age they go through a number of changes physically, cognitively, and socially. These changes can be natural or pathological in nature. Natural processes of aging occur due to the passing of time (Kimmel, 1990). This section will focus on changes associated with aging and how they can influence the experience of loneliness for seniors.

Some of the physical changes that are influenced by normal aging processes include alterations in hearing, vision, elimination, skin, sleep, and mobility. Hearing is affected as a result of physiological transformations in the nervous system and anatomical parts of the ear (Stanley, Blair, & Beare, 2005). The ability to hear high frequency sounds, especially voices decreases as people age (Tabloski, 2006). This alteration can contribute to frustration when communicating with those who have high-pitched voices. Older adults with hearing problems may stop going to large social gatherings and participating in activities they enjoy, such as singing, watching movies, and playing bingo. Hearing aids may be beneficial but some seniors have verbalised that background noise, if too loud, is disruptive and prevents them from wearing the aids.

There are also physical changes that occurs in the eyes and one of these is a shrinking in pupil size decreasing the amount of light entering the eye (Stuen & Faye, 2003) making it difficult to see in the dark. Therefore, seniors have decreased night vision, in addition to reduced visual acuity, and accommodation of the lens, which are all normal age related changes in vision (Tabloski, 2006). These changes could influences seniors' functional abilities, leisure and social activities. Some seniors are unable to drive, watch television, play cards or participate in other activities they once enjoyed.

Problems with elimination are not an inevitable part of aging, but according to Tabloski (2006) it is hard to determine what changes are age related or the consequence of other things such as medication or disease. Elimination difficulties, more commonly urinary incontinence may affect the self-confidence of seniors due to the fear of unpleasant odour or the possibility of having an accident. These fears could cause some older adults to reduce the amount of time they spend in public places and around others.

Falls are a part of life for everyone on occasion but can result in serious problems for seniors. According to Kenny (2005), the rate of falling increases with age among those in community setting. The fear of falling and decreased mobility related to falls can limit or negatively influence an older adults participation in activities they enjoy and decrease the amount of contact with friends and family.

Natural alterations of the skin occur as individuals age including the development of lesion and wrinkles (Miller, 1999). These alterations of the skin may make some seniors feel self-conscious around others, possibly causing then limit their socialisation generating feelings of loneliness. As people age how they sleep also changes, it is harder to fall asleep and they wakeup more frequently (Tabloski, 2006). According to Hoffman (2003), older adults experience a decrease in the production of melatonin and the state of the circadian rhythm changes, altering patterns of sleep. There are less "restorative periods of sleep" and it is more disrupted (Hoffman, 2003, p. 211). Feeling tired can lead to daytime napping; these two things can cause seniors to miss out on socialising and activities they enjoy. Loneliness may result.

Normal aging changes can negatively influence the socialisation of seniors and contribute to loneliness. In addition to the natural physiological changes of aging, there are a number of other factors that affect how individuals' age and the possibility that they will experience loneliness. Loss, relocation and changes in roles are some of the factors that accompany aging and may cause loneliness. The death of loved ones and friends often occurs more frequently with age (Miller, 1999). Losses can be difficult to cope with especially if there is more than one and they occur close together contributing to loneliness.

Relocation is inevitable for a number of seniors due to health, safety, or financial reasons and can negatively influence relationships. For those who relocate some adjustments are necessary to adapt. Relocation may require settling into a new environment, coping with the loss of friends, material things such as a home, and possibly accepting help from others. Role changes, such as retirement are often a part of normal aging and a welcome occasion for many. For others, retirement can be associated with a loss of purpose, income, status, identity, and social contacts by some older adults (Miller, 1999). Some older adults enjoy the social aspects of work and retirement results in the loss of important social contacts. A loss of purpose, status, and identity related to retirement may lead to feelings of loneliness for some older adults.

Knowledge of normal aging processes may assist in understanding the experience of loneliness for seniors because some of these changes can negatively influence self-confidence and socialisation. There is a risk for loneliness to develop when socialisation is limited as a result of the fear of falling, decreased self confidence, lack of sleep, or other normal aging changes. Other factors that commonly accompany aging such as loss, relocation, and role changes may also cause changes in social support contributing to feelings of loneliness for seniors.

Theories of aging.

The normal changes that occur with aging discussed above may influence the social networks and socialisation of older adults. If individuals are unable to accept or adjust to these changes then loneliness may result. Various theories have been developed that attempt to explain aging but according to Powel (2006), few focus on aging. Disengagement theory, Socio-environmental theory, Selective theory, Continuity theory, and Selective Optimization with Compensation are theories that are commonly mentioned are in Stanley, Blair, and Beare (2005); Thorson (2000); Morgan and Kunkel (2001) and; Bengtson, Putney, and Johnson (2005).

Disengagement theory developed by Cumming and Henry, (1961) proposed that as individuals age the quantity of their contacts decrease, which is initiated by the individual and/or society. Cumming and Henry consider aging to be complete when this "inevitable mutual withdrawal" occurred and new balance is obtained were only

important relationships to individuals are maintained (p. 14). The withdrawal process takes place because of the realization that death is inevitable. The process consists of three steps. The first step begins by individuals altering the type, amount, and possibly the purpose of the interaction with those they customarily have contact. These changes in interactions occur so the shift in goals of the social network can be distinguished. In the second step, individuals become less involved and there is evidence of changes in quality of the interactions. In the third step, there is alterations in personality of individuals that lead to less social participation and an increase focus on the self (Cumming & Henry). "Stages of disengagement are broadly defined . . . according to three simple measures: age, occupation with a characteristic central task (marriage for women, work for men), and reduction in ego investment . . . " (Cumming & Henry, 1961, p. 133). When older adults disengage, they become less active in society and more of a spectator, this giving them greater freedom from the norms that are expected by those actively involved in society. Mental, physical, and socio-economic resources influence whether an aging individual decides to disengage. This theory claims that culture can shape the disengagement process but that the process does occur in various cultures and that withdrawal differs for men and women due to the different roles they have throughout life. The loss of roles as a result of retirement and widowhood can initiate the disengagement process, but Cumming and Henry indicated there is limited support for this claim.

In their book *Growing Old*, Cumming and Henry (1961) discussed the findings of the Kansas City study, which the theory of disengagement is based on, they also claim that other study findings support their theory. Other authors, such as Anchenbaum and Bengtson (1994) and Marshall (1999) argued that there is little evidence to support this theory. Cumming and Henry view normal aging from an objective perspective of disengagement not a subjective one. If this mutual withdrawal is the norm then older adults should not experience loneliness except when someone that is part of their close social network dies. According to this theory, it is also possible that those who fear loneliness may resist disengagement. There may be some seniors who disengage, but

what if they are unhappy and decide to re-engage by taking on a partime job? This would likely be considered a maladaptive behaviour.

Gubrium (1973) provided evidence and a number of references that support the Socio-environmental theory of aging. Gubrium claimed the theory is beneficial in understanding social behaviours in seniors and that the environment they live in includes individual and social factors that influence their morale, behaviours (actions), and aging. Individual factors that influence a person's behaviour consist of health, financial solvency, and social support. Beliefs about the potential to be active and availability of activities also influence how an individual behaves. For example, if older adults feel that they will be unable to complete an exercise class they may just think there is no point in going at all. Morale is determined by the way a people are expected to act by others and if they have the resources to do so. Social settings is another factor that is influential on a person's behaviour (actions). In a given social setting, individuals are expected to behave in a certain manner. Those in the group understand this expectation. Behavioural expectations may vary from one social setting to another. The way older adults are expected to behave in certain situations may be viewed by them as a burden. Degrees of burdens are variable in different situation but it is important that seniors are able to cope with the expectations in a given situation. If seniors are unable to cope, it may have a negative impact on their sense of morale. For example, an older woman recently widowed with failing health is still lonely long after her husband's death. Her children feel she should be more involved at the local senior's center. The widow tries to explain that it will not help. The pressures from her children make her feel bad and contribute to a low morale.

If seniors have limited resources (health, finances, or social support) and limited flexibility of their behaviours, they are likely to be more sensitive to varying social situations. For example, the widowed woman's lack of motivation to socialise more and pressure from her children make her more sensitive to situations she is not used to. People's actions also influence their social situations. In the case of the widow, if she decided to move to a senior's residence with others who are in a similar situation, this may contribute to her and her children being happier. According to Gubrium (1973),

society has certain expectations of older adults and as a result of this "kind of stereotyping" older adults develop their own subculture generating their own specific behaviour expectations and social situations important for them (p.54).

In this theory, the uniqueness of individuals, their feelings about themselves based on the expectations of others, and their social surroundings are considered when examining behaviours (actions). Therefore, older adults may feel lonely depending on individual factors such as lack of social support or the death of a spouse. The experience of loneliness may also depend on the ability to cope with factors such as a lack of social support or new social surroundings. Loneliness may be a situational experience, meaning in a certain social environment people could potentially feel lonely if their feelings conflict with what others define as normal. Some individuals may only consider feelings of loneliness normal for a certain amount of time, such as after the death of a spouse and if an older adult felt lonely longer then what was acceptable by others this person may develop a low moral. However, if the widowed woman was in a situation with other widowers, where feelings of loneliness are common and accepted, her morale might improve.

According to Carstensen, (1991) Selectivity theory now known as Socioemotional Selective theory postulated that age and perception of mortality influences social interaction. When people are young and death seems distant, social goals are made according to potential future results not emotional results, for instance many young adults date to find a future spouse. On the other hand, if time left to live seems limited, social needs are reorganized. For example, seniors shift their focus to maintaining close meaningful emotional relationships and ending those that seem superficial; quality becomes more important than quantity (Carstensen, Isaacowitz, & Charles, 1999).

Carstensen (1991) described three functions for social interaction as part of the Selectivity theory: 1) to obtaining information, 2) to develop and sustain personal identity, and 3) to regulate emotions. The purpose of obtaining information through social interaction starts the day individuals are born. Social interaction is used to learn and gather information but as individuals become older adults, less new information is obtain in this manner. When people are young, they gather information for future use,

older adults on the other hand may feel that their time is limited so less information is required to make decisions for the future. Self-perception is also shaped through social interaction. As individuals become older, relationships are selected cautiously to avoid negative influences on their self-concept. The perception of limited time left to live also influences an individual's social interactions and relationships. For example, role changes such as retirement may negatively influence self-perception.

The regulation of emotions in older adulthood is obtained through social interactions. Older adults desire to be around others that generate positive emotional experiences, which make the formation of new relationships risky. With new relationships, a person's history and personality are unknown. Taking a risk may not be worth the reward if a person has an ageist attitude, which would likely produce negative emotions for others. For this reason, older adults are hesitant to enter into new relationships and prefer to maintain present ones that are predictable and supportive.

Selectivity theory described what the disengagement theory attempted to (Bengtson, Putney, & Johnson, 2005) that the quality of social relationships are more important than the quantity of relationships among older adults and "perceived social connectedness influences both physical and mental health (Carstensen, 1991, p. 205). In her longitudinal study of 50 participants ages 18-52, Carstensen (1992) found that overtime social contact with acquaintances decreased beginning in early adulthood, yet feelings of emotional closeness and frequency of interaction increased with spouses, parents, siblings, children, and close friends. However, it is not evident that these patterns continue into old age. In four studies conducted by Fung, Carstensen, and Lutz (1999), findings supported what the Socioemotional selective theory proposed. This theory does not identify age, but rather lack of time left to live as causing individuals to focus their social goals on emotionally meaningful relationships. This theory may explain why some seniors who have lost those people who were part of their close emotional networks experience feelings of loneliness and they are too afraid to make new friends. What is not explained in this theory is those who have relationships with people that may be abusive, like the children of some older adults. If an older adult can not

distance themselves from a abusive child the results may contribute to an unhealthy and sad time in life that include feelings of loneliness.

Continuity theory, according to Atchley (1989) postulated that older adults maintain balance socially and psychologically and make decisions using strategies/resources they are familiar with and have worked in past. The theory described how people prefer to employ familiar skills and beliefs to adapt to changes in life and that the idea of continuity is subjective. Continuity is classified as either internal or external. Internal continuity includes personal aspects such as attitudes, personality, skills, and affect. It is maintained when these aspects are constant overtime and there is balance between how people feel about themselves and what they think they should be. When examining internal continuity, it is important to consider activity domains (place of activity including workplace, house etc), competences (physical and mental ability to perform activity), and preferences of individuals. Activities play a significant role in personal identity and the views a person holds about oneself. Atchley (1993) stated "internal continuity is thus a gradual evolution in which new directions are closely linked to and elaborate upon already existing identity" (p.9).

An individual's view of external continuity comes from being surrounded and involved in familiar environments, seeking out familiar interests, conducting familiar skills, and interacting with familiar individuals. "External continuity is defined in terms of a remembered structure of physical and social environments, role relationships, and activities" (Atchley, 1993, p.12). Being involved in routine physical and mental activities is necessary for continuity and can assist older adults in decreasing the negative effects of aging (Atchley). Obtaining external continuity is motivated by the behavioural expectations of others and related to previous experiences with them. If people desire social support, it may be necessary to demonstrated external continuity to those they wish to receive support. Therefore, the greater number of social roles a person is involved in, the greater the pressure there may be to demonstrate external continuity. There is also a desire for others to be somewhat predictable, which requires the demonstration of continuity. Atchley (1989) described normal aging as the absence of physical and mental pathologies and as representing the experiences of the greatest number of older adults in a

specific culture. Aging normally can be achieved through maintaining continuity, which helps older adults to adapt to the changes that accompany aging. According to Atchley's definition of normal aging, there would be very few seniors that would be considered to be aging normally because many have some type of mental or physical disease.

When attempting to understand the experience of loneliness in relation to this theory, a state of discontinuity may be the result of loneliness or visa versa. Feelings of discontinuity as a result of not being accepted, may cause loneliness. However, loneliness and discontinuity may not occur if a person does not care if a certain group of people accepts them or if he/she can adjust his/her behaviour according to the what the group desires.

One of the most current theories about aging found was the Selective Optimization with Compensation by Baltes and Carstensen (1996). This theory described three psychological processes: selection, compensation, and optimization that are adapted to age successfully (Powel, 2006). By adapting these processes an individual's goals can be reached or maintained through balancing losses (such as declining health) and gains (such as increasing support). The selection process involves the modification of behaviours or surroundings to meet goals that are of high priority to individuals because of their increasing limitations on life. "Selection can be active or passive, internal or external, intentional or automatic" (Baltes & Carstensen, 1996, p.406). Active selection is actively doing something to acquire results and passive selection includes the lack of action to obtain a desired result. According to Baltes and Carstensen (1996), compensation helps individuals cope with changes and/or losses that influence their ability to function at an adequate level. Depending on what is compensated for, it may be a difficult or easy for individuals to make changes. Compensation can be automatic or planned and differs from selection in that goals are maintained by adapting new behaviours (or skills). Optimisation refers to the development of new goals or enhancement of resources to improve functioning.

This model by Baltes and Carstensen (1996) may be helpful in understanding the experience of loneliness for seniors. It can clarify why for some seniors coping with loneliness may or may not be a priority. For example, loneliness may be the result of

decreased contact with friends, or due to relocation, which was selected as a higher priority than staying at a current place of residence. On the other hand, coping with loneliness may be selected as a priority for some older adults. This would require compensation in another area of life so resources can be used to focus on loneliness. For example, a married woman is very lonely because she is unable to see her friends as much as she wishes since she spends a lot of time at the nursing home with her husband who suffers from dementia. She decides that the loneliness is too much to handle and that she will spend less time visiting her husband so she can spend more time with her friends, which results in a decrease in her feelings of loneliness.

The theories of aging discussed described various requirements necessary for older adults to age well socially. They include a mutual withdrawal from society in disengagement theory; or the necessary resources of the health, financial solvency, social support of socio-environmental theory; or the reorganization of relationships in Selectivity theory; or using past strategies/and resources to determining how to meet current needs of in continuity theory; or lastly the use of selection, optimization, and compensation. Although theories attempt to explain how people age, their definitions of normal aging often vary and not all of them consider the perspective of the aging individual. What one senior may consider aging successfully may not be the same as another's view.

However, these theories may be useful, to some extent, in the understanding of loneliness in seniors. Similar to feelings of continuity, the experience of loneliness is subjective. Social relationships, roles, and activity are valued differently among older adults. Some seniors may disengage from certain social relationships and be content; others may feel the need to become more socially involved as they age to replace lost social roles. If social desires of individuals do not match their reality, loneliness may develop. For many seniors, their social networks and relationships are frequently changing due to things such as death, illness, and relocation.

Research on loneliness not specific to seniors.

