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SOCIAL ISOLATION AND QUALITY OF LIFE IN AN ELDERLY CARE INSTITUTION



ABSTRACT

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The purpose was to identify and deepen the knowledge of elderly social isolation, loneliness and what it means to quality of life in care institutions. Reliable research done previously on this theme formulated the basis of this study. A nursing home was the working life partner and the professionals at the facility participated in the study through interviews. Set criteria were used to select participants at the working life partner. The criteria for selecting the participants aimed at those that would give as much information as possible. The participants selected were permanent workers who had worked at the institution for a prolonged period of time. Good command in English and Finnish languages was also a factor.

This is a qualitative research and data was collected through interviews. The data was analyzed with content analysis. The study reviewed whether social isolation and loneliness in the elderly affects health, quality of life, mortality and whether it increases the risk of long term institutionalization. The study found that social isolation and loneliness are linked to higher risk to a variety of physical and mental conditions.

The study reviewed the framework for social isolation and loneliness interventions in elderly care institutions. Promising approaches were identified that addressed three key challenges: Reaching lonely individuals, understanding the nature of an individual's loneliness and developing personalized response and supporting lonely individuals to access appropriate services.

The findings of the study found similarities with various researches done that connects loneliness, chronic medical conditions, demographic socioeconomic factors and the risk of long term admission into institutional care.

Keywords: Social Isolation, Quality of life, Elderly care institution, social work with elderly people

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1 INTRODUCTION

Social isolation and loneliness in the elderly exacerbates the risk of poor health and quality of life. Later life is often a time of changes in roles, abilities and change in physical and social environment. Social isolation can be part of this stage in life, an experience that negatively affects health and quality of life. Social isolation is low quantity and quality of contact with others and has been defined as diminished social connectedness in terms of the quality, type, frequency, and emotional satisfaction of social ties (Elder & Retrum, 2012).

Social isolation is estimated to affect more than 40% of seniors on regular basis. The elderly who are socially isolated are more likely to experience poor physical and mental health. Figures published by statistics Finland show that 950,000 Finns aged 16 or older (21.2 %) suffer loneliness. Those aged 75 or older were loneliest, as 7.3 % of them were lonely all the time or most of the time and around 28.7 percent were lonely at least some of the time.

Understanding the factors that influence how the elderly in care institution become and or remain isolated is the key. The factors include and are not limited to: being age 80 or older, an elderly having compromised health status that may include having multiple chronic health problems, having no children or contact with family and changing family structures, for example migrating children leaving seniors behind. Critical life transitions such as death of spouse or family member, late onset or age related disabling conditions such as incontinence or fear of falling are factors that also influence social isolation. Shifts in society, for example, immigration where by the elders in care institutions are looked after by professionals from different cultures are also determinant factors.

Seniors at high risk of social isolation includes the elderly with physical or mental conditions including Alzheimer's or other related dementia, multiple chronic illnesses and immigrant seniors as well as lesbians, gay, bisexual or transgendered seniors. Social isolation in an elderly care institution can cause negative health behaviors such as smoking, being sedentary, drinking

and not eating well. It has also being connected to cause reduced social skills, increased risk of developing low esteem and lack of confidence, psychological and cognitive health effects associated with higher levels of depression and anxiety which have an impact in the elderly quality of life.

Various factors can help to prevent or reduce social isolation. Ageism is stereotyping and discrimination against individuals or groups on the basis of their age. This may be casual or systematic. There is a need to dispel myths associated with aging. These are stereotypes that portray the elderly as either weak or frail, which consequently cause discriminatory practices against the elderly. The elderly themselves can be deeply ageist due to fear of death and fear of disability and dependence. Ageism in elderly institution is the major cause of institutional practices and policies that perpetuate stereotypes about elderly people. It causes avoiding, segregating and rejecting elderly people. The prejudice cause people to assume that the elderly should behave in a certain way because of their age, denies them certain rights and cause people to ignore their ideas.

Promotion of healthy aging in the elderly is also an important factor in curbing social isolation. Health is a determinant for social isolation and therefore there are benefits from promoting active and healthy aging. Physical activity, eating well, healthy body weight, not smoking, stress reduction and good sleeping habits are among the healthy habits that reduce the risk of social isolation. Programs designed to connect individuals and family affected by Alzheimer or dementia with support as soon as possible after diagnosis may prevent or reduce chances of social isolation of an elderly in care institution. Social isolation and loneliness are also predictors of mortality from coronary heart diseases and stroke.

2 THE AIM AND PURPOSE OF THE STUDY

The aim of this thesis is to deepen the knowledge on social isolation and quality of life in elderly care institution.