The previous section reviewed the experience of loneliness from a theoretical perspective. This section will cover the body of research-derived knowledge on the

experience of loneliness as it has been studied at various ages across the life span. Lauder, Sharkey, and Mummery (2004) conducted a community survey on loneliness. They used the de Jong Gierveld and Kamphuis Loneliness scale to generate questions used in telephone interviews with a random sample of 1241 people over the age of 18 years old. The sample had a mean age of 45.10 and consisted of 624 males and 617 females. Among the participants, "407 were quite lonely, 30 were moderately lonely, and six were severely lonely" (Lauder, Sharkey, & Mummery). The authors identified predicting factors of loneliness, which included having experienced domestic violence in a recent relationship, martial status, having paid work in the last week, and the number of children under 18 years old living in the residence. Given the mean age of the sample and the last two predictive factors identified, it is questionable if these findings would be found in a sample of seniors.

Rokach and Brock (1997a) conducted a study on the multidimensionality of the loneliness experience with a sample of 633 participants, ages 13-79, from universities, colleges, a provincial jail, and various group meetings. A factor analysis produced five factors that constitute the loneliness experience: 1) emotional distress, 2) social inadequacy and alienation, 3) growth and discovery, 4) interpersonal isolation, and 5) self-alienation. The differences between various age groups were not explored.

Utilizing the five factors identified by Rokach and Brock's (1997a) study, Rokach and Sharma (1996) developed a 15-item questionnaire to examine the influence of cultural differences on the experience of loneliness in 679 people, ages 18 – 89, from three different cultures. Those cultures were South Asian (including India, Sri Lanka, Bangladesh, Singapore, Pakistan), West Indian (including Guyana, Trinidad, Barbados, Jamaica), and North American (largely Canadians). The results indicated that culture and the length of time that immigrants had spent in the country influenced their experiences of loneliness. The factor of self-alienation was a consistent finding amongst all cultural groups. However, there were no other commonalities in the loneliness experience among the three groups. North Americans experienced lower levels of emotional distress than did participants from South Asian and West Indian cultures. Interpersonal isolation and alienation were identified more frequently among those with South Asian backgrounds

than the other cultures. Participants born and raised in North America identified growth and discovery as part of their loneliness experience more frequently than the other groups. Diverse cultural beliefs, values, and norms are just a few factors that may affect how loneliness is experienced within these three cultures, resulting in the differences found. It is also possible that if the subgroups were studied separately there would be differences in the experiences of loneliness due to difference cultural values and beliefs within each subgroup. This study only explored three cultural groups; there are many other cultures in North American that may have yielded findings not identified in this research.

Rokach and Brock (1997b) explored factors that constitute current, chronic, and situational experiences of loneliness using the same questionnaire as the previously cited study. They found that of the 633 participants (ages 13-79), 30% were currently lonely and reported experiencing social alienation (16%), growth and discovery (8%), self-depreciation (a factor of the element of social inadequacy and alienation) (4%), and emotional distress (4%). The experience of loneliness for the participants, who were not lonely at the time of the study, consisted of emotional distress (18%), social inadequacy and isolation (6%), growth and discovery (5%), self-alienation (4%), and interpersonal isolation (3%). The experiences of those who were chronically lonely yielded these factors: growth and discovery (15%), emotional distress (8%), interpersonal isolation (5%), self-alienation (4%), and self-generated social detachment (3%). For those who experienced situational loneliness, the following factors emerged: social inadequacy and alienation (17%), emotional distress (7%), growth and discovery (5%), self-alienation (4%), and interpersonal isolation (3%). The study findings indicate that the type of loneliness (chronic, situational, and current) may influence how individuals experience it.

In the same study, Rokach and Brock (1997b) explored the differences in experiences of loneliness among different age groups. The age groups were adolescents (13-20 years), young adults (21-30 years), middle-aged adults (31-49 years), and older adults (50-79 years). The researchers' factor analysis indicated that other than the score for the factor of growth and discovery, all scores varied for each age group. The older adults' experiences were characterised by four factors: social inadequacy and alienation

(23%), interpersonal isolation (7%), emotional distress (6%), and growth and discovery (5%). The positive aspects of loneliness were found less often among the oldest age group compared to those in the young age groups. These findings indicated that loneliness is experienced differently in various age groups, which supports the need for this writer's research study. The studies by Rokach and Sharma (1996), and Rokach and Brock (1997a, 1997b) have demonstrated that the experience of loneliness is a multidimensional one influenced by age, culture, and the type of loneliness.

Some researchers have explored specific factors and their relationship to loneliness. Social support is one of the most popular areas investigated. With a sample of 60 widowed men and women (mean age of 53.05) and 60 married men and women (mean age of 53.75), Stroebe, Stroebe, Abakoumkin, and Schut (1996) conducted a longitudinal comparative study on loneliness and the role of social support in adjusting to loss. Data was collected through interviews and questionnaires at three points in time: 4-7 months following the death of a spouse, 14 months after the loss, and one year following the previous interview. Emotional and social loneliness were measured through participants answering true/false questions. The statements, "I feel lonely even when I am with other people", and "I often feel lonely" were used to determine emotional loneliness. The statements "I have a really nice set of friends", and "I have friends and acquaintances with whom I like to be together" were used to determine social loneliness. Results indicated marital status influenced emotional loneliness, and social support influenced social loneliness, but not vice versa. Those who suffered the loss of a spouse but had greater social support adjusted to the loss more easily than did those with less support. Still, the support of family and friends could not makeup for the loss of a spouse.

Van Baarsen (2002) explored the impact of social support, self-esteem, and loneliness following the death of a spouse among individuals 55 to 89 years of age, using a longitudinal correlational method. She utilised the de Jong Gierveld and Kamphuis Loneliness Scale, which measured emotional and social loneliness. Social support was measured by asking participants "how many times over the last (half) year has . . . helped you with daily tasks?" (van Baarsen, p.36). To inquiry about emotional support

participants were asked, "How many times over the last (half) year has . . . given you attention and affection?" (van Baarsen, p.36). Van Baarsen's findings at the end of the six months following the death of a spouse were similar to those of Stroebe et al. (1996) and indicated actual and/or perceived social support increased, resulting in the alleviation of social loneliness for two and a half years. Social supports only alleviated emotional loneliness at the two and half year mark after spousal death and not before that time. Furthermore, when exploring the presence of a close confidant and its impact on social and emotional loneliness after a spouse's death, van Baarsen found females who had a close confidant initially experienced less emotional loneliness than those who did not. For males, the presence of a close confidant had no affect on emotional loneliness, and seemed to be ". . . predictive of greater social loneliness . . ." (van Baarsen, p.39) the two and half year mark.

Van Baarsen's (2002) also found that widows and widowers who possessed a higher level of self-esteem prior to the death of their spouses experienced lower levels of emotional loneliness, and those who had lower self-esteem had higher levels of emotional loneliness at the six month, 1.5 year, and the 2.5 year time periods after the loss. Levels of social loneliness were also elevated among those with low self-esteem but not until the 1.5 years and 2.5 year post-loss time periods.

The findings of van Baarsen (2002) and Stroebe et al. (1996) suggest that Weiss' (1973) theory on emotional loneliness as related to the lack of an attachment figure may be accurate, and once the figure is gone, emotional loneliness can only be alleviated by finding a new one. For women, a close confidant may be able to take on the role of an attachment figure preventing or decreasing the intensity of emotional loneliness. For men, a close confidant does not provide the same support and does not decrease or prevent emotional loneliness. The study by van Baarsen is beneficial in that it demonstrates that older males and females deal with the death of their spouses differently and may experience loneliness in varying ways, and they therefore potentially require distinct interventions for loneliness. There may be a possible connection between self-esteem, partner loss, and loneliness as found by van Baarsen.

Penninx et al. (1999) examined loneliness, social support, and social networks among 2788 individuals with chronic conditions between the ages of 55-86. Social network size was assessed by the number of non-family and family relationships, and functional social support was measured by asking participants who they had the most contact with and how often. Loneliness was measured using the de Jong Gierveld and Kamphuis Loneliness Scale. Penninx et al. concluded that participants with chronic conditions received greater active social support and had increased feelings of loneliness compared to participants without chronic conditions. Specific chronic diseases (lung disease, arthritis, and peripheral vascular disease) were associated with greater feelings of loneliness compared to those with diabetes, cancer, or no chronic illness. Those with chronic conditions received greater emotional support and provided less of it compared to participants without chronic conditions. Perhaps certain chronic conditions limit some seniors' ability to socialise as much as they desire.

The concepts of loneliness, social support, and chronic illness also appeared in a qualitative study by Beyene, Becker, and Mayen (2002), which focused on the sense of well-being among a group of 83 Latino immigrants age 51 years and older (mean age of sample 72.5). They found that loneliness influenced the sense of well-being and the quality of life for the participants. Participants identified fears of loneliness and being placed in a care centre, in which they believed loneliness was inevitable. Those participants who were unsatisfied with their relationships with family members perceived old age as a sad stage of life, they felt disrespected, rated their health as poor, and identified feelings of loneliness. However, those who felt satisfied with family relationships perceived their health as good to excellent, they acknowledged old age as a positive stage in life, and did not identify feelings of loneliness. Within this sample, cultural views of respecting elders and the relationships between seniors and their family members played an important role in whether older Latinos experience loneliness or not. Family members, such as children and grandchildren, showed respect for older Latinos by providing emotional support by frequently visiting or calling, rather than physical assistance.

In addition to examining the factors of social support and loneliness, Hagerty and Williams (1999) also studied the sense of belonging. They conducted a pathway analysis on these three factors and their effects on depression. The sample consisted of 31 individuals diagnosed with depression, ages 21-75 (mean age 38.8), as well as 379 community college students ages 18-72 (mean age 26). A questionnaire was developed using the Beck Depression Inventory, the Sense of Belonging Instruments, the Revised ULCA Loneliness Scale, and the Interpersonal Relationship Inventory (to measure social support). The results indicated three of the phenomena had a direct effect on depression: type of person (depressed or college student), psychological sense of belonging, and loneliness. Social support and sense of belonging had a direct influence on loneliness indicating that the lack of perceived social support and not feeling connected to others may contribute too loneliness among participants who were lonely. The influence of social supports on the experience of loneliness is somewhat unclear due to the variation with regard to what constitutes social supports among the conducted studies. A greater understanding of the experience of loneliness could clarify the role of social supports among seniors.

Some researchers have explored coping mechanisms and interventions for loneliness across the life span. Rokach and Brock (1998) researched coping mechanisms for loneliness among the 633 participant, 13 to 79 years (mean age of 30.0), and of them 192 were currently experiencing loneliness. Data gathered from the participants' questionnaires was analysed using factor analysis, and six coping strategies emerged: evaluation and acceptance (14%), self-development and understanding (5%), accessing social support networks (4%), denial and distancing (3%), religion and faith (3%), and increasing activity (3%). All participants initially coped with loneliness by reviewing their experience and accepting it. However, the next coping strategy used varied depending on marital status and gender. Participants who were married or common-law accessed their social support networks, while those who were single (divorced/separated/widowed/never married) chose to implement distancing and denial as their next coping strategy. The second coping mechanism for males was accessing their social support networks, and the second coping mechanism for females was self-

development and understanding. It is helpful to know when working with lonely individuals that depending on their martial status and gender, they will potentially cope with loneliness in a diverse manner and probably require different interventions. Unfortunately, coping mechanisms were not assessed among different age groups. Had there been a greater number of participants who were single (separated, widowed, or divorced), it would be useful to know if, as individual subgroups, they dealt with loneliness differently.

Among the studies that have examined loneliness interventions, Stevens and van Tilburg (2000) studied the influence of participating or non-participation in a friendship program with 32 women from 50-80 years of age. Individuals who agreed to participate in the study were interviewed and completed the de Jong Gierveld and Kamphuis Loneliness scale at the conclusion of the program and then again the following year. A control group, which did not participate in the friendship program, consisted of 913 participants who were drawn from a longitudinal survey on social networks and living arrangements. The control group was interviewed and completed loneliness questionnaires at 9-14 months. For comparison, participants from each group were matched with one another based on their level of loneliness and demographics (age, marital status, number of children, and presence of friends in their social network). Baseline loneliness scores were higher for those in the friendship program (7.1 out of 11) than for those of the control group, which varied from 1.7 to 3.3 depending on marital status. The findings indicated that participants of the friendship program experienced a greater decrease in loneliness compared to the control group. Therefore, developing or improving skills necessary to create and/or improve friendships may result in decreased feelings of loneliness for women. The befriending program examined by Stevens and van Tilburg (2000) identified that improving the necessary skills to develop and maintain friendships may be a valuable method in assisting some women to decrease feelings of loneliness.

Stewart, Craig, McPherson, and Alexander (2001) examined a different intervention for lonely individuals. They explored the effectiveness of support groups on decreasing emotional and social loneliness for widows between the ages of 54 to 77.

Twenty-eight widows were separated into four different support groups of nine, eight, six, and five individuals. The researchers did not provide an explanation as to why each group had a different number of participants. Participants kept journals, group leaders kept field notes, and interviews were conducted following group meetings. The contents from these sources were thematically analysed. In addition, participants completed a pre-test and two post-tests for quantitative analysis. Quantitative findings did not indicate that support groups affected emotional or social loneliness, whereas qualitative analysis indicated that participants' had decreased feelings of loneliness.

Stewart et al.'s (2001) study indicated that social support by other widows is also effective in decreasing feelings of loneliness among some widows. This method may not be successful with men since Rokach and Brock's (1997b) study indicated men experience loneliness differently from women. In summary, due to the multidimensionality of the experience of loneliness, certain interventions will be effective for some individuals and not for others. Appropriate interventions will depend on the individuals, if they want assistance, the reason(s) they are lonely, and the availability of interventions. Further research in the area of interventions for loneliness is needed.

Research conducted on loneliness not specific to seniors but at various points across the lifespan provides valuable information on factors related to the phenomenon itself, coping mechanisms, and interventions. Nevertheless, this reviewed research is not exclusive to seniors. To understand the experiences of loneliness for seniors, research needs to be conducted with samples consisting of seniors only. This is necessary because seniors are at a different stage in their lives than individuals under the age of 65 years. Seniors face different life events and age related challenges, such as retirement, physical changes, and losses in many forms: objects, health, independence, friends, family, and spouses. These factors can increase the vulnerability of seniors becoming lonely as well as how they cope with it.

Research on loneliness specific to seniors.

The previous section reviewed research on loneliness at various points across the life span. This section will review research on loneliness specific to seniors. Seniors are defined as those individuals 65 years of age and older. A number of studies have

examined seniors, loneliness, and social supports; however, some of the results are conflicting. In a cross-sectional study by Prince et al. (1997), interviews were conducted with 654 seniors examining the relationship between social supports, loneliness, and depression. Loneliness occurred more often among participants who lived by themselves, had neighbours who were unsupportive, had one or no supportive friends, and those who were distressed about their relationship with their children. The participants who experienced loneliness had greater chances of being depressed than those who were not lonely. Frequency of contact with relatives was not found to be related to loneliness in the seniors. Furthermore, the findings indicated that loneliness was experienced more often by those 82 years and older than young seniors. These results are similar to those found by Holmen, Ericsson, and Winblad (2000) that as participants' age increased so too did the occurrence of social loneliness.

In a sample of 221 seniors, 80 years and older, Bondevik and Skogstad (1998) explored loneliness and social networks using the Revised Social Provisions Scale. Conversely, to Prince et al.'s (1997) results, they found that the less frequent the contact with family members, the higher the rates of emotional loneliness, but not of social loneliness. On the other hand, the less frequent the contact with friends and neighbours, the higher the occurrence of social and emotional loneliness. The diverse results could be related to the older sample Bondevik and Skogstad utilized and the fact that a portion of the participants resided in a nursing home setting. Additionally, the definition of a relative was not clear in the study by Prince et al. (1997). Miedema and Tatemichi (2003) conducted a study on loneliness and social networks using a sample of 138 seniors 80 years and older. They did not indicate if the relationship between the seniors and their friends had an impact on feelings of loneliness, but seniors' satisfaction levels of their relationships with their children influenced feelings of loneliness. These contradictory results between Prince et al., Bondevik and Skogstad, and Miedema and Tatemichi may be due to different tools utilised to measure loneliness in the studies. When exploring the influence of relationships between seniors and their siblings Prince et al. (1997) discovered similar results as Miedema and Tatemichi, such that feelings of loneliness were not significantly affected by these relationships.

Findings from Holmen and Furukawa's (2002) study on loneliness and social support indicated that satisfaction with friends was important in protecting seniors against loneliness. Over a 10-year period, there were four time intervals at which personal interviews were conducted with seniors aged 75 years and older. The number of participants was initially 1702, and dropped at each point of data collection to 1032, 658, and 398. The researchers believed that the high drop out rate was due to participants relocating, failing health, and increasing age. The method in which loneliness was identified and assessed was by asking participants if they experience loneliness. The more seniors feel satisfied with friendships, the fewer feelings of loneliness they experience. The results also indicated that at each point in data collection, or as participants aged, the frequency of loneliness experiences decreased; this could be because seniors learned how to cope with their loneliness. Bondevik and Skogstad (1998) examined the relationship between social supports and loneliness. They found that different types of supports are provided by the relationships with friends and family members.