The purpose is to describe social isolation and quality of life among the elderly in care institutions

In my thesis, the research questions are following:

1. What is the meaning of social isolation and loneliness on health and quality of life?
2. What aspects could improve the quality of life for elderly in care institution?

3 BACKGROUND OF THE STUDY

A research made in the United Kingdom (UK) as a campaign to end loneliness explored the concept of social isolation and its impact on quality of life in the elderly. The research meant to increase and develop the evidence based on the issue of loneliness in elderly. The research identified loneliness in the UK as a new epidemic among the elderly. Murayama et al. (2011) identified social isolation among the elderly in Japan a new crisis, where 23.1% of the population is aged 65 years and over. Holt-Lunstand, (2015) has made connections to the effects in health by social isolation and loneliness being equivalent to smoking 15 cigarettes a day. Social networks and friendships not only have an impact on reducing the risk of mortality or developing certain diseases, but they also help individuals to recover when they do fall ill (Marmot, 2010).

Clifford, (2018) identified a relationship to social network, perceived isolation, health and mortality. From a methodological perspective, the study assumes that health status contributes to one's ability to be socially engaged. Health status can therefore contribute to loneliness and isolation, as a result, creating a "cause and effect" dilemma when defining the relationship between loneliness, social isolation, health and mortality

According to Hawkey & Capitanio (2015), adverse effects on health from loneliness are seen at every stage of the lifecycle. However the elderly are at particular risk for loneliness and the health consequences of loneliness.

In a questionnaire study conducted in Finland, involving a large number of older adults in Finland, 39% suffered from loneliness, at least some of the times, while 5 % often always. In the study, loneliness was statistically associated with several demographic variables; illnesses, loss of spouse, lack of friends and poor health status (Savikko et al., 2005).

A study by (Cacioppo & Cacioppo 2014) found loneliness to be associated with ill health to a greater degree than just social isolation. Social disconnectedness and perceived isolation were two elements of social isolation that were examined independently on both physical and mental health. Greater

relationship between ill health and loneliness was shown including cardiovascular diseases, inflammation, and depression, than social isolation itself. Loneliness in elderly was shown to significantly increase risk of functional decline and death in a recent cohort study of 1604 conducted over six years period. 43 % of the cohort reported loneliness and they were at high risk for both functional decline and death (Perissinotto et al., 2012).

On the other hand, other investigators have found social isolation on itself to be a risk factor for ill health. Holt- Lunstad (2015) found a 29% increased risk of mortality over time from social isolation and 26 % increased in mortality risk from loneliness. An increased risk of 32% was observed from just living alone, independent of social isolation. "Aloneness" was therefore seen to be at least as strong, if not stronger influence on health. This finding was counter- intuitive, in that the stress of loneliness would be assumed a driving factor for ill health, yet aloneness was just as significant if not more.

Stephoe et al. (2013) investigated whether the health impact of social isolation was caused by loneliness in a study of 6500 men and women participants in a longitudinal study of aging. They quantified contact with family, friends and community organizations and administered loneliness questionnaires. They monitored mortality for an average of 7.25 years per subject. After adjusting for demographic variables, social isolation was seen to increase mortality whereas loneliness did not. The subjects with least social contact had an even higher risk. Loneliness in this study was associated with high baseline levels of depression, arthritis, and mobility impairment than the social isolation without loneliness cohort. After baseline health variables were factored out, loneliness cohort was factored to not have as high mortality rate. In actual fact, both social isolation and loneliness are associated with increased mortality rates (Stephoe et al.2013).

The comparability of social isolation and loneliness remains unclear in regards to their impact. However, the evidence seems to lean towards the conclusion that they both pose risks to health. In a study conducted by Valtorta et al. (2016) whereby a meta-analysis of 11 cardiac and eight strokes subjects were studied, social isolation and loneliness were associated with a

29% increase in coronary heart disease and 32% increase in stroke risk. This was comparable to the risk of obesity and lack of physical activity.

The aim of the literature review is to provide this study with background information about the topic. Literature review is a process of identifying, reviewing and compiling relevant information to a study from past academic literature. A systematic literature search is done and conducted on various key words; social isolation, quality of life, care institutions, and elderly social work. Subsequently, selection of abstracts will be performed based on relevant of titles to the topic (Kumar, 2014).

4 KEY CONCEPTS

Concepts are research associated terms that play important roles in a specific work, defining the central idea of a study from which other ideas generate from. In this study, the key concepts are social isolation, quality of life, elderly care institution and social work with elderly.

Loneliness has been portrayed as part of human condition. However, recognition of the significant adverse consequences to health has come more recently. In the year 2003 in Europe, the death rate rise of the elderly caused by high temperatures in that summer triggered much interest after it was linked with deaths of more than 40,000 elderly people. In proportion, fewer deaths were recorded among frail and the sick elderly people residing in institutions, in comparison to healthier but less supported people leaving in general population. The occurrence caused great discussion and reflections regarding the way elderly people are treated in the society (Valtorta, & Hanratty, 2012).

Following these death occurrences, Campaigns were started by non-profit organizations to address the issue of loneliness and isolation among the elderly. The campaigns and research from other disciplines linked social isolation and loneliness with adverse health outcomes and premature mortality.

Loneliness and social isolation are forever more increasing part of the experience of growing old. Social isolation and loneliness are two distinct concepts. An individual can be lonely without being socially isolated, or one can be socially isolated without feeling lonely. Reported rates from community studies in Europe have shown severe loneliness among adults aged 65 and over ranging from 2% and 16% while at any time up to 32% of individuals aged over 55 feel lonely (Robine, 2007).

Loneliness is believed to be a common experience in long term care. However, the prevalence of loneliness among institutionalized elderly is less well documented. One study conducted found that more than half of nursing

homes residents without cognitive impairment reported feeling lonely (Jansson, 2017)

4.1 Social isolation in Elderly care institution

Valtorta et al. (2015) noted that there is strong evidence that links social isolation and loneliness with poor health and that effort to reduce cardiovascular disease need to consider social interventions aimed at reducing isolation. While it might be too early to prove this claim, there are studies that have suggested increasing social networks can improve on health. Social engagement and social inclusion are key dimensions of current thinking concerning the promotion of quality of life in elderly. There is a strong and positive relationship between social participation and a high quality of life as demonstrated by research. Rowe and Kahn (1997) suggested that a high level of social engagement is a key factor in achieving the goal of successful aging. Rowe and Kahn furthermore argued that as an individual grows older, social context in combination with physical environment exerts a more potent influence upon the experience of aging than intrinsic genetic or biological factors (Walker, 2005; 100).

Given the importance of social environment to quality of life, there is concern to promote social engagement in the elderly that is evident in policy makers in such themes as social capital and social exclusion (Douglas 2017).

Social isolation and loneliness are among the predominant problems in the elderly care institutions in Finland: they have a negative impact on health and quality of life. Social interactions are vital in overcoming this ever growing problem of isolation. Social isolation could therefore refer as the separation of an individual from their family; a deficiency of healthy relationships with others or decreased involvement with society. On the other hand, loneliness is described as a negative feeling that can occur as a side effect of social isolation (Ellen, 2017).

People experience “aleness” in different ways. A person is considered socially isolated if they live alone, have less than monthly contact with friends or family, and do not belong to a social group. Some however, choose isolation

as preferred lifestyle. Some elderly on the other hand have isolation imposed on them through the death of loved ones, family and friends moving away, unfamiliar relocations, impaired mobility and other situations that lead to depleted social networks and isolation. People in these situations may be more likely to experience loneliness and feeling of isolation (Clifford, 2018).

More so, there are improved research instruments that definitely quantify social isolation and loneliness primarily in terms of number and frequency of social contacts. Furthermore social isolation in quantitative terms may not always be valid. Research, as well as our own experience, tells us that the quality of our social interactions, more than the number of our relationships, determines loneliness (Clifford, 2018).

It is important to note that lack of social interactions is not the only cause of loneliness. Elderly people living in group settings such as care institutions often experience the feeling of loneliness even though they are surrounded by others. Physical barriers such as loss of hearing, dementia and depression can all cause a resident to spend time away from others or exclude themselves from community activities (Ellen, 2017).

Social Isolation is precipitated by a number of factors. This includes living alone, health problems, disability and sensory impairments such as hearing loss. Other factors include major life events, for example a loss of spouse or death of aged siblings and friends. Other than the general feelings of sadness as well as loneliness, the impact of isolation and shrinking of social networks can lead to a variety of negative physical and emotional effects in the elderly (Snedeker, 2017). A study by Filipa et al. (2017) indicated that social isolation affect approximately one-third to half of the elderly population in the UK and it has a negative impact on their physical and mental health. Studies in different part of the globe have approached social isolation as a unidimensional concept and have defined it as the objective lack of adequate social contacts and interactions with family members, friends or the wider community. Other definitions have incorporated low quality as well as quantity of relationships.

To combat social isolation and loneliness in care institutions, it is crucial for the elderly people to feel as though they have a sense of purpose and are involved in a community. This consequently helps to avoid health issues caused by isolation and loneliness.