Costello (2002) conducted case studies on grief and loneliness with four seniors after the death of their spouses. Feelings of loneliness seemed to be embedded in participants' experiences of bereavement. In this study, when the seniors were asked how they were coping at that time and what were their strongest feelings, they included loneliness in their responses and indicated that the feelings occurred at specific times of the day, such as at night in bed or first thing in the morning. Participants stated that being surrounded by people did not alleviate their emotional loneliness, and they were not motivated to participate in social activities. The case studies explored by Costello described the absence of a specific attachment figure supporting Weiss' (1973) theory on loneliness of emotional isolation. Although, Costello indicated that loneliness is a part of the grieving experience when an older adult loses a spouse, an indepth description of the experience was not provided, which is essential in understanding the meaning of what it is like for seniors to live with loneliness.

Furthermore, there is research on loneliness among seniors in different living arrangements. Krohn and Bergman-Evans (2000) examined the emotional health of 29

nursing home residents (mean age 81.9 years) using the UCLA Loneliness Scale and the Geriatric Depression Scale. Results indicated that 66% of the participants were lonely and 86% were depressed. Russell, Cutrona, de la Mora, and Wallace (1997) examined the relationship between levels of loneliness and nursing home admissions of 2721 seniors ages 65 – 97 over a four-year period. They found, after controlling other variables (age, income, education, mental status, physical health, morale, attendance at religious services, and prior nursing home admissions), that individuals with an extremely high score on the UCLA Loneliness Scale during their initial interview were more likely to be admitted to a nursing home than those with moderate to low scores. It remains unclear if those admitted to a nursing home due to extremely high rates of loneliness had decreased levels of loneliness once they were in the facility. It was also unclear in the study by Krohn and Bergman-Evans if those who currently live in the nursing home were lonely prior to their relocation or if they became lonely after their relocation.

Holmen et al.'s (2000) study examined living arrangements and loneliness with a sample of 589 seniors with and without dementia. They concluded that 86% of seniors living alone experienced emotional loneliness and 90% experienced social loneliness. Those who lived alone experienced emotional and social loneliness more frequently then those who lived with others and seniors in hospital settings experienced loneliness more than those who lived at home.

Researchers have also explored chronic conditions such as dementia and hearing loss in relationship to loneliness seniors. Holmen et al. (2000) found social loneliness to be reported at greater rates by participants with dementia than those without it, but they found no significant differences between the groups for emotional loneliness. Chen (1994) conducted a descriptive correlational study on loneliness and hearing handicap using a sample of 89 seniors. A hearing handicap ". . . is the individual's response to the hearing loss, which may affect normal functions in daily life" (Chen, p.22). The tools used in this study were the UCLA Loneliness Scale, the Rosenberg Global Self-Esteem Scale, and the Hearing Handicap Inventory for the Elderly. According to Chen, seniors with higher levels of hearing handicap experienced greater feelings of loneliness

compared to those with lower levels. These findings are valuable for health care professionals because they identify seniors who may be at risk of experiencing loneliness if they are unable to adapt to their hearing loss; moreover, this study indicates that those with dementia experience loneliness as well, possibly more often than those without it.

Many seniors have chronic conditions that range in severity and influence on their lives. When Miedema and Tatemichi (2003) conducted their study on chronic conditions (diabetes, high blood pressure, cardiac insufficiency, and angina) and loneliness, no relationship was found between the two factors. However, there are a number of other chronic conditions that were not examined in this study that may influence loneliness among seniors. Chronic conditions can lead to decreased functional ability for some seniors, which can create challenges in performing activities of daily living (ADL) and cause some to limit their involvement in leisure activities. In a study, Bondevik and Skogstad (1998) found community dwelling seniors who required assistance with toileting, continence, and transfers had lower levels of emotional and social loneliness than independent seniors. Perhaps this is a result of the presence of those helping.

Tijhuis et al. (1999) conducted a longitudinal study on factors related to loneliness with a sample of 939 men aged 75 – 84 using the de Jong Gierveld and Kamphuis Loneliness Scale and assessing ADL with a 14 item scale that indicated participant limitations. The specific ADL measured were not identified. Tijhuis et al. concluded changes in limitations in ADL were not related to increased levels of loneliness among the sample; however, those participants who relocated to a nursing home experienced higher rates of loneliness than those who did not. Therefore, if the level of independence decreased enough to cause relocation to a nursing home, it may be related to the experience of loneliness in this sample of older men. Tijhuis et al. also found perceived health status to influence feelings of loneliness. The men who rated their health as poor felt lonely more frequently than those who rated their health as good. These results are similar to those found by Beyene et al. (2002), who indicated an individual's perception of health can play an important role in feelings of loneliness.

In a cross-sectional study with a sample of 1903 community dwelling Chinese seniors, Chou and Chi (2005) investigated the prevalence and the correlates of depression

using The Geriatric Depression Scale. Loneliness was measured using the question "how often do you feel lonely" and participants would have the option of choosing zero (*never*) to four (*always*). The researchers found a significant relationship between loneliness and depression for the groups of the oldest-old (80 and older), the old-old (70-79), and the young-old (60-69). The occurrence of depression was the highest at 31%, in those 80 years and older. Findings also indicated that for oldest-old, loneliness was a direct cause of depression. Results may have varied if other cultures were included in this study.

Ekwall, Sivberg, and Hallberg (2005) conducted a cross sectional survey to examine loneliness as a predictor of quality of life for 4278 caregivers and non-caregivers, 75 years of age and older. A definition of caregivers was not provided, but participants described the activities they provided in this role, such as "keeping in touch" to "helping with personal care", and the amount of time spend providing care, which varied from less than once a week to daily assistance. They found that 40% of caregivers provided help on a daily basis and reported feelings of loneliness less than non-caregivers did. Reoccurring loneliness was associated with low quality of life among the participants. Care giving can provide an individual with enough social contact to prevent or decrease feelings of loneliness. Also, it is possible that many of the caregivers were providing care to their spouses, and those who were not caregivers were widowed or single because their average age was higher than that of non-caregivers.

Other than the study by Prince et al. (1997), only one other study was found that explored the impact of loneliness on seniors. Wylie, Copeman, and Kirk (1999) examined the influence of health and social factors on the nutritional intake of 15 seniors aged 67 and greater by conducting semi-structured interviews and 24-hour diet recalls. They found that seven of the 15 seniors indicated that being lonely decreased their desire to eat, to prepare meals, or to eat meals after they had been prepared. Of the participants, 11 were widowed and seven of them stated that since the death of their spouses, they had decreased the amount of food they consumed. While this study contributes to understanding the loneliness experience and its influences on eating patterns, its description of the experience of loneliness is limited.

Limited studies have also been conducted on loneliness interventions for seniors. A grounded theory study by Andrews, Gavin, Begley, and Brodie (2003) explored seniors' views of a befriending program on combating loneliness. Of the 13 service users who received the one-hour a week visits from volunteers, it was identified that these visits decreased feelings of loneliness. Some participants indicated that befrienders also helped them deal with difficult events, such as the death of a spouse. Seniors who accessed the befrienders identified important elements in the development of successful friendships: the services were voluntary with no price attached, there was a common interest between user and befriender, there was a sense of reliability that the visits would occur regularly at similar times each week, and a sense that the relationships were beneficial to both involved. If these elements were not present, friendships may not have developed and feelings of loneliness among seniors may not have decreased. In conclusion, given the above elements and an appropriate match between befriender and user, this type of program may be a valuable intervention in helping to reduce feelings of loneliness in seniors. Unfortunately, it is likely that more seniors need befrienders than there are volunteers available.

Only two qualitative studies were found that explored the lived experience of loneliness in seniors. Van der Geest (2004) conducted one of these studies, which was part of a larger study on culture and social meanings of aging. He explored loneliness among seniors in Ghana using a snowball sampling method to find 35 seniors to have conversations with regarding loneliness. Van der Geest concluded that loneliness among seniors in this group was related to a decrease in socialization that was due to a lack of respect they believed should come with age. However, in this research the term loneliness is not used in the author's conversations with seniors because of language differences. The experience of loneliness for the seniors in this study was based on conversations with older adults and some of their relatives, and the researcher's search for the definition of loneliness for the old in this area. Participants did not necessarily identify themselves as lonely.

McInnis and White (2001) conducted a phenomenological study exploring the experience of loneliness among 20 community dwelling seniors. Participants were

recruited through flyers that were left at senior centres, congregate housing facilities, churches, and other sites. Nurses, welfare workers, clergy, and social workers also assisted in participant recruitment. Interviews using open-ended questions were conducted with 20 individuals aged 71- 85, 17 of whom were women, 16 were widowed, one married, one never married, and two separated. The inquiry revealed five main themes that described the experience of loneliness for these seniors. Themes identified by McInnis and White were:

> 1. Loneliness occurred when the older adult experienced the perceived absence or fracture of important relationships as a result of either death or separation.
> 2. Loneliness occurred in older adults as a response to pain, darkness, and desolation accompanying the perceived ending of a relationship with their loved ones, and their resistance to the invitation of openness to the community to which they lived.
> 3. Loneliness is avoided or dealt with by using ways of coping, which may or may not be helpful.
> 4. Loneliness is a state of anxiety, fear, and sadness influenced by the actual or fear of dependency, and the decreased level of functioning.
> 5. Loneliness is a state of silent suffering in which the person is reluctant or unable to verbalize his or her loneliness. (McInnis & White, 2001, p. 132).

The phenomenological study by McInnis and White (2001) contributes to a clearer understanding of what it is like for seniors to be lonely. However, the method utilised by the researchers does not document member checks, which is going back to participants to validate the findings. Member checking would have increased the authenticity of identified themes. Further phenomenological studies on the experiences of loneliness for seniors will increase the understanding of it.

This section reviewed the literature on loneliness among those 65 and older. The majority of the quantitative studies reviewed offered objective knowledge on factors that may relate or contribute to loneliness in seniors. Little information was found on

interventions and coping mechanisms for seniors who suffer from loneliness. The few qualitative studies provide useful information on grief, nutrition, culture, and interventions in relation to loneliness, but they have limited subjective information on the experience of loneliness for seniors. The majority of the studies reviewed do not assist Registered Nurses in understanding the experience of loneliness for those 65 years of age and older.

Gaps and inconsistencies in the literature.

There has been extensive quantitative investigation on loneliness. However, some of the studies' findings are inconsistent and confusing, such as the findings concerning social support on loneliness. The influence of social support on loneliness is unclear due to the various types of social support that were not always defined in the literature. The findings that support the relationships between chronic illness and loneliness are also contradictory. When Penninx et al (1999) examined the correlation between chronic conditions and loneliness in individuals across the lifespan, they concluded that chronic conditions (lung disease, arthritis, and peripheral vascular disease) were associated with increased feelings of loneliness, yet Miedema and Tatemichi (2003) did not find a relationship between chronic conditions and loneliness in their sample of seniors. These conflicting results may be due to the various ages of the samples or that some seniors may have learned to cope with their chronic conditions or their loneliness. Contradictions found among these studies could be related to different tools used to measure loneliness. Some tools categorize loneliness into emotion or social loneliness and others do not. These inconsistencies in the research cloud our knowledge on this topic.

There is a lack of qualitative research in general on loneliness. Of the current research on loneliness reviewed, only seven studies were qualitative studies or contained both qualitative and quantitative analysis. Furthermore, there is a lack of qualitative research specific to seniors in particular. Among the qualitative studies reviewed, only five were specific to seniors. Greater qualitative research on loneliness will provide added knowledge, which will contribute to a greater understanding of the experience for seniors. Furthermore, qualitative investigations gather more subjective data than

quantitative ones and explore the phenomenon with participants in great depth, which contributes to a deeper understanding of the experience for seniors.

Additionally, qualitative inquiry into this complex, multidimensional, and subjective phenomenon is essential to develop and enhance the understanding of loneliness. These gaps and inconsistencies in the literature support the need for a greater understanding of what it is like for seniors to experience loneliness. The best approach to obtain this knowledge is through qualitative inquiries. This method of research will allow seniors who experience loneliness to share what it is like to live with this phenomenon. The goal of qualitative research is to develop an understanding of the way people experience the world from their perspectives (Streubert Speziale, 2003a).

Relevance to nursing

In Alberta, "The goal of registered nurses is to assist people to attain and maintain optimal health, wellness and independence within each client's ability to do so" (College & Association of Registered Nurses of Alberta, 2005). Part of this goal is to provide holistic care to clients, which involves caring for the body, mind, and spirit. To provide this care, it is necessary to understand the experiences of those being cared for. In attempting to understand the experiences of the client, Registered Nurses can communicate that they genuinely care about the individuals they work with and what these patients are going through.

This descriptive research on loneliness will assist Registered Nurses in understanding the personal thoughts and feelings of lonely seniors. This insight will aid Registered Nurses in providing optimal care for lonely seniors. If Registered Nurses' posses more knowledge of the experiences of loneliness for seniors, they will understand why there is a need for greater recognition and attention of this phenomenon in this population. It is hoped that with this recognition there will be an increase in the identification of loneliness through early assessment resulting intervention and assistance for those who are lonely.

Loneliness is a negative experience for most seniors and has been linked to depression (Chou & Chi, 2005; Krohn, & Bergman-Evans, 2000). With a comprehensive knowledge base of loneliness, appropriate interventions can be developed and

implemented, which potentially leads to a decrease in feelings of loneliness and decreased rates of depression. The overall goal of nursing is to enhance the quality of care for seniors, thereby increasing their quality of life and successful aging. This can be accomplished by increasing the knowledge and understanding of the loneliness experiences of seniors for those who work with them.

Conclusion

This chapter has reviewed the literature on loneliness in relation to seniors. The findings, some of which are inconsistent and unclear, indicate that the experience of loneliness is complex, multidimensional, and not well understood. Until there is a better understanding of the experience of loneliness, seniors will suffer. Due to the multidimensionality of this phenomenon, a qualitative inquiry will enhance the understanding of the loneliness experience in a way that quantitative inquiry is unable to accomplish. Greater knowledge and understanding of the lived experiences of loneliness in seniors can lead to the development of effective interventions and improvements in seniors' nursing care and quality of life. The intent of this research is to answer the question, what is the experience of loneliness in seniors?

CHAPTER TWO: DESCRIBING THE JOURNEY

The evolution of the research question

While working with seniors in the hospital setting for the last few years, I have often wondered how and why many of them are socially isolated; is it due to deteriorating physical or mental health or other issues? My original research topic was going to be on social isolation among seniors. I had explored the topic of social isolation in my previous graduate classes and with seniors. However, there seemed to be a wealth of information on this topic, and I lacked passion for inquiring about social isolation as a topic. After brainstorming with my supervisor, the topic of loneliness arose. I wondered if loneliness among seniors was a concern and if the topic required further research. While I was at work or participating in my clinical sessions for my program, clients would often ask what I was researching for school. I would reply that I was thinking about conducting a study on loneliness in seniors. Many seniors would reply with comments of "that is a great topic" or "I could tell you about loneliness". This feedback indicated to me that this was an important topic to them, which motivated me to explore the concept in the literature. The review of the literature demonstrated that there was substantive quantitative research on the topic of loneliness in general. With these findings and the feedback I received from seniors themselves, my motivation to explore the experience of loneliness among seniors grew. The journey to understand the experience of living with loneliness for seniors began.

The previous chapter reviewed the literature on loneliness. This chapter presents the chosen research method, a general generic description of the conceptual framework that was used, the study participants, how data was collected and analysed, trustworthiness of the research, and ethical considerations.

Research method

Qualitative researchers believe that there are social and cultural influences on how people experience the world, which contributes to multiple realities (Streubert Speziale, 2003a). Van Manen (2003) stated that the most important things in life are those determined by individuals themselves, not others; therefore, to understand phenomena, it is necessary to go to the individuals who experience them. The purpose of a descriptive

qualitative study is to provide a detailed description of an experience/event and communicating these findings in everyday language (Sandelowski, 2000). The findings of this study will assist the researcher in understanding the phenomenon being explored from the views of individuals who experience it; therefore, this method is an appropriate one for learning more about loneliness in seniors. A general qualitative method will guide this inquiry, in addition to the phenomenological perspective of Max van Manen (2003). However, the analysis and communication of the findings will be descriptive and less interpretive than van Manen's phenomenological approach. According to Sandelowski, all studies are descriptive and describing requires a certain amount of interpretation. Nonetheless, the analysis and findings of this specific study will remain closer to the data provided by participants than the in depth interpretation that phenomenology would explore.