4.2 Quality of life in Elderly care institution

There are four broad domains identified by the World Health Organization (WHO) as universally relevant to the quality of life, namely physical, psychological health, social relationships and environment. The world health organization defined quality of life as including the individual's perception of his or her position in life in the context of the culture and value systems in which they live and in relation to goals. Gilhooly et al. (2002) defined quality of life as "what our chosen measures measure"

Mendole and Pelligrini (1997) defined quality of life as "the individual's achievement of a satisfactory social situation within the limits of perceived physical capacity". McGaha, (2019) stated that quality of life is defined by: personal feelings, details, outlook, and day to day experiences, how happy and positive one feels, how productive and desired, how healthy and free an individual considers themselves. Quality of life can also be defined as possession of resources necessary to the satisfaction of individuals' needs, wants and desires, participation in activities enabling personal development and self actualization, and satisfactory comparison between oneself and others. Quality of life has increasingly been defined in specific domains, for example, health related quality of life, as well as in relation to specific illness, for example, Asthma quality of life measure, and diabetes quality of life measures (McKee et al. 2002). A high proportion of quality of life measures consider a range of domains in life; health, employment, relationships, and environment. In this regard, it appears that the core notion of quality of life is one of degree satisfaction over all areas of life important for the individuals concerned (Walker, 2005; 18).

Blane et al. (2002) conceptualized quality of life as consisting of the satisfaction of needs in four areas; control, autonomy, self realization and pleasure.

Control was conceptualized as the need to be able to act freely in ones environment. Autonomy on the other hand is the need to be free from the undue interference of other. Self realization was conceptualized as the need for fulfillment of personal potential and pleasure as the need to enjoy oneself (Walker, 2005; 18-19).

Quality of life is a multi-dimensional collection of objective and subjective areas of life, the parts which can affect each other, as well as the sum. Elderly people accommodate to deteriorating health, family, social circumstances in order to feel good. Individual coping mechanisms are of relevance to perceptions of quality of life. Definitions and measurement of quality of life need therefore to include greater recognition of dynamic interplay between perceptions, personal characteristics, circumstances and surrounding social structures (Walker, 2005; 26).

The meaning and measurement of quality of life shifted away from the previously negative paradigm of old age which focused on ill health, functional decline and poverty towards a more positive view of old age as nature component of the life span. Old age is a period of life when individuals are freed from a number of structured social roles, for example, employment and the care of dependent children. The freedom to explore areas and activities which can provide personal fulfillment leads to new meanings for the term 'quality of life' in old age (Walker. 2005; 26).

There is a perception among policy makers in Finland which suggests that living in an institution is associated with lower quality of life than living in one's own home. While policy makers are probably right in assuming that people want to live in their homes as long as their health status permits them, the debate in regards to differences in quality of life while living at home in comparison to elderly institutions is not so straight forward. In Finland, municipalities have great autonomy in deciding which criteria to apply when admitting people to the institutions. Access to elderly homes residency is limited. It is therefore by no means clear that two individuals with the same limitations in functional status who live in different municipalities will be admitted to an institution at the same time. At any given time, there are elderly people wait-

ing for a place in an institution whose health is just as fragile as some of those living in institutions (Einiö, 2010).

There is a fundamental reason for argument that admission to an institution may actually increase an elderly quality of life. Elderly homes are subsidized through the tax system, which means that the elderly residents pay less than the true cost of living there (Einiö, 2010). It could therefore be argued that in the event of admission to an institution, the elderly may receive increased utility from the government subsidies. This consequently could improve the quality of life to the elderly, in regards to health and income controls. However, during the process of writing this thesis, identified disparities between provision of services and users' needs in elderly due to limited vacancies available in care institution and how this affects their quality of life.

4.3 Elderly care institution in Finland

This thesis study aimed to explore how institutional care influence social dynamics and the quality of life of the elderly residents in Finland. Elderly people, due to frail health have in most cases substantial difficulties living at home. In Finland, 12 % of people aged over 75 are in long term institutional care (Einiö, 2010). Elderly care institutions are formal institutions that range from assisted living facility, adult care, long term care, nursing homes, and hospice care. The main purpose of an elderly institution is to meet the physical, emotional and social needs of the residents.

Elderly institutions play a vital role in providing everyday routine to the elderly, rehabilitation support and guidance, recreations activities and health care needs. Their main purpose should be to secure and maintain functional abilities and general well-being of an elderly resident. The quality of long-term care services in elderly intuitions has a crucial effect on the quality of life of their users (Böckerman et al, 2011).

In Finland, the basic principle of long term care system is that it is publicly funded, universal system that is open to every citizen. The Finnish public administration system is consisted of three levels; state, province and muni-

cipality. Long term care services in Finland are governed by two main laws; Primary health care act 66/1972 and the social Welfare act 1301/2014 (MSAH, 2013). The designate the municipalities as responsible for the public sector provision of health care and social services, including long term care (Böckerman et al, 2011).