Conceptual framework.

Qualitative research is flexible in the methods by which data are collected compared to that of quantitative research (Liamputtong & Ezzy, 2005). According to Morse and Richards (2002), the only way to learn how to conduct research is by actively doing it. This section will describe the qualitative methodological activities used in this study. These activities are as follows: exploring an experience as it is lived and not how it is defined or identified; taking the themes identified, reflecting on them looking for commonalities; and reviewing the description received in the context of the whole as well as in parts (van Manen, 2003). The researcher performed some of these activities simultaneously at times, and independently for others. For instance, the researcher had the research question foremost in mind throughout the entire researcher process.

According to van Manen, (2003) these methodological activities are intended to arouse insight in researchers and assist them in creating methods, procedures, and techniques appropriate for their specific inquiry. This openness will permit the exploration of procedures, techniques, and sources that may not always be predictable at the beginning of the study.

Once the researcher identified the phenomenon of focus, specifically loneliness in seniors, her intent was to develop an understanding of that experience as it was lived in

daily life. To accomplish this, detailed descriptions of the experience of loneliness for seniors were collected and simultaneously analysed. The researcher's analysis included searching for themes in participants' descriptions, discussions regarding identified themes with her committee, and by referencing van Manen's four lifeworld existentials.

There are four "lifeworld existentials" (van Manen, 2003, p.101) that are shared by all human beings and how they experience being in the world. These existentials shaped the researcher's thinking and influenced the structuring of her interview question and data analysis. The four existentials are a valuable guide in the questioning, analysis, and writing aspects of the research inquiry (van Manen). These existentials are lived body (corporeality), lived space (spatiality), lived time (temporality), and lived human relationships (relationality). Corporeality refers to how people are present in the world through their body, as well as how they are continuously revealing and concealing things about themselves through the body (van Manen). Lived space or spatiality refers to the space individuals live in and how that space influences their life. For example, when people are at work in their workspace, they act differently than if they were in their home. Temporality is lived time, not objective time or the time on a clock. It is subjective time or the time individuals perceive while living their lives. For instance, when people are having fun with friends, time may seem to go by quickly, but when they are at the dentist, it may seem to go by slowly. According to van Manen, the temporality of the past influences the decisions people make and how they live in the future. Relationality refers to the relationships people have with others and the interpersonal space that they share with them (van Manen).

Study participants.

Criterion sampling, a form of purposive sampling, was the method the researcher utilized to recruit participants. Purposive sampling is when the researcher consciously chooses certain individuals to participate in the study (Burns & Grove, 1995). The criterion seniors possessed to participate in this study were:

1) Identified himself or herself as being lonely or having experienced loneliness within the last month.

2) Lived in a community setting (seniors complexes/communities, manors, lodges, private or rental housing)
3) Were 65 years of age or older.
4) Spoke, and understood the English language.
5) Alert and oriented to the extent that they were able to articulate their lived experiences of loneliness.

The researcher recruited participants who were currently experiencing loneliness or those who had recently experienced it. According to van Manen (2003), to gain a greater description of the experience, it is beneficial if participants are presently living with the phenomenon and are able to describe their experiences as they endured it. Seniors who were not presently experiencing loneliness must have experienced it at least once within the past month. This criterion was selected with the understanding that the more recent the experience, the more detailed the description could potentially be. The researcher verified that participants met the criteria on the phone prior to arranging the interviews. The focus of this qualitative inquiry was on the experience of loneliness for seniors in general, not those of a specific cultural or social group.

The recruitment process began after receiving ethics approval from the Calgary Health Research Ethics Board and the managers of the involved sites, such as the seniors' apartments and day hospitals accessed. Participants were recruited on a voluntary basis with assistance from a number of health care professionals who work in the community with seniors, such as Home Care Nurses, Outreach workers, Seniors Resource Nurses, and staff in Outpatient clinics and seniors buildings.

Those who assisted in participant recruitment did so by distributing information sheets (Appendix B) produced by the researcher. The information sheets were developed by the researcher with the input of the Seniors Resource Nurses who work in the community with seniors. The information sheets briefly described the researcher's background, the rationale for conducting the study, why the participants were required, and their role in the study. The researcher's contact information was also on the information sheets for seniors to use if they had any questions or if they were interested in participating. When seniors contacted the researcher, arrangements were made for

interviews at times and locations convenient for them. In addition to the assistance from health care professionals, information sheets were posted in a number of seniors' apartments/complexes, lodges, and manors.

Recruiting participants for this study was a slow and difficult process. There are a few possibilities for why lonely seniors were hard to locate. First, seniors did not want to talk about their loneliness. Second, perhaps they did not want to talk to a stranger about their experiences. A third reason might be that there are few seniors who are lonely, and the fourth possibility may be that those who are lonely are isolated and could not be accessed.

The sample consisted of eight seniors. Three of the seniors had their Home Care or Seniors Resource Nurse contact the researcher to provide the contact information. The researcher then phoned the seniors directly to inquire if they would still like to volunteer for the study. If so, information was gathered to ensure they met the criteria to participate. All other participants contacted the researcher directly. All participants chose to conduct the interviews in the privacy of their homes. At the time of the initial interview, the researcher provided the participant with a consent form (Appendix A) to read and sign. A copy of the consent form was given to participants. Participants were informed that their involvement was voluntary and they could withdraw at any time without any negative implications to their health care; the researcher then offered to answer any questions they had.

After interviews were conducted with eight participants, the researcher felt that data saturation had been reached. Holloway and Wheeler (2002) described data saturation as a point in data collection when there is little likelihood that any new themes will arise and redundancy is evident. In qualitative studies, the concern lies with the quality of the data gathered from participants rather then the quantity of participants used to supply the information (Polit, Beck, & Hungler, 2001).

Age/gender	Marital status	Living status	Children	Education
68/F	Widowed 27 months	Alone - seniors apartment	1- son	University Degree
81/F	Widowed 23 years	With son & daughter-in-law	2- sons	Grade 4
82/F	Widowed 22 years	Alone - Seniors apartment	1 son, 1-daughter	Grade 11
86/M	Widowed 16 years	Alone - Seniors residence	None	1 year University
93/M	Widowed 11 years	Alone - Seniors residence	None	Grade 9
92/F	Widowed 8	Alone - Seniors residence	2 step children	1 year Junior college
86/F	Widowed 15	Alone – Assisted living	2 sons	Teaching certificate
68/F	Divorced 14 years	Alone - Seniors apartment	1 son	University degree

F= female, M=male

Table 1 Participant's demographics

Data collection and analysis.

A goal of qualitative descriptive studies is to collect as much information on a experience/phenomenon and provide a comprehensive summary on the contents obtained (Sandelowski, 2000). Prior to beginning this phase, the researcher performed reduction/bracketing, an important activity in qualitative research according to van Manen (2003). Reduction required the researcher to examine her beliefs, presuppositions, and theories on the topic, allowing for a clearer vision of the experience. If this act is not completed, the view of the experience may become distorted, preventing the researcher from seeing the experience or understanding it as it is lived (van Manen). Reduction was accomplished by the researcher writing her beliefs and presuppositions in a journal throughout the research process. The contents of the journal were used by the

researcher, as an additional tool, in the reflection process by challenging her beliefs and presuppositions.

The primary method of collecting data was individual face-to-face interviews with seniors. The researcher used interview material to reflect on, which contributed to a deeper understanding of the phenomenon. Prior to beginning the interviews, the researcher engaged in conversations with participants to build rapport. According to Murray (2003), sharing part of the researcher's life with participants is beneficial to building rapport, but it is necessary to be brief.

The initial interview questions (Appendix C) were structured to obtain demographic characteristics from the participants, and then the questions were semi-structured. Following the collection of the demographic data, the first interview question on loneliness was, "please describe your experience of loneliness" or "think of a specific time when you were lonely and describe that for me please." Wording the questions in this form assisted the researcher to obtain a detailed illustration of how participants lived in everyday situations experiencing loneliness.

Van Manen (2003) indicated it is not possible to generate questions prior to the interviews because it depends on participants and where their descriptions begin. Since the researcher was a novice, notes were brought to the interviews on the four existential themes described by van Manen, to assist in the development of questions if needed. Throughout the interviews, the researcher kept the question foremost in mind, focusing questions as closely as possible on how the experience was lived. This is imperative, according to van Manen, otherwise the majority of data obtained would contain excessive amounts of causal explanations of the phenomenon and not the lived experience. To stimulate the memory of participants, the researcher used probing questions without guiding or leading them. At other times during the interviews, it was necessary for the researcher to be silent--this limited her from interrupting the thought process of participants. Throughout the interviews, to encourage participants to share their experiences, the researcher responded with nonverbal cues, such as nodding of the head, and maintaining eye contact. The researcher attempted to remain neutral during

interviews, but it was difficult not to respond with positive comments and give advice at times.

The initial interviews lasted approximately 45 to 80 minutes, were audio-recorded with consent from participants, and then transcribed verbatim. Second interviews last between 20 to 30 minutes. Only five participants agreed to conduct second interviews, and two of those were on the phone. The second interviews were more like conversations as van Manen (2003) referred to them, and during these sessions, the researcher and participant jointly reviewed identified themes. In addition, during the second interviews, the researcher identified areas for participants to clarify or elaborate. Throughout the interviews, the researcher took notes as recommended by Streubert Speziale (2003b) in case some of the information provided by participants required clarification or elaboration later in the research process. After each interview, the researcher immediately wrote field notes on the emotions and body language of the participants and any other factors she thought were important, such as comments some of the participants made after the tape recorder was turned off.

After each interview was completed, the researcher immediately had the audio-recorded interviews transcribed by a transcriptionist. This allowed analysis to begin as soon as possible. The researcher reviewed the transcribed text while listening to the audio-recorded interview to ensure accuracy. The analysis of the text then began by the researcher reading the transcribed interview as a whole to develop an understanding of the experience. Next, the text was analysed in sections, paragraph by paragraph and sentence by sentence, for themes.

In qualitative research, data collection and analysis are two phases of the research process that often occur simultaneously (Morse & Richards, 2002; Sandelowski, 2000). For instance, what was learned from listening and reading one interview was then explored in subsequent interviews. During the second set of interviews conducted among the five of the eight participants, the researcher collected lived experience material from the participants while analysing previously gathered material. Furthermore, during the data collection and analysis, the researcher had conversations with her supervisor that encouraged further reflection on identified themes. This form of reflection assisted the

researcher in identifying themes that may have been absent, incorrect, or those that may have required rearticulating. In order to maintain organization of the identified themes, they were recorded onto a theme chart. These charts identified the theme, the corresponding portions of the transcription, and the lines on which they were located. The theme chart evolved as the researcher conducted interviews and analysed transcripts.

In addition to obtaining participants' descriptions, the researcher explored etymological meanings of certain terms that participants used in their descriptions, such as 'loneliness' and 'lost'. Etymological meanings are those that are developed from the earliest origin or history in which the term was created (van Manen, 2003). The rationale for this action was that the terms are often based on lived experience, yet the manner in which the terms are used today has often taken on different meanings than those from which they were originally developed. According to van Manen, looking back into the meaning of terms, from when they were initially created, can provide a greater understanding of the terms in today's way of life. This facilitates deeper insight into the lived experience. The etymological meanings of terms were located in an etymological dictionary or an online etymological dictionary.

Trustworthiness of the research.

To convince others of the value of qualitative investigation, the researcher strives to produce findings that are trustworthy and accurate; however, there is no single strategy for the researcher to follow to achieve this goal. To improve the trustworthiness and accuracy of the findings, it is necessary for them to be credible, authentic, and confirmable. Credible data is data that readers believe to be truthful (Polit, Beck, & Hungler, 2001). To increase the credibility of the findings, the researcher returned to participants for a second interview to discuss themes she identified from the initial interviews, ensuring she captured what it is like for them to experience loneliness. This is referred to as member checking (Whittemore, Chase, & Mandle, 2001).

Authentic findings are those that are real and genuine (Streubert Speziale, 2003b). To demonstrate authenticity of the findings, the researcher provided sections from the participants' transcripts in the written results for readers to develop their own opinions on the identified themes. Additionally, the researcher maintained focus on exploring the

lived experience, and not the causes, concepts, or definitions of loneliness. This was completed by the researcher having conversations with her supervisor and through the act of reduction.

Lastly, the researcher provided her supervisor and committee members with copies of transcribed interviews, theme charts, and drafts of the research paper to demonstrate how themes were generated. These actions assisted the researcher in illustrating that her findings were authentic, credible, and thus confirmable. Confirmable findings illustrate that the researcher had remained neutral and unbiased throughout the research process (Streubert Speziale, 2003b). As well as producing authentic, credible, and confirmable findings, the researcher wrote numerous drafts of the description of the findings. These drafts encouraged insight into participants' experiences and assisted the researcher in providing a description that demonstrated a full, complete, and detailed representation of loneliness.

Ethical considerations.

The researcher received ethics approval from the Calgary Health Region and the Conjoint Health Research Ethics Board at the University of Calgary to conduct this study. The researcher strove to protect the confidentiality and anonymity of participants. Participants were informed that their confidentiality would be protected and the information they provided would not be divulged to anyone other than the researcher and her committee members. Additional steps taken to protect participants' confidentiality were that all interviews were carried out on an individual basis in a private location and the transcriptionists were required to sign a confidentiality agreement.

To protect participants' anonymity, their real names were not identified in any written documents or audio-recorded interviews. However, anonymity was not guaranteed because of the participant recruitment method used and because some of the readers may recognize participants by the information (descriptions and/or narratives) they provided, for example, the Seniors Resource Nurses, and others who cared for these seniors. To facilitate anonymity, randomly chosen pseudonyms were used in all written documents. The researcher assigned a pseudonym to each interview and the transcribed text for recognition purposes. A list containing participants' names, phone numbers,

taped interviews, and the corresponding pseudonym of the participants was stored in the researcher's home office, in a locked file cabinet. Upon reaching the time period recommended by the Ethics Review Board, the researcher will destroyed all raw and sensitive data (tapes, consent forms, and other related notes), erase audio-recorded interviews, and shred documents.

Protecting participants from harm is a priority when conducting research (Gerrish, 2003). At the beginning of each interview, the researcher provided participants with a contact sheet (Appendix E & Appendix F) that contained numbers of support services available for seniors in their geographic area if they became distressed from the interviews. There was only one case when a participant was very emotional during the interviews and she was given the option to discontinue. The researcher remained with her until she seemed fine and encouraged her to use the phone numbers on the contact sheet if she needed. Had any of the participants wished to discontinue the interview due to distress, the researcher would have stayed with them until it had passed. Alty and Rodham (1998) stated that it is vital to allow participants a chance to verbalize their emotions and not minimize their concerns. It was important the researcher not act as a therapist, but only as an investigator, meaning the researcher did not provide any advice to participants other than suggesting they use the contact numbers she had provided. Nonetheless, the researcher was aware that there might be unpredictable consequences related to interviews and acted in the best interest of the participants at all times. For example, the researcher conducted follow up phone calls to ensure participants were not distressed from the interviews.

CHAPTER THREE: WHAT WAS FOUND ON THE JOURNEY

The intent of this study was to describe the loneliness experience of community dwelling seniors. This chapter will present the themes found for those seniors who participated in the study. The themes identified will then be discussed, followed by study limitations.

The loneliness experience

This section identifies and describes the themes that are part of the experience of loneliness for the seniors who participated in this study. Throughout this section, quotations from the participants' transcribed interviews are used so the reader can have a sense of how themes were generated. In this section, the themes are described in individual sections and they are as follows: the trigger, the aloneness of loneliness, lost – an unpleasant experience, the influence of loneliness on the self, and coping with loneliness.

Theme One: The trigger.

With life come unexpected events, the consequences of which are not always pleasant or welcome. For all participants, there were specific occurrences or triggers that initiated feelings of loneliness and/or intensified them. It was difficult for participants to explain because it was not as if they just woke up one morning and thought to themselves, 'I feel lonely all of a sudden'. Something in life had changed, something was not right, or was missing all together. That something was a special relationship. Kim did not indicate specifically when her loneliness began, but it worsened when she moved to Calgary. Jim and Linda's experiences of loneliness began when their spouses' mental illnesses worsened and influenced their relationships. Loneliness began for Fred, Jen, and Beth when their spouses passed away and for Kay when her companion moved away. Nancy's loneliness began during her marriage because of how her husband made her feel.

Some of the seniors had been lonely for many years, others for only a short time, and a few were only experiencing brief, occasional periods of loneliness. Kim did not specifically indicate that her loneliness began after her husband's death, but she did state she was lonely prior to moving to Calgary. Her experience of loneliness changed after she moved and left her house and friends in a different province. Kim stated:

> It was up into last October I went to the hospital there [in Montreal] it was my breathing again, and I was in until December, but anyways what they wanted me to do . . . after all the tests, breathing tests. . . they said I shouldn't be alone.