Once the needs of an elderly have being assessed, several forms of long term care are available in Finland. The forms of institutions can be classified according to the intensity and coverage of care (stake, 2006). The basic level of service is home based care. On the other hand, there is institutional care, provided both in nursing homes and in inpatient departments of health care centers. Entitlement to long care in Finland is based on domicile. If an individual is in need of long term care, he or she, relative or friends should contact the local municipality. Municipalities together with the elderly then decides on type of services that should be provided from that point onwards. (Böckerman et al 2011).

The determinants of why people in Finland become institutionalized are forever more expanding, including social economic factors, family dynamics, and other mental and physical conditions. On the other hand, factors vary into whether there are differences in the quality of life depending on whether an elderly individual is institutionalized or not, taking health and income at constant (Böckerman et al 2011). The first quantitative study regarding institutionalization in Finnish context deals with the effects of urge incontinence and other conditions on individual's probability of ending up in institutional care. (Nuotio et al., 2003) in a study of population based prospective survey that involved 366 man and 409 woman aged 60 years and over, urge incontinence was found to have an independent effect on institutionalization (Böckerman et al 2011).

A data base from the administrative registers was utilized by the University of Helsinki. The data consisted of a 40 % random sample of everybody residing in Finland aged 65 years and over. By using this data for analysis, it was found out that the probability of admission to long term institutionalized care is inversely associated with house hold income. Women belonging to the

lowest household income quintile are 35 % more likely to enter long term institutionalized care than those from the highest income quintile. The corresponding figure for men was 58 % (Böckerman et al 2011).

By utilizing the administrative register data, it was also indicated that dementia, Parkinson's disease, stroke, depressive symptoms, hip fracture and diabetes increased the risk of entering long institutionalization by 50 % or more (Böckerman et al 2011).

Nihtilä & Martikainen (2008) put into focus the risk of institutionalization after the death of a spouse. The results of the study showed that the risk of institutionalization was highest during the first month following the death of a spouse and then decreased over time. Elderly people living with a spouse were observed to be less likely to be institutionalized. Men who were living alone had a 70 % probability chance of institutionalization. The corresponding figure for women was 29 %. Having a spouse seemed to have a major role in preventing and delaying institutionalization among the elderly (Böckerman et al 2011).

5 SOCIAL WORK WITH ELDERLY PEOPLE

Social welfare for elderly people in Finland is made up of social and health services, and income security. The ministry of social affairs and health is responsible for the running of services for the elderly people. Municipalities are responsible for arranging the social and health services that the elderly people require (MSAH 2017-2019).

In 2019, the population of Finland at the end of September amounted to 5,525,487 people (Statistic Finland 2019). The population aged 65 or over amounted to 19.2 % of the total population (statistics Finland 2018). According to United Nations (2017), aging is a global phenomenon, and Europe has aged in advance of most regions of the world after Japan. Declining birth rates and high number of aging generation means that the balance of younger people and that of older people is tipping

Adjusting to old age and frailty that comes in later life is difficult for most people. Elderly individuals more often have to cope with a lot of changes and challenges in their lives, including health, economic and social issues. Geriatric social workers however, can help elderly individuals to adjust and cope with life changes that come with old age. They have the potential to make a difference. As defined by the international federation of Social Work (IFSW)

“Social work profession promotes social change, problem solving in human relationships and the empowerment and liberation of people to enhance well-being. Utilizing theories of human behavior and social system, social work intervenes at points where people interact with their environment. Furthermore, principles of human rights and social justice are fundamental to social work” (IFSW, 2014).

Exploring family and community support inevitably raises the key concerns about family structures, and also about the general arrangement to address

the needs of vulnerable elderly people. However, protecting vulnerable elderly people raises other issues concerned with the elderly people's rights to self-determination, and the balance between protection and interfering in people's privacy (Robert, 2011; 3, 4).

The point at which the role of a social worker begins and ends is determined by various social and political forces and the extent to which a social worker can do or not do to help a vulnerable elderly person is determined by what the law allows. For a social worker, deciding at what point to do things for elderly people is not a matter of individual social worker's choice or whim, rather a complex set of interwoven ideas about personal responsibility, the role of the state in welfare and also economic considerations. While answers to some problems are not determined by social workers as individuals, quite often how they carry out tasks influenced by their own beliefs towards these problems. The twentieth century has seen the transformation of social work from an activity based on charity to a period where social work became a major component of the welfare state. The extent to which the state feels under obligation to intervene depends, most importantly, on assumptions by policy makers about the general relationship between individuals and the state (Robert 2011; 3, 4).