Jim and Linda's experiences of loneliness began when their spouses' mental illnesses worsened, which negatively influenced their relationships. Jim's wife started to cut off communication with him and refused to see or talk to any of their friends, which contributed to his loneliness. Jim described it by saying "She didn't want any visitors, anybody to come and see her . . . . I couldn't get out and talk to people like I'd like to you know . . ." After Jim's wife passed away, he continued to experience loneliness. Linda's husband developed severe Alzheimer's disease and was unresponsive prior to his death, which was when her loneliness began. In her interview, Linda said "Well, he was absolutely unresponsive . . . I spent a lot of time with him, but there wasn't much there." Nancy was the only divorced participant and her experience of loneliness began when she was married and continued after her separation from her husband. The researcher asked Nancy in the second interview if her loneliness started in her marriage, and she replied, "Well, that was my reaction to some of the things he did."

The experience of loneliness began for Jen, Fred, and Beth after the deaths of their spouses. Jen explained, "Now, I doing every thing alone, and even I spoke [sic] with his picture. Almost every day after 27 months I go to sleep, I say him goodnight." Fred stated how he felt after his wife passed away, "Well, naturally you've lost your partner and that's ah . . very heavy on your mind." When the researcher clarified with Beth that the trigger to her loneliness was her husbands death she stated, "That's right."

Kay did not indicate if she was lonely after the death of her husband, but she had a male companion up until a few years ago and it was not until he moved back to the United Sates that she started to feel lonely. The researcher inquired, when do you think you first realized you were lonely? Kay replied, "When I was left alone, when I had nobody in the house anymore." For all the participants there was one event, often related to loss or disruption in their relationships that triggered their experience of loneliness.

Theme Two: The aloneness of loneliness.

The feeling of aloneness was an integral part of the loneliness experience for participants. The term "alone" was used by the seniors in all interviews, and they described feeling as if they were alone on one or two levels, a physical and/or emotional level. What is it about aloneness that relates to being lonely? The term 'lone' is a shortened form of the word alone and is developed from the words lonely, loneliness and lonesome, and they mean 'one' and 'all' (Klein, 1971). The word 'loneliness' originated from the words 'solitude' and 'solo', meaning alone (Online etymology dictionary, Jan 9, 2006). Being alone on an emotional and/or a physical level was part of being lonely, and it was difficult for participants. Some of the seniors described a lack of physical contact with others, such as a companion, friends, or family. They indicated they wished they could spend time and/or socialise with others. Kay verbalised her unhappiness about being alone:

> I come to my apartment, there is no one to talk to, nobody to sit down and laugh or cry. I sit down to meals, terrible, I don't like to sit and look across at the emptiness. Now I am one and alone, nobody is there.

Seven of the participants were widowed and loneliness seemed to be part of adjusting to the fact that they would be living the rest of their lives without the presence of their significant other. Jen described how things were when her husband was alive, "I was not so lonely because every place we go [*sic*], we go together." Beth stated, "When he passed I was relieved in a sense that he wasn't suffering anymore, and yet I knew that my life was going to change so much . . . . I knew that we wouldn't be going on any trips anymore." Participants desired company, someone to talk to and do things with. Fred stated, "I have nobody to go places with, I don't, you're not interested in going on holiday anywhere, who wants to go alone on a holiday." Jen talked about her physical aloneness, "I am alone. Nobody can answer me. What I read is in my head." Kay identified what was missing and expressed her desire to be with somebody again:

> I would still love to meet a gentleman that is company. We'd be able to go out together, we'd be able to eat together, we'd be able to sit and watch TV together . . . . I need my own man to talk to.

Next to a spouse, the presence of and satisfaction with friends are important in preventing feelings of aloneness in loneliness. When lonely, many participants indicated dissatisfaction with their lack of friends or lack of contact with current friends. Nancy described a time when her sister in law had a heart attack, and she really wished she had a friend to whom she could talk about it in person: "I kind of moaned and groaned to them [her sisters] about my own . . . not having anyone to talk to right here." Kim explained how since she moved across the country to Calgary, she had no friends to spend time with and how she wished there was someone to visit with her, "No, it's more or less like I said to have someone come visit me, that is what I would like. Someone to come and sit with me and have a cup of tea, talk for an hour . . . ." Kay had also moved to Calgary a couple of years ago and stated ". . . I miss my friends back home very much." Jen illustrates what it could be like if she had a friend: ". . . if I have a friend for example, she call to me, Jen, I [will] wait for you [in the] hallway. Would you like to go for a walk? Would you like to go for a movie?" Friends are often individuals people have something in common with and who provide us with company. Participants who lacked friends desired them, yet physical contact with them is important because those who felt contact was insufficient also felt physically alone.

Only a couple of participants indicated they wished they could spend more time with their children. Kim described how she would like it if her son spent more time with her: "I know we don't watch the same thing, I'd be willing to compromise. If he wanted to come up, put the TV on, sit here and watch hockey, I wouldn't mind. Just to know somebody's here." Jen explained how her son does not spend enough time with her, "My son came to me and bring [*sic*] me some vegetables, some food and I told him, you know I don't need them, I need you. Sit and speak with me . . . . I know he is busy, but he should make time I think." Fred did not have any children, but thought that if he did they would provide him with company. He said, ". . . there would be somebody around that would . . . come and pick you up."

Feelings of aloneness in the emotional sense meant participants felt there was a lack of a connection with someone special that could provide support and care. Fred

illustrated what emotional aloneness felt like for him, "It just feels like everybody has forgotten about you. Cause you feel . . . it's so alone, it's like nobody cares." Beth described how she felt after her husband passed away, "There is sort of an emptiness . . . you have to make decisions that you didn't have to make before and sometimes you question your decisions and wish you had someone to discuss them with." Kay illustrated her emotional aloneness, "Nobody is there, nobody care . . nobody cares. You know, I have no one to look after me." Kay indicated she had a good relationship with her family and that the only type of relationship that would decrease her feelings of aloneness was a companion. Like Fred, Jim did not have any family either, and he felt that it would have made a difference, that he would have more emotional support. He stated, "I would [have] felt that I had somebody close."

Other participants described emotional aloneness in the form of being unhappy with their current relationships. Jen was very unhappy with her relationship with her son and described how he should take more time to show he cared for her: "I know he is busy, but he should make time I think . . . he doesn't ask me how I feel, what I need and he doesn't tell me about his family." She desired a friend, but a friend may have not helped her feelings of emotional aloneness because she stated she could not be as open with a friend as she is with her family. Jen also stated how she talks to her husband's pictures on the wall because she does not feel she can talk to others about these things, not even her son: "I try tell my husband all my problem . . . . because I cannot tell that to anybody else what I tell to his pictures."

Are the things that are talked about and done with friends significant, or is it the fact that they care. For many of the participants, it appeared that the time spent with friends or the communication with them was inadequate. Having contact with friends is important when individuals are lonely. Participants identified the need to have someone to talk too when they were lonely. Jim stated, "The big thing was I had nobody to talk to, that was the big thing". If individuals know they have the emotional support of a friend they may not feel alone in the world.

Being able to communicate with others is an important component in preventing feelings of emotional aloneness. A few participants felt alone on an emotional level in

the presence of others because there was a lack of communication. Jim and Linda both had spouses who had mental illnesses, which impeded their ability to communicate. This inability to communicate left Jim and Linda feeling emotionally alone. Linda stated, "Well, he was absolutely unresponsive . . . I spent a lot of time with him, but there wasn't much there." The lack of communication caused Jim and Linda to feel like the support and care they once had was gone.

There were occasions when some participants felt emotionally alone around other people because of poor communication causing them to feel left out or uncomfortable with their company. Linda stated that when she was with a group of people, her hearing did not work well, and she could not always hear what was being said. As a result, she said, "I feel out of it." Nancy also described periods when she felt emotionally alone around a group: ". . . in a social situation where you feel uncomfortable . . . you don't know what to say. Sometimes people will say something people will laugh and you don't get the joke."

In summary, feelings of aloneness were an integral part of the experience of loneliness for these seniors. When the participants were lonely, they described feeling alone in a physical and/or emotional sense. Physical aloneness occurred when seniors missed the presence of others around them. Emotional aloneness occurred when seniors felt nobody cared about them and that they lacked support or access to support.

Theme Three: Lost - an unpleasant experience.

The experience of loneliness was an unpleasant one that was difficult for participants to describe. This experience elicited negative emotions and thoughts among the seniors. A few of the participants used the word 'lost' when talking about their loneliness. The etymological meaning of the word lost is past tense for lose (Klein, 1971) meaning *'no longer to be found'* (Online Etymology Dictionary, Jan. 13, 2006). What is it that becomes lost when seniors are lonely; perhaps it is a sense of belonging in this world? Linda wondered what it was about her that inhibited her from having more friends. She said, "I wish I could think of something that would . . . about my personality that I could make more attractive so I wouldn't be lonely, so people would want my company more than they do." Nancy also felt she did not belong at times and explained when she was

lonely how she felt inferior to her neighbours, rejected and unaccepted by society because of her smoking and past.

Jen was very emotional while describing her experience of loneliness and cried on and off throughout her interviews because the respect and need that her family once had for her was lost. She indicated she felt sad and angry because her son did not call or spend enough time with her or see if she needed anything. Jen stated what she vocalizes to her son:

> Because you don't come to me and you don't speak with me. You don't tell me anything . . . . you make me very sad. Even I don't need the care, I don't need [care] I am not so disabled to go to Safeway across the street and I can buy everything, but he should ask. I think it's polite for him to ask me.

Jen talked about how she used to look after her grandson all the time when he was growing up, but now that he was older, he did not need her anymore. She stated, "I have one grandson. Now he's big boy. He doesn't need me."

For some seniors, it was an important relationship with a specific person or people that had been lost and caused unpleasant feelings. The loss could have been due to death or relocation. The widowed participants talked about memories and indicated that they missed their partners and the life they once shared with them. Beth illustrated how she felt:

> Loneliness is a sad time, it is time going through past memories and not being able to repeat them. There's sort of an emptiness too . . . . the emptiness comes from you having to make decisions that you didn't have to make before. And sometimes you question your decisions and wish you had someone to discuss it with.

For Beth, it was specific times when she found herself lonely because she was used to her husband being there, such as mealtime and first thing in the morning when they would pray together: ". . . It bothered me an awful lot to eat alone. You know that's the time when you're visiting back and forth so . . . . I miss our morning devotions." Many of the participants talked about things they did with their spouses, friends, or family and how those days are lost, which was difficult for some to accept. Fred talked about the many

cruises him and his wife went on and added, "But you miss the ones you've been living with all this time." Kim described how she missed her husband, " . . . I often wish he was back again, many, many times." and she talked about how she missed doing things with friends and family members: " we always called her aunt she used to come out quite often, every weekend . . . I miss her very much, I miss her a lot."

Kay, Jen, and Beth described feelings of fear and a lack of security related to the loss of their spouses or companion. Kay said, "it's frightening", Beth stated "I was fearful because I was alone", and Jen explained how she thought about moving to a nursing home so that if anything was to happen to her, there would people around to help: "I think I should go to nursing home . . because I [am] afraid nobody can help me [here]. . . ." (in the building she lived in).

Two participants described feeling as if they had lost their freedom and independence. Kim moved here six months ago from Montreal, and just before moving here, she was told she could not drive anymore: "What I miss now more than anything is my car because I felt very independent with it . . . . I didn't have to rely on anybody. I was doing my own thing and that made me feel good." Linda's freedom had been lost and she was limited in what she could do because she could no longer drive. She stated, "I could get places and do things with other people I can't do alone without a car." Kim also felt that she had lost some of her freedom since she has moved into her son's house. She described what she used to do if she was lonely:

> I would just take my walker and walk into the kitchen sit up to the counter and make a pie or make a cake or make some stew. I would take it out on cooking, that's what I like, and that's what I'm missing too. Which my son and daughter say's I could do everything here that I could do at home, but it don't feel the same.

Kim also indicated that she would get frustrated and mad because of loss of independence due for her need for oxygen therapy: "It is just different things that you think about, that you used to do. And that makes me mad because I go so far and then I'm short of breath." Linda was worried about losing her independence, "I am afraid I will go on to long before I can't take care of myself."

The word lose also means '*defeated*' (Online Etymology Dictionary, Jan. 13, 2006). There were times when this experience of loneliness was such an unpleasant battle that it had some participants feeling defeated against it. This sense of defeat could have created the feelings of hopelessness that some participants described. Jim illustrated how he felt, "No help. I had nobody to turn to. I was on my own. I wish I had somebody with me. I'd get despondent. At times I felt, was it worth going on. I used to break down and cry. I was lost." Kay also stated, "I wish the end would come, enough is enough." Jen sadly described, "When you're alone everything [is] bad . . . . bad things scream in your head . . . . sometimes I think about my why I live." Fred explains how he felt at times, ". . . wonder if it's worthwhile sticking around."

Losses were evident in all participants' descriptions of loneliness in one form or another. The degree of suffering related to these losses and the feelings experienced varied among participants, some days were better than others and the suffering seemed to decrease over time for many. The participant who was the most recently widowed appeared to be having the most difficult time with her loneliness and adjusting to life without her husband.

Theme Four: The influence of loneliness on the self.

The experience of loneliness interfered with some of the participants' daily activities in life, such as the ability to eat and sleep. Jen described her inability to eat even though she knew how important it was that she consume a well balanced diet to control her diabetes. "My loneliness affect [*sic*] my appetite, my sleep, I cannot eat alone. It doesn't go in my mouth. I cannot swallow. Even I know I must eat and I cannot." A number of the participants expressed a disinterest in eating adequately or preparing meals for themselves. Kay stated, "I didn't bother to cook, I didn't bother to eat". Is there something about eating alone or even the thought of it that disinterests lonely people? Meals can be a social time, a time for discussion and catching up on one another's activities of the day. The simple routine of eating meals with others can be enjoyable and can often be taken for granted, as Beth illustrated:

> I used to set the table for two in the beginning . . . it bothered me an awful lot to eat alone . . . . I found I was not eating properly too because I had no interest in it. There was only me to cook for.

The participants who described a disruption in their eating all cooked and ate their meals alone; the other seniors ate at least one of their meals with other people, for example Jim and Fred would go to the dinning room for 2 out of their three meals. Jen states how she felt when she ate with others ". . . I have [an] appetite. I enjoy to eat." If the social aspect of a meal is removed, eating can become a chore especially when individuals are used to eating with the same person/people on a regular basis. Then, meals are a painful reminder of what is missing in life.

Sleep habits were influenced by feelings of loneliness for some of the participants. Jen indicated that there were times when falling asleep was difficult because her thoughts would not leave her alone: "I go to bed; I try to think about happiness. I should be asleep and after a minute I think, when can I see them next and my dream gone away, I cannot sleep." For other participants like Nancy, getting out of bed in the morning was an issue: "sometimes I don't feel like getting out of bed in the morning and I wakeup too early." Jim stated, ". . . it wasn't easy to get up in the morning and go through the day . . ." Beth explained many times when she had woken up in the middle of the night:

> I would be dreaming I was asleep with my husband and I reached out to put my arm around him and then I'd wake and he wasn't there. I likely wouldn't sleep the rest of the night because I kept going through things we had done together and it present . . oh, a lot of anguish.

What is the point of jumping out of bed in the morning anyway when there is no one to talk to and nothing to do but kill time? Sometimes loneliness interfered with seniors' abilities to care for themselves as Kim illustrated:

> It's a very long day that's why I know with my medication I should get up earlier than I do. But if I get up nine, nine thirty that's early enough . . . . if I get up too early the day's too long then. So that's why I stay in bed.

When lonely, some participants indicated that they lacked motivation to get things accomplished or even go out and do things they enjoy; some isolated themselves. Linda stated ". . . if I am depressed enough then I, I don't get anything done. I will just sit and sleep, waste a lot of time that way." Jen explained:

> Like sometimes, I feel I even cannot do anything. I push myself to do, but I have not energy . . . . even I cannot got for a walk . . . best for me to sit and read and nobody around me is best for me.

Beth described times when she was unable to do things she enjoyed, "Like there are times when I've been lonely that I haven't been able to go to sing-along and still I enjoy to sing. But there are times when I feel I'd rather sit with my thoughts somehow. Why, I don't know." She indicated that there was nobody she wanted to talk too.

Nancy indicated that she had some bad habits, such as smoking and drinking coffee that she did more when she was lonely. She explained how she often turned to these habits when she was lonely, "Sometimes when I don't know what to do with myself, I just make coffee, you know and that's not good for you to drink a lot of coffee."

One participant wondered what it was about herself that caused her to be lonely. Linda indicted she would feel sorry for herself and think about what it was that was so unappealing that contributed to her lack of friends. "I wish I could think of something that would . . about my personality that I could make more attractive so I wouldn't be so lonely, so people would want my company more than they do . . . there is something lacking in me that I can't attract friends." Nancy stated she would start to do a lot of thinking when she was lonely to the extent she would over analyse things.

Feelings of loneliness influenced some participants' subjective time. They described how time seemed to go by very slowly when they were lonely. Kay had illustrated how time passed for her:

> Time doesn't pass it drags dear, it drags. Yes . . . when I look at my watch and I see it moves and then I look at my watch again. Oh my god! It's only half past twelve! I think it is about four o'clock. It drags and drags.

Jim identified specific times when he was lonely and these were times when there was often little to do but think: "Come night it would catch-up with me [loneliness]. I would be like, oh golly I wish I had something to do and that, or I wish I was with somebody you know." Jen talked about how when she has nothing to do she waits for her son to call:

I have not anything to do. I sit outside, very hard for me to sit inside and listen to phone when it [to] rang [*sic*], because not so often [the] phone rang [*sic*]. So I get annoyed. I go out and try doing anything."

At times, feelings of loneliness related to triggers; aloneness and losses influenced participants' daily activities, such as preparing meals, consuming food, and sleeping. Behaviours, ability, and/or motivation to care for oneself were disrupted by loneliness for some participants as well. Subjective time was influenced when participants felt lonely, and at certain times during the day loneliness seemed to bother some more than others.

Theme Five: Coping with loneliness.

Participants coped with their loneliness in a number of ways, and some strategies were more effective than others. They described using strategies such as exercising, cooking, reading, and volunteering. By focusing on other things, loneliness was temporarily removed from their current focal attention, but as soon as their minds were not distracted, loneliness invaded their thoughts.

Linda described what she did to occupy some of her time: "Well, I try and find useful things to do, like I help in the coffee room and I water the plants in the lobby. At least it makes me feel a little bit useful." Jim talked about how he coped with his loneliness by going on a cruise stating that he felt he had to get away from the environment for a while. The researcher asked him what he need to get away from, and he responded "from everything I had known for all those years . . . just up and get away go somewhere I didn't know anybody, didn't have to think about talking to somebody about it or anything like that" (When he said 'it' he was referring to his wife's passing). Fred explained the strategies he employed to distract himself from feeling lonely: "I go to the library and get a book to read." In addition to baking and letter writing, Nancy used reading as a pastime to deal with her loneliness and she said, "I do a lot of reading and I

enjoy that . . . . I get into the shoes of the person in the book and escape." Kim descried how she took pleasure in writing letters and cooking because when "cooking your mind is on something else, I think about what I am cooking, not loneliness." Sewing and reading were a couple of the activities Beth employed to help address her loneliness, she would also cook something special and illustrated why, "Sometimes I'd cook for myself one of the things he'd ask for just to feel that he was close to me" (he being Beth's husband).

The majority of the participants identified volunteering or doing things for others as a pastime that they enjoyed because they were helping others and it assisted them to cope with their loneliness. Kay stated, "Volunteering I try keep my mind off my loneliness. So I . . . you know substitute volunteering for my loneliness. That's what I do." In addition to helping others, volunteering often provided participants with an opportunity to be around others and socialise. Fred indicated, "it keeps me busy and that's what I want, something to do." The time spent volunteering varied among participants, and Kim was unable to volunteer any more due to her poor physical health. Volunteering and helping others contributed to participants feeling useful, needed and valued. Jen explained "It make[s] me happy. I like helping people" and Fred commented ". . . I feel like I am being useful, helping someone . . ."

A few participants looked to their religion to help them cope with their loneliness. Beth explained how her religion helped: " . . . it has sustained me through it all, I think because without the belief that I will see Bill again it would be so difficult. God has put me in this position and he expects me to deal with it." Fred mentioned how his religion assisted him when he was down, ". . . I think the prayer brought me through a lot . . . . I read the Bible right through, two or three sessions and . . . you got to have faith and carry on." Religious beliefs provided seniors with the hope to carry on with life and try and make the best of things.

Other than two participants, none of the others mentioned they accessed assistance from professionals such as doctors or nurses for loneliness. One participant stated that there was the occasional time when she felt low and would phone the Crisis line. A different participant indicated during her last interview that she had recently arranged to go and talk to someone about her loneliness to see if it would help.

At times, participants would unintentionally employ strategies that intensified feelings of loneliness rather then helped to reduce it. Beth talked about how she made a scrapbook of pictures for her grandsons " . . . it distracted and yet it brought back so many memories." When the researcher asked Beth if she got lonely when she was doing the scrapbooks she replied "Sometimes the tears would come . . . . I'd see the pictures and I'd remember what happened that day and wish that things were like that again." Kay stated, "I often think of times that were and that makes me more lonely."

Many of the participants had experienced loneliness for a number of years and indicated that the longer they had been dealing with it, the easier it became to live with. Jim insisted that he rarely experiences loneliness anymore now. Jen, on the other hand, had only been lonely for the past two and a half years at the time her interviews were conducted. Jen's experiences of loneliness were a very emotional and difficult time for her, which seemed to affect her life on a daily basis.

Seniors' views on their loneliness influenced how they dealt with it. Jim stated, ". . . I have an attitude got to carry on, to do the best I can and put a lot of things out of my mind." Fred stated, "I don't ever let it get me down." This is how Kim felt about her loneliness: "you just have to make yourself do things . . . I mean, nobody can help you really but you've got to help yourself. That's the way I look at it."

Summary.

All the themes were discussed in separate sections; however, they are all interwoven aspects of the experience of loneliness. The feelings of emotional and physical aloneness were often related to the triggers of the loneliness. It is natural to feel physically alone when your spouse, the person you had spent much of your days with is gone. Triggers, such as bereavement and feelings of emotional and/or physical aloneness, generated unpleasant feelings for seniors, such as lost, hopelessness, sadness, and emptiness. For some, there were times they even felt like life was not worth living. The theme of Lost – an unpleasant experience, encompasses some of the feelings and other losses seniors identified as part of their loneliness including the loss of a way of life, loss of independence, and loss of sense of belonging.

Triggers, losses, and feelings of loneliness influenced seniors' ability to care for themselves and behaviours such as eating, sleeping, and coping. Participants' coping strategies depended on the trigger of loneliness, additional losses experienced, their outlook on life, available supports/resources and their willingness/ability to use them. For most of these seniors, their spouses were a main support system. Losing their spouse made coping with their loss and loneliness difficult. Some seniors were happy with their social support systems and did not experience social loneliness. Other seniors were lacking or dissatisfied with their relationships with friends and/or family and also experienced social loneliness in addition to emotional loneliness.

Discussion of the findings

The previous section described themes identified as part of the experience of loneliness for the seniors in this study, and this section will discuss those findings. As a background, those seniors who participated in this study were all Caucasian, lived in the community, and the majority were widowed, female, and lived alone. According to Canadian Statistics for 2001 of females 65 – 74 years of age almost half lived with a spouse or partner, which decreased to 7.2% those 85 years of age and older (Statistics Canada, 2002). Females outnumber males in this population (Government of Alberta, 2006), which could be related to them outliving their spouses, and consequently living alone. Men over the age of 65 are more likely to live with a spouse or a partner due to shorter life expectancy and they tend to marry females who are younger than they are (Statistics Canada, 2002). Miedema and Tatemichi (2003) found being female, widowed, and living alone to be associated with loneliness in their research.

The research on the relationship between age and loneliness is inconsistent. In a seven-year longitudinal study with a sample aged 55 – 84 years, Dykstra, van Tilburg and de Jong Gierveld (2005) found that loneliness episodes increased with age, especially among the older. However, in a 10 year longitudinal study Holmen and Furukawa (2002), with a sample 75 years of age and older found, the frequency of loneliness experiences decreased as the participants aged. Over time, in this current research most participants indicated that their loneliness had decreased, which could be related to their acceptance of it as time went on or their ability to do what was necessary to relieve it.

It is difficult to determine if loneliness is related to increasing age alone. As seniors age, there are possibly more factors that can influence whether they experience loneliness, such as relocation and losses, which were found in this study. Seniors may also encounter more physical limitations influencing their ability to socialise as much as they desire. Other than one participant, this sample of seniors was quite physically mobile. Only one participant talked about her poor physical health and how it influenced her loneliness by restricting what she could do.

Understanding relationships among seniors is complex because they have a number of roles and provide various types of support. The investigation of the roles of support systems in loneliness has been a common topic for researchers, perhaps because they play a large part in the experience of loneliness for seniors. Findings from this study identified the triggers of loneliness for seniors were all related to relationships, and they were as follows: the loss of a spouse as a result of death; a change in the relationship between husband and wife due to mental illness or feelings of resentment; and dissatisfaction with the relationship due to relocation. Losing a spouse from death or separation is often a difficult event for individuals at any stage in life, but seniors are more likely to encounter numerous losses in short periods of time. Dealing with losses can be difficult to cope with for some seniors if they lack support predisposing them to becoming lonely. Seven participants were widowed and one was divorced, and all indicated they missed their spouses/ex-husband in one form or another. Loss of a spouse through either death or separation has been identified as a cause of loneliness by other researchers, including McInnis and White (2001), and Victor, Scambler, Bond, and Bowling, (2002). Spouses often provide company, security, and valuable support for one another, and when one dies, it is often a life-altering event for the living spouse.

This study yielded findings that were consistent to those of Costello (2002). His case studies on grief and loneliness found that seniors identified loneliness as one of their strongest feelings after the death of their spouse and that being around others did not ease feelings of emotional loneliness. The participants in this current study stated that they missed their spouses and that involving themselves in activities with or around others, such as volunteering, provided them with a distraction from their loneliness, but it did not

seem to relieve it. It may have decreased social loneliness but not the emotional loneliness. These findings possibly supports van Baarsen's (2002) claim that emotional loneliness can only be reduced by finding another attachment figure.

Who can be considered an attachment figure? According to Weiss (1973), an attachment figure is an individual who provides a sense of security, and if one is lacking such a figure, loneliness as emotion isolation results. The researcher found this type of isolation in the theme of emotional aloneness identified by feelings of being alone in the world and not feeling cared about. Not all the participants felt emotional aloneness, yet none of them were remarried, so perhaps a close friend, family, or companion could be an attachment figure. Bondevik and Skogstad (1998) found that among their study's participants (80 years and older), that contact with friends and family influenced emotional loneliness. Perhaps as age increases the need to replace attachment figures decreases or seniors realize it is unlikely.

According to Costello (2002), loneliness related to the death of a spouse does not disappear completely; it just changes in intensity over time. This may be true, and most participants in this study indicated that their feelings of loneliness had decreased over the years, except on certain special days such as holidays and anniversaries. These days are often full of memories of missing loved ones, which can awaken or intensify feelings of loneliness. Holmen and Furukawa (2002) indicated that friends are important in protecting seniors against loneliness, which may be partially accurate. They did not use an instrument that assessed social and emotional loneliness. They asked participants if they experienced loneliness and how often. Having the support of family and friends can assist some seniors to cope with loneliness related to the death or separation of a spouse better than they would if they did not have the support. However, van Baarsen (2002) found that after the death of a spouse social support from friends and family relieved social loneliness, but did not relieve emotional loneliness until a two and a half year period following their loss. Stroebe et al. (1996) found a similar result regarding emotional loneliness not changing even with social support.

Seniors can also experience loneliness while married. Two of the participants indicated that their loneliness began when their spouses were suffering from a mental

illness. In these cases, it was not the physical lack of an attachment figure, but the lack of a reciprocal emotional connection due to decreased communication between husband and wife. Another participant stated her loneliness did not develop because of lack of communication, but as consequence of how her husband treated her. Therefore, it is important to remember married seniors may also experience loneliness. If there is little emotional connection due to mental illness, dissatisfaction with the relationship, or abuse, then there is a possibility loneliness will occur.

Another example in which communication can be distributed causing seniors to feel lonely and disconnected from others is the inability to hear. One participant indicated she felt lonely due to her poor hearing. Chen (1994) identified seniors with higher levels of hearing handicap (ability to adjust to hearing loss) as experiencing greater feelings of loneliness compared to those with lower levels of hearing handicap. Also poor vision can interfere with seniors' ability to be mobile, and this could therefore potentially limit their socialisation. Hearing and vision deficits are common in this population.

This study identified the importance of friends in feelings of loneliness, which were similar to those found by Wenger and Burholt (2003). They found not having friends close by, a desire for more friends, and not having enough physical contact with them are contributing factors of loneliness. The word friend originated from the words *freond, freon, frend* and means 'loving' or 'to love' and is also related to the word *freo* meaning 'free' (Klein, 1971). Marriages and friendships are types of loving relationships individuals often choose to freely form with others. What is it about these absent relationships, what is desired or missed? Are there certain traits or types of relationships that are essential to preventing loneliness? Friends often share something in common, for example a portion of childhood, views on life, common interests, or experiences. They often support and care for each other for who they are. Friends communicate with each another in any number of forms, for example by phone, email, or by writing letters. The amount of contact between friends may vary, but there are important elements in friendships. The time friends spend together can vary, but it may be the quality of this time together that is important. Some friends shop, watch movies, or have dinner and

enjoy each other's company. Nonetheless, friends are an important part of most people's lives. They can provide the support, security, and company that may be absent if a person is widowed, single, divorced, or unhappily married.

When Haight (1995) conducted research on suicide risk, she found that those who lacked a non-family member confidant had suicide thoughts more than those who had one. This again identifies the potential importance of an attachment figure for seniors. However, there is a conflict because males in this age group are less likely to live alone than females (Statistics Canada, 2002), so they are possibly living with a confidant, yet are four times more likely to commit suicide in old age than females (Public Health Agency of Canada, 2002). It may be that older males have difficulties in finding new attachment figures that can provide the emotional support needed or that many female's just lack the ability to successfully commit suicide.

For seniors who are separated from their spouses due to illness, death, or divorce, there is an adjustment required. In addition to adjusting to the lack of emotional support, they have to get used to not having the physical presence of a spouse around anymore, someone they were possibly used to spending every day with. Some seniors spend much of their time with their spouses eating, sleeping, and doing other activities. Couples often do things with other couples, and when one has a spouse pass away, the survivor may feel uncomfortable doing things with other couples. If seniors do not have any friends who can spend the desired amount time with them, or if they feel they lack friendships that can provide the desired support, social loneliness may result in addition to the emotional loneliness that likely already exists. According Weiss (1973), a lack of actual or perceived social relationships or the dissatisfaction with the quality of relationships can create loneliness as social isolation.

Feelings of emotional or social loneliness can result depending on what support the seniors expect from their relationships. Bondevik and Skogstad (1998) found the less frequent the contact with family members, the higher the rates of emotional loneliness, but not social loneliness. They also found frequency of contact with friends and neighbours was associated with emotional loneliness and social loneliness. For some, social support by family and friends prevents emotional loneliness, while for others only

a spouse could offer the necessary support. However, for social loneliness, socialisation with friends and spouses seem to be required to prevent social loneliness. Family members may be able to provide support, but not the socialisation seniors' desire. As seniors age, their desired or required level of support may change due to decreased independence. As dependence increases, the inability to socialise with friends as much as desired may be the reality. These changes could lead to family members being the main support provider and a source of social contact. Nonetheless, seniors' subjective views on the quality of their relationships seem to have the greatest influence on loneliness.

Part of the loneliness experience for seniors could be related to reviewing and evaluating their lives. This could include regretting some of the decisions that were made, such as not having children, which could influence an individual's loneliness. For example, two of participants in this study did not have family and believed that having children would have influenced their loneliness. One participant believed that he would have more things to do and think about if he had children and grandchildren. The other participant thought that if he had children at least he would know that the support would be there if he needed it. However, findings by Koropeckyj-Cox (1998) examining the relationship between childless seniors and loneliness did not indicate that there was a correlation between the two. It is perhaps easy for the two seniors to say that if they had children, it would have possibly altered their loneliness, but it does not necessarily mean that they would not experience it. The frequency at which they may have felt lonely may have varied and support may have helped. Moreover, feelings of loneliness could be intensified if seniors regret not making certain choices; it may also cause seniors to feel there is nothing else they can do about their loneliness.

When participants described their loneliness, they seemed to experience it more often when they were at home. This could have occurred for several reasons: in their homes, the seniors were often alone with no one to talk too; there was little to occupy their time; and there were memories in the home environment that perhaps initiated their loneliness. The items in their homes, such as pictures, can sometimes be a reminder of loved ones whom they missed. When conducting interviews at participants' homes, they all showed the researcher pictures or crafts and shared stories about the past and people

they missed. Most of the seniors lived alone, and at one time they were used to living with a spouse who they may have spent a lot of time with. After living with someone for many years, it can be challenging to adjust to being alone. The one participant who lived with her son and daughter-in-law desired to spend more time with them. This suggests that the presence of others is important, but the nature of relationships also matters for seniors.