It is important to understand the social policy dimension, along with the interwoven theories about the state and the individual. There are differences in-between social arrangements for protection of particular groups. Protection of children is given more weight and thus more state intervention than the protection of vulnerable elderly people. This policy also determines the extent to which services are available to promote the well-being of vulnerable elderly people (Robert, 2011; 4).

Provision of services to the elderly also inevitably relates to the financial resources made available, which depends on a series of political decisions in regards to fiscal policy. Various broad issues also have direct or indirect impact on social work practice in regards to elderly support. This includes; the role of the family and community, the economy and the individual, ageism and priorities as well as the role of the state (Robert, 2011; 4, 5, 6, 9, 11).

6 EFFECTS OF SOCIAL ISOLATION AND LONELINESS IN ELDERLY

Human beings are a social species; our biological, psychological and social systems thrive in collaborative networks of people. Social networks comprised of family, tribe, communities and other societal similarities enable the human species to survive and thrive. Some studies suggest that the impact of social isolation and loneliness on health and mortality are of the same order of magnitude as such risk factors as high blood pressure, obesity and smoking (Clifford, 2018).

Social isolation and loneliness is a common phenomenon in the elderly which has called for much more attention in clarifying for their adverse effects on health in old age. However, it is difficult to distinguish the effects of social isolation and loneliness on health when pre-existing health conditions such as immobility and depression can themselves both contribute to poor health as well as increase isolation and loneliness. It is also important to note that every individual social norm differs, not all who are isolated are lonely and not all who are lonely are alone.

The effects of social isolation and loneliness in the elderly on health are strong forces that have emerged in various studies. In a prospective study that was conducted over 4 year period looked at total mortality in a group of men. 511 of the deaths that occurred out of 32,624 of men sampled, socially isolated men had a 90 % increased risk of cardiovascular death and more than double the risk of death from an accident or suicide; they also had double risk of non fatal stroke (Clifford, 2018).

Loneliness signifies a break down in self-worth, connectedness, and belonging. The break down in the social self can take a toll in mental and physical health and wellbeing with the elderly. Loneliness has continued to exhibit a strong and prospective association with depressive symptoms in older age. Quality of sleep is also affected by feeling of loneliness in the elderly. Even though sleep duration does not differ between lonely and non lonely elderly

individuals, the same amount is however less restful in lonely elderly. These result in greater daytime fatigue and dysfunction (Louise et al, 2014).

Gow et al. (2013) found a significant association between loneliness intensity and general cognitive ability, processing speed and memory in a study cohort of 70 year olds. Loneliness contributes to cognitive decline and dementia which has a significant impact on quality of life and also contributes to individuals' further isolation from social networks. C.O' Luanaigh (2012) in a study of elderly with a mean age of 75 years, loneliness was associated with global impairments in cognition, independent of depression and social network integration. The study suggested that loneliness accelerates ageing effects. Loneliness was estimated to cause more rapid decline in cognitive performance and greater risk of Alzheimer's disease.

Lonely and socially isolated elderly account for poorer health and are at a greater risk for morbidity, mortality and high likelihood of being admitted to nursing homes. The severity of effects is linked to the frequency and duration of exposure to the feelings of loneliness. Chronic loneliness was associated with incidents of coronary heart disease in a 14 year follow up study of women in a national health and nutritional survey. Research showed that persistent aspects of loneliness predicted larger increases in blood pressure over a 4 year follow up period (Louise et al, 2014). Social isolation and loneliness affects cortisol regulations in the body which leads to inflammatory process that play a role in hypertension, atherosclerosis and many other chronic disease of aging (Louis & John 2014)

7 ELDERLY SOCIAL ISOLATION AND LONELINESS INTERVENTION

Social isolation and loneliness interventions identified in this study are those designed to tackle three key challenges: Reaching lonely elderly, understanding the nature of an elderly loneliness in order to develop a personalized response, and supporting lonely elderly to access appropriate services.