Many participants used distractions to cope with loneliness, but it can be hard for some of them to keep busy and find things to occupy their time. Some participants had greater opportunities to socialise and keep busy. Those participants who lived in a senior's residence stated they had numerous organized social activities to go to if they choose. They also had libraries, exercise and games rooms, which they indicated provided them with options for finding things to keep busy. Those who lived in senior's apartments or houses do not have all these resources easily accessible to help them occupy their time. Having resources that are easily accessible where seniors live is important for socialisation. Seniors who have active social lives feel greater life satisfaction than those who are not socially involved (Nezlek, Richardson, Green, & Schatter-Jones, 2002). Isolated living may contribute too but not necessarily be a controlling factor of loneliness. It is necessary to recognize that those seniors who are not socially isolated may still be lonely because they do not have anyone to whom they feel connected or they may lack an attachment figure.

Feeling comfort in a living environment was identified as influencing the experiences of loneliness. Two participants described how their comfort level with the living environment influenced loneliness. One participant identified the following features as reasons why he disliked his living environment: the people were unfriendly; there was no exercise or games room; and there was a lack of a social atmosphere. Changing his place of residence decreased his loneliness because there now are many people to talk to, the staff is friendly, and there is much to do because there are organized day trips, games rooms, an exercise room, and a library. Social opportunities need to be made more available and accessible for seniors living in private housing and seniors' apartment buildings. While phone calls and letter writing decreased loneliness for some

participants, it was only temporarily gone. They desired to be around people they cared about. Humans are social beings, and if they are not able to be around friends and family, organized social activities can provide opportunities to make new friends.

Culture can influence how individuals experience loneliness as illustrated by the findings of Rokach and Sharma (1996). Culture determines the values and beliefs individuals have. One participant indicated that her upbringing was very different in Russia than it was for her son in Canada. This aspect may have influenced her expectations regarding the roles her family should have upheld. Van der Geest (2004) found that participants' loneliness in his study was the result of a lack of socialisation due to disrespect for the aging. Chou and Chi (2005) found that among their Chinese sample of older adults, childlessness did influence loneliness, whereas Koropeckyj-Cox (1998) did not find an association in her American sample demonstrating the possible cultural influences on the experience. Some cultures stress the importance of respect for their elders more than others, and this respect is demonstrated in certain forms. In some cultures, it is expected that once parents can no longer care for themselves, they should move into their children's homes. However, in North American society, it is not uncommon for dependent seniors to be placed in Nursing Homes or Care Centres. Canadian statistics for 2001 indicated this number is decreasing and show that among this population only 9.2% of females and 4.9% of males are living in health care institutions (Statistics Canada, 2002).

The beliefs individuals possess can affect their understanding of why they believe they are lonely, how they deal with it, and if they inform others about it. Some seniors mentioned age as a factor that influenced their ability to make friends or find companions. One participant felt that loneliness just comes with age. If seniors feel loneliness is a normal part of aging, then they may believe they are powerless in doing anything about it and may not inform others how they are feeling, which prevents them from possibly receiving any help. Other seniors felt guilty about being lonely, indicating they had no good reason to feel the way they did and that they should be happy with what they have. These feelings of guilt could be related to this older generation's views on life

and the idea that as long as you have the necessities, such as food, clothing, and shelter, you do not complain.

There has been little research on personality and loneliness, but self-esteem seemed to influence loneliness for at least one participant in this study. Van Baarsen (2002) found in her study on bereavement that emotional and social loneliness can increase after the death of a spouse for those seniors with low self-esteem. For seniors who have low self-esteem, the death of a spouse that may have provided the emotional support that person needed is now gone contributing to increased feelings of loneliness more than for those who have higher self-esteem. Low self-esteem can contribute to one's feeling of having little control over one's loneliness, which may perhaps make individuals feel like it is their fault. Some seniors with low self-esteem may isolate themselves and worsen their loneliness. Those who have low self-esteem may be less likely to have the confidence to feel they can do anything to easy their loneliness and prevent them from socialising. Moore and Schultz (1987) found among their study participants that the more control and responsibility they felt they had over addressing their loneliness, the less they experienced it. Many of the seniors in this current study felt that dealing with their loneliness was their responsibility and that nobody else could really help them, which inhibited them from seeking help.

Independence is an important factor associated with the experience of loneliness for some seniors. Not being able to drive can be seen as a huge loss to independence. Inability to drive causes seniors to feel they have to depend on others for transportation and it is perceived as limiting their freedom. Inability to drive may decrease the frequency of socialisation and contribute to a discrepancy between desired and actual socialisation. Many seniors may have access to alternative transportation but do not like the fact that it often has to be pre-booked. Transportation may be more of an issue for those in private housing and general apartments where there are fewer organized social events, which forces seniors to leave their homes or buildings to partake in social events. In areas were winter conditions can be poor, transportation may be more of an issue for those who do not have their own vehicles or access to someone who will take them places limiting social contact.

Loneliness was an unpleasant experience that included feelings of sadness, despondency, and emptiness for participants in this study. This study only produced three of the five factors Rokach and Brock (1997b) found when they conducted a factor analysis on the experience of loneliness among a sample ranging in age from 50 – 79 years. These factors were emotional distress, interpersonal isolation, and growth and development. Emotional distress for seniors included feelings of hopelessness, emptiness, and sadness, and for some even the feelings of not wanting to continue living at times. Interpersonal isolation included feelings of aloneness due to a lack of desired social support related to the absence of an important relationship with someone who they felt valued and cared about them, such as a spouse. This factor also included feeling abandon by others, and this resulted in seniors feeling like nobody cared about them. Most seniors identified growth and development in their attempts to make the changes necessary in their life to cope with and get past the painful feelings that accompanied their loneliness. The factor of self-alienation was not evident as a theme among the seniors in this study. The majority of the participants in this study were over 80 years of age, which could explain the differences in the findings. Rokach and Brock also had a much larger sample size.

McInnis and White (2001) conducted a phenomenological study on the lived experience of loneliness in 20 seniors, over the age of 71, and found themes similar to those in this research. Themes were as follows: 1) loneliness was the result of loss of an important relationship causing seniors to feel alone; 2) loneliness was the result of emotion pain that came with the apparent ending of a relationship; 3) senior dealt with or avoided loneliness using coping methods that were or were not useful; 4) loneliness was the result of actual or perceived loss of independence and functioning, which resulted in a state of anxiety, fear and sadness; and 5) seniors suffered alone due to the unwillingness or inability to verbalise their loneliness (McInnis & White). Theme four was the only theme not found to be true for all participants in this study. With regard to theme five, many participants had trouble describing their experience, but as for informing others that they were lonely, four of the participants would not tell others or would only tell certain people. Their reasons why were: they do not want people feeling sorry for them, do not

think others would understand, feel others would not be able to do anything to help, and would not want to be a burden on others or upset them. One participant did not indicate whether he would tell others, but from the researcher's observation during the interview, including his tendency to go off topic, fidgeting and lack of eye contact, it was thought that he would not inform others he was lonely. It was unclear if two of the other three participants would inform others and one participant would tell others she was lonely.

The mention of a potential stigma related to feelings of loneliness is identified in the literature by Fromm-Reichmann (1959), and Perlman and Joshi (1989). There are a number of possible explanations on why a stigma could be attached to loneliness. First, when the researcher was talking to seniors (that did not participate in the study) they felt that individuals are in control of their lives, that loneliness can be prevented, and people can choose to be social or not. Perlman and Joshi (1989) offer the explanation that lonely individuals are viewed as ". . . deviant, as someone who is spoiled or generally undesirable" (p. 65). These explanations do not consider that loneliness can be divided into the categories of emotional and social loneliness and that when a person experiences the death of a spouse, socialisation may not relieve the emotional aspects. Fromm-Reichmann believed that it is an experience too difficult to deal with and people would prefer to distance themselves from it.

The intent of this study was not to focus on differences in the experience of loneliness among males and females, yet some were found. Rokach and Brock (1997b) identify similar results to this study, in the differences in the experience of loneliness for females and males. Males largely identified feelings of social isolation and alienation; females experienced loneliness in more of an emotional manner such as severe pain. Perhaps females experience loneliness differently than males because they are often the attachment figure who provides the sense of security and support, and once their spouses are gone, those feeling are lost. It is also possible that females are willing to talk about the experience of loneliness more in terms of their feelings than males tend to.

The loneliness experience influenced participants' quality of life in a negative manner most of the time. For some, loneliness was so unpleasant that they felt life did not seem worth living, and they used the words "depressed" and "depressing" when

describing their feelings. It seems safe to presume that there were occasions that participants were depressed as well as lonely. Some of the characteristic of loneliness described by the seniors are similar to the common traits for depression, but whether the seniors themselves would consider themselves depressed or not was not explored. Those who experience loneliness may be at risk of suffering from depression according to Adams, Sanders, and Auth (2004). Chou and Chi (2005) identified a significant relationship between loneliness and depression in their sample of seniors 60 years of age and old. Seniors, like most people, need to feel cared about and have somebody to share their lives. Seniors who are lonely and are not able to make the necessary adjustments to their life could be more likely to experience depression than those seniors who can cope or manage their loneliness. It is understandable that following the death of a spouse a person would experience loneliness and possibly some depression, but for what length of time would this be considered normal? Seniors themselves and those who work with them need to be aware of the potential negative impacts of loneliness and depression. It is unclear if loneliness is a descriptor of depression, or a possible cause, or if it can even be examined in isolation. Nonetheless, depression has been associated with decline in cognition, functioning, mobility, and institutionalisation (Stek, Gussekloo, Beekman, van Tilburg, & Westendorp, 2004), which contributes to the potential for lonely seniors to experience serious mental or physical health problem.

Participants indicated that loneliness interfered with their daily functioning. Wylie, Copeman, and Kirk (1999) found similar results among a group of widowed seniors who were lonely. Seniors in the current study who stated loneliness interfered with their meal preparation and/or consumption were all females. Preparing meals could have been a role for these females in their marriages, and having to cook only for themselves now could be a reminder of what is missing in their life. Poor appetite and sleep disturbances are also signs of depression. Lack of sleep and poor nutrition can lead to physical and mental health issues for seniors. Russell, Curtrone, de la Mora and Wallace (1997) established that high levels of loneliness increase seniors chance of being admitted to a nursing home. This could be due to failing health as a result of lonely seniors not caring for themselves appropriately.

Participants identified various strategies used to cope with and avoid feelings of loneliness. Rokach and Brock (1998) identified six methods used to cope with loneliness among their sample of 13-79 year olds, only two of which were found in the present study: increasing activity and social involvement. Seniors indicated that they distracted themselves from feeling lonely by reading, exercising and baking. These activities assisted seniors in not thinking about loneliness or things that caused them to become lonely. Coping through increased social involvement was described by being around and/or talking with others, which was accomplished by participating in activities such as volunteering, talking on the phone, and becoming involved in local organizations. Contact by phone is better than no contact with friends and family. Drageset (2004) found that telephone calls decreased levels of loneliness. One participant stated she would go crazy if she did not have the phone service she had; however, most seniors desired greater physical contact. Participants indicated they enjoyed volunteering because they were around others, but also because helping others made them feel good and useful. When seniors are lonely and experiencing the low feelings that accompany loneliness, it can be important that they have a sense value by others, and volunteering can assist in instilling this.

Religion is beneficial in dealing with loneliness (Walton, Shultz, Beck, & Walls, 1991). Two seniors described how their belief in God helped them deal with their loneliness. One participant felt that God had put her in this position and expected her to deal with it, which helped to her cope with loneliness at times when she strongly missed her husband. Religious and spiritual beliefs can help some seniors deal with loneliness; if they feel the death of a spouse and friends happened for a reason and/or that they are in a better place, it can ease their suffering. Religious organizations can be great places for providing emotional support and opportunities for individuals to socialise. Religious facilities, such as churches, can offer a safe environment to get to know people with a similar interest.

Many participants identified dissatisfaction with the lack of a current relationship with friends; therefore, a Friendship type program may be an effective intervention in decreasing feelings of loneliness for seniors. Stevens and van Tilburg (2000) found that

an educational program could decrease loneliness among seniors by teaching them methods to strengthen existing friendships and create new ones. This type of intervention may be ideal in assisting those seniors with low self-esteem or those who feel they have inadequate social skills. Such a program may provide them with the knowledge skills and characteristics necessary for making and maintaining friends. This type of program would also put them in contact with people with similar goals and provide them with an environment to use what they have learned.

Andrews et al. (2003) identified that a befriending program in which volunteers went to the homes of seniors to visit decreased feelings of loneliness. This approach may be beneficial for lonely seniors who are unable or find it difficult to leave their homes due to health or mobility concerns. This type of program would be a great opportunity for lonely seniors who are mobile and want to get out and help other seniors. Seniors helping others of a similar age may be beneficial due to the increased likelihood of having more in common than with those of younger age groups.

Another approach to assist seniors to deal with loneliness is support groups, Stewart et al. (2001) found them to decrease feelings of loneliness in their study of widows. Support groups could be a valuable intervention for many seniors if they are connected with the appropriate groups, such as a support group for widows. If lonely seniors do not want to tell others they are lonely, then it may be difficult to find out about available resources. Since there is a possibility that men and women experience loneliness differently, similar interventions may not be beneficial for men. Women may like support groups where they can talk about their feelings, whereas men may not want to discuss their feelings but would rather find methods to distract themselves from feelings of loneliness.

Study limitations

When interpreting the findings of this study, there are limitations that must be considered. One common occurrence evident in the interviews with participants was a difficulty in describing their experience(s), which made it challenging to obtain detailed descriptions. An additional limitation was that one participant spoke English as a second language and had trouble finding the English word she desired to describe her experience.

There were also small portions of her interview that were not clear and could not be transcribed accurately. Having inaccurate and unclear transcripts may have influenced the researcher's interpretation of this participant's loneliness experience.

Another limitation was that one of the participants indicated he was not currently experiencing loneliness, yet in the researcher's screening he stated he was. Another participant indicated after the screening that he only experienced occasional brief periods of loneliness. Therefore, the experiences of loneliness for these two participants may not have been as clear in their minds as it would be if they were currently lonely, possibly limiting the detail they provided in their descriptions. Furthermore, three of the participants decided not to participate in the second interview. Two of these participants were among the first to be interviewed. Given the lack of experience on conducting qualitative interviews by the researcher the first interviews contained limited detail and depth resulting in many unanswered questions. Not being able to conduct the second interview with participants resulted in the inability of the researcher to review identified themes and obtain clarification on certain points with them.

Lastly, due to the researcher being a novice in qualitative research, the depth and detail of information obtained on seniors' loneliness may have been restricted. With the use of additional probing questions, further information might have been obtained on participants' experiences. Another factor that may have influenced data obtained from the interviews was that the researcher asked more than one question at once, resulting in only one of the questions being addressed by participants. The use of more open-ended questions and less closed questions would have been beneficial in attaining greater detailed responses. However, this factor was identified early and addressed.

CHAPTER FOUR: A POSSIBLE DESITNATION

The previous chapter discussed the findings and limitations of this study. This chapter will review some future recommendations for research and the implications for nursing. The final section of this chapter will review how this study has influenced the researcher.

Recommendations for future research

This section will address recommendations for future research on loneliness in seniors. There are numerous questions that require further qualitative research. In this study, it was clear that the relationships seniors had with others influenced feelings of loneliness. Qualitative research on the types of relationship/social supports and their qualities and their role in loneliness can clarify the value of certain supports for those who work with seniors. Research questions should also ask how the support of family and friends assist seniors in managing or preventing loneliness.

The majority of the seniors in this study coped with their loneliness without assistance or intervention from health care providers. They coped by keeping themselves distracted and occupied at times in social settings and at other times alone. Additional information is needed on why seniors do not seek help for their loneliness from health care professionals and what they think could be done to assist them through this unpleasant experience. A qualitative study asking this research question would be helpful, especially with regard to why seniors will or will not seek assistance for their loneliness. Greater research is required on interventions for seniors, and on what programs have been successful in assisting them deal with their loneliness. This knowledge could assist health care professionals with the implementation and recommendation of interventions that have been beneficial for others.

The length of time participants had been experiencing loneliness varied. Further research exploring how the experience of loneliness differs for those who have recently become and those who have been lonely for a long period of time would be beneficial. This knowledge could inform health care professionals if there is any difference in how loneliness is experienced and why some seniors remain lonely and others do not. A research question that could address this might be, how is the experience of loneliness

influenced by time? Due to the subjective nature of loneliness, greater qualitative research on this topic among seniors would provide a better understanding of this complex and multidimensional phenomenon. North America is full of multicultural societies, and a better understanding of the experience of loneliness and how it is coped with among various cultures would be of great value for health care professionals. Some possible research questions on culture could be, what is the experience of loneliness for seniors of various cultures? How does culture influence the coping strategies of lonely seniors?

Some researchers have identified gender as an influence on the loneliness experience, and in this study only two men participated. Why is that? Is it because males do not want to talk about their loneliness? It would be beneficial if there were further research on the influence of gender on the experience of loneliness. A future study could ask, how does gender shape the experience of loneliness and how it is coped with?

Implications and recommendations for nursing

Nurses work in various settings with this population and are in an optimal position to assess for loneliness and assist seniors who already experience it. This section will discuss implication and recommendations for nursing practice and education.

The structure of the environment can influence loneliness in seniors. Registered Nurses work with families regarding decisions to relocate and careful consideration must be taken when determining when and where to relocate seniors because the negative implications on their mental health may out weight the positive. Whenever possible, seniors should be as involved in the decision of when and where to move; this may prevent them from feeling as if they have no control over what happens in their lives. In a study by Reinardy and Kane (1999) on decision making regarding moving to a nursing home or adult foster home with participants aged 75- 84 years old, those who felt their relocation was good were more likely to believe they had control over whether to move or not. When conducting their study on relocation among older women, Rossen and Knafl (2003) found those who viewed their move as voluntary reported being content and had greater social participation than those who were forced to move. Personal autonomy is an important aspect in quality of life for seniors (Mowad, 2004), and they should feel

the relocation is necessary. To assist in the prevention of loneliness, it is beneficial if seniors feel comfortable in their places of residence and that it provides opportunities for socialisation.

Reduced hearing can lead to poor communication and feelings of loneliness in this population. Seniors should be encouraged to have regular hearing checkups and wear hearing aids that work. It is also beneficial if social environments contain as little background noise as possible for those who do wear hearing devices. It is important for Registered Nurses to recognize that health issues that influence communication abilities such as Alzheimer's disease may contribute to loneliness in seniors and their spouses. If nurses are aware of this possibility, then they can assess and help those in this type of position.

This study demonstrates that there are commonalities in how loneliness is experienced in seniors, but there are also unique aspects to their experiences; therefore, nurses need to be encouraged to listen to each individual's story. In this study, the triggers for loneliness were related to a lack of the desired quality or quantity of relationships often due to the death of a spouse. Registered Nurses who work in hospitals and hospices may be able to provide information on support groups for those seniors they are working with who have recently lost a spouse. Support groups may provide seniors with the support they need to feel like they are not alone, provide an atmosphere that facilitates coping and where new friendships could be developed, which will potentially decrease or prevent feelings of loneliness that accompany the recent loss of a spouse.

The recognition and identification of loneliness can be difficult because some seniors will not inform others, including their families, about how they are feeling. They may hesitate on informing their families they are lonely because some do not want to become a burden on them, or they do not think family members will be able to do anything to help them. This leaves Registered Nurses with the tasks of recognizing, assessing, and assisting seniors who are lonely. If they can build a rapport with seniors, those who are lonely might open up to them, putting nurses in an optimal position to inform seniors that they are not alone and that others experience loneliness as well, and there is no reason to feel guilty about or hide what they are going through. The more

seniors understand this, the more likely they will be willing to talk about their loneliness, which will increase opportunities for Registered Nurses to help.

Currently, there are tools and questionnaires on loneliness used for research; however, their use and appropriateness for Registered Nurses in practice is unclear and requires further exploration. This may be one reason why assessment of loneliness is not currently common practice among most Registered Nurses. If they feel that they are working with a senior who may be lonely or even those who seem sad and down, they could simply ask them "are you lonely?" or "do you get lonely often?" If Registered Nurses attempt to understand the individual experiences of seniors, they can communicate that they genuinely care about the client. This is the groundwork to facilitate the building of a good rapport with seniors. If seniors feel that those working with them genuinely care about them, they may be more willing to open up to them, share their experiences, and accept help, such as recommendations and health education. The more Registered Nurses know about their clients, the better equipped they will be to provide quality care for them.

For Registered Nurses who work with seniors in the community, such as Home Care, when screening for loneliness it is important for them to assess seniors' social supports, what these supports offer, and their levels of satisfaction with them. Understanding the client's social support can help determine the type of intervention necessary to possibly prevent loneliness or help seniors cope with it. It is important for Registered Nurses to encourage lonely seniors to be socially active. This will facilitate physical and psychological health. Exercise groups, if they are not contraindicated, are a great way for seniors to be physically active in a social environment. Seniors who are socially involved may cope with loneliness better if they feel socially connected.

For Registered Nurses who work in all settings, it is beneficial to be aware of the methods of coping that can assist seniors in deal with loneliness but to also recognize what is effective for one person may not be for another. By possessing knowledge on interventions and understanding coping methods, a Registered Nurse's recommendations can be made to others struggling with loneliness. If appropriate, Registered Nurses can assist seniors with where to go to volunteer, how to participate in local organizations, and

exercise groups. Community based Registered Nurses can facilitate and empower seniors who are lonely to start support groups or recreation groups, like bridge clubs. It is helpful if Nurses can assist these types of groups to get started, but it is important for seniors to organize and run them so they feel a sense of ownership and accomplishment. This sense of ownership in things can boost the self-confidence and self-efficacy of the seniors contributing to them feeling valued and useful.

From personal experience and informal discussion with University instructors in nursing, it is apparent that formal education for undergraduate nurses on loneliness among seniors is insufficient. There is a need for the topic of loneliness in this population to be incorporated into current undergraduate nursing curricula. Depression is a topic that is frequently addressed in the mental health section in undergraduate nursing curriculum. Loneliness has been identified in the literature as a correlate of depression; therefore, these topics could be addressed together. However, it is important that these topics be discussed in relation to seniors because loneliness does not always influence this population the same and it is not necessarily experienced, manifested, or dealt with in the same ways as individuals in different age groups. If nursing students are educated on how to identify and assess loneliness as well as the potentially negative effects it has on seniors, they can be prepared to provide support and assist those dealing with it.

Today's Registered Nurses can often be overwhelmed by their workload, but to provide holistic care it is necessary to attempt to understand the experiences of the client. Listening to seniors' stories, being educated on the experience of loneliness for seniors, and reviewing current research on this phenomenon will help Registered Nurses understand what clients are going through, the potential triggers, how loneliness influences their lives, coping strategies, and interventions. Knowledge on loneliness, can better prepare Registered Nurses to identify and provide care for those who are or may be lonely.

For Registered Nurses who work with this population, it is vital that they inform those they are working with that it is a partnership that focuses on the goals and objectives seniors have set. If seniors feel like they are in control regarding decisions concerning their health, they may be motivated to make positive choices.

The researcher's journey

The first research project a person conducts will often change him or her in many ways. In this section, I will review many ways this research project has influenced me and what I have learned as a researcher, a nurse, and a person. This being my first research project, there are obviously some things I would do differently the next time. For instance, when recruiting participants, I would use a few methods and try to reach as many individuals in my target population as possible. In this study, I initially only used the Seniors Resource Nurses when I should have also included Home Care Nurses, Outpatient Clinics, and Day Programs. This decision to later access these areas to assist with recruitment lengthened the time of the research process because the ethics board needed to approve this change prior to me involving these areas.

One aspect of doing qualitative research that was more difficult than I had anticipated was the interviewing. Prior to doing qualitative interviewing again, I would practice conducting the interviews more; the more a person does them, they will likely become better. It is easy to read how to do interviews, but when it comes to actually doing them, it is not that easy. During unstructured qualitative interviews, you need to be very attentive to a number of factors including what participants' say, how they say it, including their word usage, and their body language. These factors will influence subsequent questions you will ask participants. If you can go into an interview with the thought that you know absolutely nothing at all concerning the topic except what you have learned from the previous interview(s), then the information obtained may be detailed and unbiased because questions generated by the researcher will encourage the participants to provide detailed responses.

Choosing to conduct this study using a phenomenological method was initially a good decision. As a researcher, it is beneficial to be aware of your strengths and weakness prior to conducting a study. Initially I intended to conduct a phenomenological study, but when it came to analysing the data, my ability to reflect at the depth that a good phenomenological analysis requires was difficult. Describing the experience in a manner that a good phenomenological description requires according to van Manen (2003), may have been beyond my current writing capabilities.

As a nurse, my practice will never be the same as it was prior to conducting this research. Conducting this study has taught me how to listen to what seniors are saying and not to assume I know how an experience influences them. As a nurse, I have learned that an experience will have some similar meanings for one person as others, but also some very different meanings. The meaning of an experience is important for me to understand in order to provide the best nursing care I possible can for individuals. In nursing, I learn from previous experiences, but I will think twice before I make assumptions about what I may believe patients/clients need or desire and recognize they make decisions in their lives based on the meaning of their experiences. When working with seniors, I now consider how van Manen's (2003) four life existentials (Spaciality, relationality, temporality, and corporeality) influence their health, lives, and my practice.

I have experienced personal growth throughout this research process as well. My way of thinking has evolved. I often find myself unconsciously thinking about how van Manen's (2003) existentials influence and shape the meaning of my life and those around me. After listening to myself on the transcribed interviews, I am now acutely aware of some areas in my verbal communications and certain things I frequently say that I was not conscious of. Writing has never been one of my strengths; however, due to the extensive writing required during this research project it has improved.

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APPENDIX A

UNIVERSITY OF CALGARY

CONSENT FORM

TITLE:
A Phenomenological Exploration of the Lived Experience of Loneliness in Seniors.

INVESTIGATORS: Principal Investigator: Sandra P. Hirst, PhD, GNC (C);
Student Researcher: Stacy Landa, BN

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

This study is to help the researchers and other health professionals learn more about seniors' experiences of living with loneliness and the meaning of those experiences. Six to ten seniors living in the community who are lonely or who have experienced loneliness in the past 4- 6 weeks will be interviewed to assist the researcher in developing a better understanding of the experience of loneliness for seniors. Interviews will be conducted at participants' houses or other locations convenient for them.

WHAT IS THE PURPOSE OF THE STUDY?

There is currently a limited amount of qualitative research available on this topic. Therefore, the purpose of this study is to gain a better understanding of the day-to-day experience of living with loneliness for seniors. With an increased understanding of this experience, the researchers, nurses, and other health care providers can provide better care for lonely seniors.

WHAT WOULD I HAVE TO DO?

If you consent to take part in the study, the researcher will make arrangements to do two interviews with you. In the first interview you will describe your experience of loneliness. The second interview will be more in the form of a conversation that will focus on the researcher's analysis of your experience, its meanings and any clarification or elaboration that may be needed. The interviews will last about thirty minutes to an hour and, with your permission, the interviews will be audio recorded. The audio-recorded interviews will be typed out for analysis. This is called transcription.

WHAT ARE THE RISKS?

There is a possibility that the interviews may create some feelings of emotional distress, causing you to become upset during the interview. If you wish at that time, the researcher will give you the opportunity to stop the interview. The researcher will also provide you with a sheet containing contact information on the available resources you can phone to discuss your feelings, if you choose. The researcher will strive to protect your anonymity by using a false name instead of your real name in all written material. However, there is some risk that others reading the final written document of the study, for example Seniors Resource Nurses, may recognize you by the information that you provide.

WILL I BENEFIT IF I TAKE PART?

This study may or may not have a direct effect on you. By participating in this study it could help nurses and health care workers enhance their understanding of loneliness in seniors and assist in improving the care provided for lonely seniors.

DO I HAVE TO PARTICIPATE?

Your participation in this study is voluntary and you may withdraw at anytime without any risk to your health care. To withdraw, all you have to do is inform the researcher that you no longer wish to take part in the study. If any new information becomes available that might affect your willingness to participate in the study, you will be informed as soon as possible. If you choose to withdraw during the study, the information you have provided will be not be used and will be destroyed if you wish.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?

You will not be paid to participate in this study, nor will you have to pay for anything as a condition of, or because of participating in this study.

WILL MY RECORDS BE KEPT PRIVATE?

The researcher will keep your name, phone number, audio-recorded interviews, and notes in a locked office drawer that no one other than the researcher will have access to. To ensure confidentiality, your name will not be identified on the audio-recorded interviews or written documents.

All raw and sensitive data (tapes, signed consent forms, phone numbers, and any related notes) will be destroyed two years after the study ends. The University of Calgary Conjoint Health Research Ethics Board will have access to the records kept for this study.

IF I SUFFER A RESEARCH-RELATED INJURY, WILL I BE COMPENSATED?

In the event that you suffer injury as a result of participating in this research, no compensation will be provided to you by the University of Calgary, the Calgary Health Region, or the Researchers. You still have all your legal rights. Nothing said in this consent form alters your right to seek damages.

SIGNATURES

Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a subject. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time without jeopardizing your health care. If you have further questions concerning matters related to this research, please contact:

Dr. Sandra P.
(Principal Investigator and Supervisor)

Or

Stacy Landa
(Student Researcher)

If you have any questions concerning your rights as a possible participant in this research, please contact the Associate Director, Internal Awards, Research Services of the University of Calgary.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

APPENDIX B

INFORMATION SHEET

A search for understanding

INTRODUCTION

My name is Stacy Landa and I am a student in the Faculty of Nursing, at the University of Calgary. I am doing a study on seniors' loneliness as part of my Masters Degree. This study will help me, and other health professionals, to learn what it is like to be lonely. A deeper understanding will help us to give better service to seniors.

WHAT IS INVOLVED

I would like to talk with six to ten seniors who are lonely or have had periods of loneliness in the last week. I would talk with you 2 times, for about 30 to 60 minutes each time. The interviews can be done in your home at your convenience or at another arranged location. The interview would focus on your experiences of loneliness. Your conversation will remain confidential and your name will not be attached to any information we discuss.

I would be grateful if you could help with this study. If you are interested, please call me to book an appointment or to ask for more information.

Sincerely,

Stacy Landa

APPENDIX C

Research interview questions

Demographics

1. Age.
2. Gender.
3. Marital status. For how long?
4. Do you live alone? If yes, for how long? If no, then who do you live with? Type of housing:
5. Number of children? How often do you see them?
6. Education level.
7. How often do you see your friends?

Questions on the experience of loneliness

These are examples of possible interview questions, which are subject to revision throughout the data collection process. To provide some initial consistence all participants will be encouraged to share their own stories of loneliness.

8. Please describe your experience of loneliness.
9. Please describe a specific time when you were lonely.
10. Please describe your feelings and emotions during a time when you were lonely.
11. Please describe your relationships with others in relation to your experience with loneliness.
12. Please describe what it is like for you when you are not lonely.

APPENDIX D

FACULTY OF
MEDICINE

UNIVERSITY OF
CALGARY

2005-05-09

**OFFICE OF
MEDICAL BIOETHICS**

Dr. S. Hirst
Faculty of Nursing
University of Calgary
PP 2294
Calgary, Alberta

Room 93, Heritage Medical Research Bldg
3330 Hospital Drive NW
Calgary, AB,Canada T2N 4N1
Telephone: (403) 220-7990
Fax: (403) 283-8524
Email: omb~ucalgary.ca

Dear Dr. Hirst:

RE: A Phenomenological Exploration of the Lived Experience of Loneliness in Seniors

Grant ID: 18412
Student: Stacy, Landa

The above-noted thesis proposal, Consent Form, Information Sheet, Research Interview Questions, and Contact Numbers have been granted ethical approval by the Conjoint Health Research Ethics Board of the Faculties of Medicine, Nursing and Kinesiology, University of Calgary, and the Affiliated Teaching Institutions. The Board conforms to the Tn-Council Guidelines, ICE! Guidelines and amendments to regulations of the Food and Drug Act re clinical trials, including membership and requirements for a quorum.

Please note that this approval is subject to the following conditions:

(I) access to personal identifiable health information was not requested in this submission;

(2) a copy of the informed consent form must have been given to each research subject, if required for this study;

(3) a Progress Report must be submitted by 2006-05-09 containing the following information:

i. the number of subjects recruited;
ii. a description of any protocol modification;
iii. any unusual and/or severe complications, adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, or complaints about the research;
iv. a summary of any recent literature, finding, or other relevant information, especially information about risks associated with the research;
v. a copy of the current informed consent form;
vi. the expected date of termination of this project.

(4) a Final Report must be submitted at the termination of the project.

Please note that you have been named as a principal collaborator on this study because students are not permitted to serve as principal investigators. Please accept the Board's best wishes for success in your research.

Yours sincerely,

Christopher J. Doig, MD, MSc, FRCPC

Chair, Conjoint Health Research Ethics Board

CJD/km

c.c. Adult Research Committee Dr. S. Evans (information) Research Services

Stacy Landa (Student)