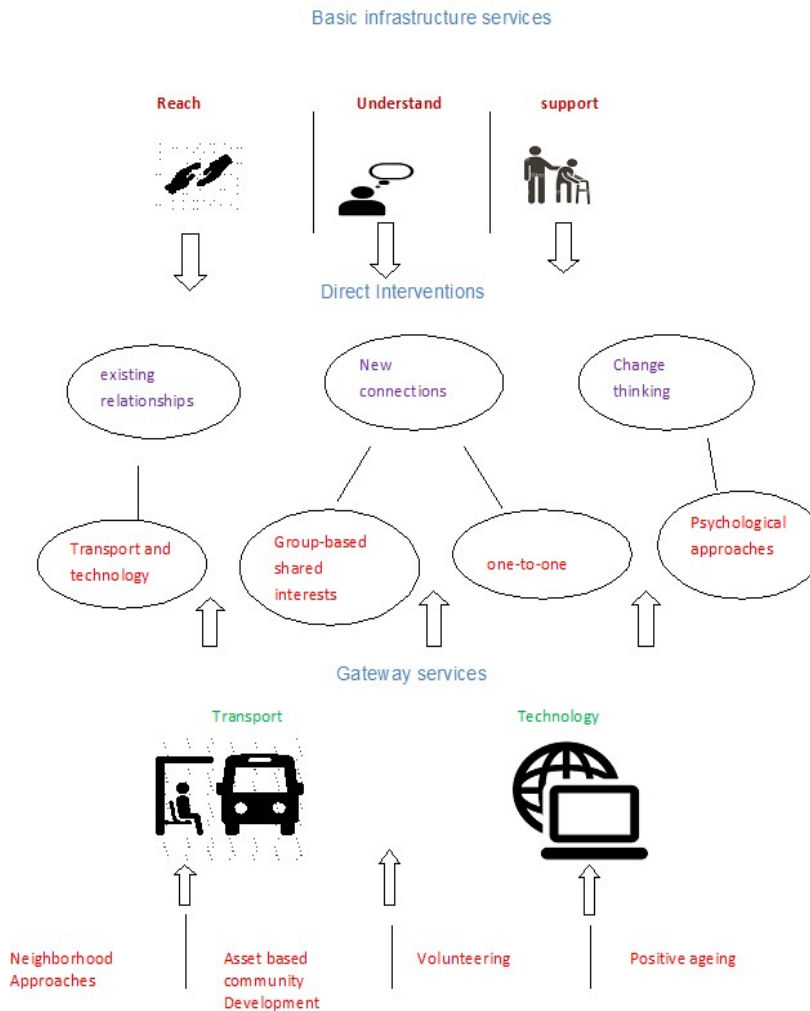


Figure 1: Interventions to loneliness (Jopling, 2015)

7.1 Basic intervention services

Various approaches have been identified as a first step, as indicated above on figure (1) to reducing individuals' social isolation and loneliness. The key challenges identified by the experts were; reaching lonely individuals, understanding the nature of an individual loneliness to develop personalized re-

sponse, and supporting lonely individuals to access appropriate services. These are vital first steps and foundations to approaching a lonely individual and supporting them to achieve a better state (O'Rourke, 2018)

7.1.1 Reaching lonely individuals

Elderly individuals who are lonely are particularly difficult to identify because most, but not all, are also socially isolated. Social stigma associated with loneliness also limits the chances that the lonely individual will seek for help, or reveal their needs. The initiatives to help lonely and isolated individuals will therefore not work without explicit targeting, because without doing so, the initiatives will only serve people with a more natural outgoing nature who maybe more able to support themselves (NHS 2018)

Initiative services to reach lonely individuals should be pro-actively offered to the elderly that are most likely to be affected by loneliness, rather than simply being made universally available. Three broad categories of approach have been identified for explicit targeting of lonely and socially isolated individuals; using data to target action, eyes on the ground, and links to the health service (NHS, 2018)

By utilizing the large body of literature that already exists on the key risk factors for loneliness and social isolation, data matching can be used for target action. This includes marital status, family network relations, mental and physical health status. These approaches utilize available data to identify individuals with high risk of loneliness and social isolation (Jopling, 2015).

Eyes on the ground work through human networks as opposed to data matching. The initiative works by recruiting and training individuals and professionals with whom the elderly maybe likely to make contact. This includes facility doctors, social workers, nurses and volunteers. The training gives them the skills to recognize the signs of loneliness and social isolation, and enable them to make appropriate referrals and offer support. These services effectively identify the elderly who might otherwise not access services and

have show positive results in terms of their ability to engage with the elderly (NHS, 2018).

Links to the health service is the linking up the provision of loneliness interventions to the health service. The health system has access to critical data around risk factors for loneliness and social isolation in particular around mental and physical health status. Health professionals are also often among the few individuals with whom lonely elderly persons have on-going contact. The knowledge and connections of health professionals are utilized to identify potential lonely individuals and connect them with lonely and social isolation initiative services. This range from schemes which aim to identify individuals whose lack of relationship might lead to worsening mental and physical health (Jopling, 2015).

7.1.2 Understand- identifying individual needs

Personalized response to loneliness is an effective way of tackling loneliness by providing a service which could first draw out and then respond to individual needs. The initiative is characterized by a relative unstructured engagement with an elderly person, in which their circumstances, needs and wishes are explored, leading into a discussion about what might be available to improve their quality of life. The in-depth discussions are vital in ensuring that the full range of an individual needs are recognized and responded to including requirements for specialist support to overcome barriers to accessibility, sensory loss, or cognitive impairment. The initiative aims to help the elderly build self-confidence by providing practical support, navigation and coordination to those most at risk of increased dependency. A multi-professional team of volunteers, nurses, general practitioners, matrons, social workers and mental health nurses are involved to provide wrap- around support (Yanguas et al 2018).

Guided conversation between the elderly and a professional who is trained in motivational interviewing is the first step of the intervention. The conversation helps to identify the elderly needs and a plan is developed to support the goals. The trained professionals then provide a continued support to build

individuals social network, help them to connect with the community, and increase their physical and social activities and this in turn improves their quality of life (Yanguas et al 2018).

7.1.3 Supported access

The provision of services to support an elderly reconnect with the wider provision in their communities involves supported access. Loneliness and social isolation can have a damaging effect on an individual's confidence and the fear which limits an elderly willingness to engage. The initiative links lonely individuals with a trusted "buddy" or "mentor" with whom they can develop a relationship. The mentor offers practical and emotional support to an elderly to support the achievements of specific goals (Kemperman, 2019)

A buddy's role is different from that of an advisor or assessor, in that the mentor or buddy may get involved in going along to activities, or in providing other practical or emotional support to an individual in meeting their goals. The buddy relationship is time-limited and focused on the achievement of very specific objectives which are often related to connecting to wider services, groups and structures within the community. The elderly is supported by the volunteer beyond the initial assessment of needs to the point of becoming confident to engage independently with wider services (Kemperman, 2019)

Supported access facilitates and enables access to direct intervention and has been reviewed to having positive effect in tackling loneliness and social isolation. Personalized assessment is taken by an enabler working with an elderly to determine their aims; how the initiative can help them to re-engage in activities which are personally meaningful and enjoyable, develop the tools, knowledge and confidence to engage, and self determine their personal and social activities in the future, as well as re-engage in the wider community (Kemperman, 2019).

The enabler helps the elderly by using coaching techniques and by accompanying them to any activity they wish to attend, for example, social groups, activity groups, exercise classes, and walking groups.

Client outcomes are regularly measured using a self-reported outcome tool developed for the service which measures health and wellbeing, and quality of life (Kemperman, 2019)

7.2 Direct interventions

Direct interventions are initiatives believed to be most likely to meet elderly people's needs for meaningful social contact and connections. The interventions seek to end people's loneliness and social isolation through three key ways; supporting individuals to reconnect with and/or maintain existing relationships, fostering and enabling new connections, and helping the elderly to change their thinking about their social connections (Jopling, 2015).

Direct interventions in cooperates three categories support: Supporting and maintaining existing relationships, supporting new connections and psychological approaches.

7.2.1 Supporting and maintaining existing relationships

Elderly residents are often confined in institutions and are no longer a part of the larger community outside the care institutions due to strict policies that govern the care homes. Improving access to transport and technology is a primary way in which care institutions could enable the resident's ongoing relationships with existing connections. The services would also serve a wider impact on elderly people's ability to engage with the services, and on the community's ability to provide them. Lack of access to these services can be a serious barrier to social connection Jopling, 2015).

It has however being disputed how technology impacts on loneliness among the elderly. Increase in the use of technology has being argued to exacerbate the exclusion of elderly people, while others have pointed to the vital role that technology can play enabling elderly people to maintain or even develop new connections. However in some studies, it has being noted that technology itself can be source of a new relationship, while in other instances technology either enables, or creates the catalyst for new social connection, and in some

cases the provision of technology created the excuse for new face to face relationships, for example, in the provision of IT orientations (Jopling, 2015). While some technologies are inaccessible and even unpalatable to elderly people, others such as telephone are now commonly accepted and accessible to elderly people. Phone technology enables the elderly maintain meaningful connections with relatives and wider community. Technology has demonstrated to playing a role both as an enabler of social connection in itself, and in making provision of social support more cost effective and easy to deliver (Jopling, 2015).

7.2.2 Supporting new social connections

Direct interventions services that show promising, are those that enable the elderly to develop new connections in later life. The services falls into two categories; group based approaches, and one-to-one approaches. Group based interventions are focused on a shared interest and set up to involve elderly people in running the groups. Numerous initiatives would fit these criteria within the care institutions. This would for example include; groups to coffee, faith groups, music and art and other activities with meaningful interactions. The groups offer explicit support to one another while carrying out challenging experiences (Jopling, 2015).

The figure below illustrates the vital role a shared learning experience could provide for giving meaning to social interaction and strong bonds that could be forged when individuals in the same situation come together for the explicit purpose of supporting one another

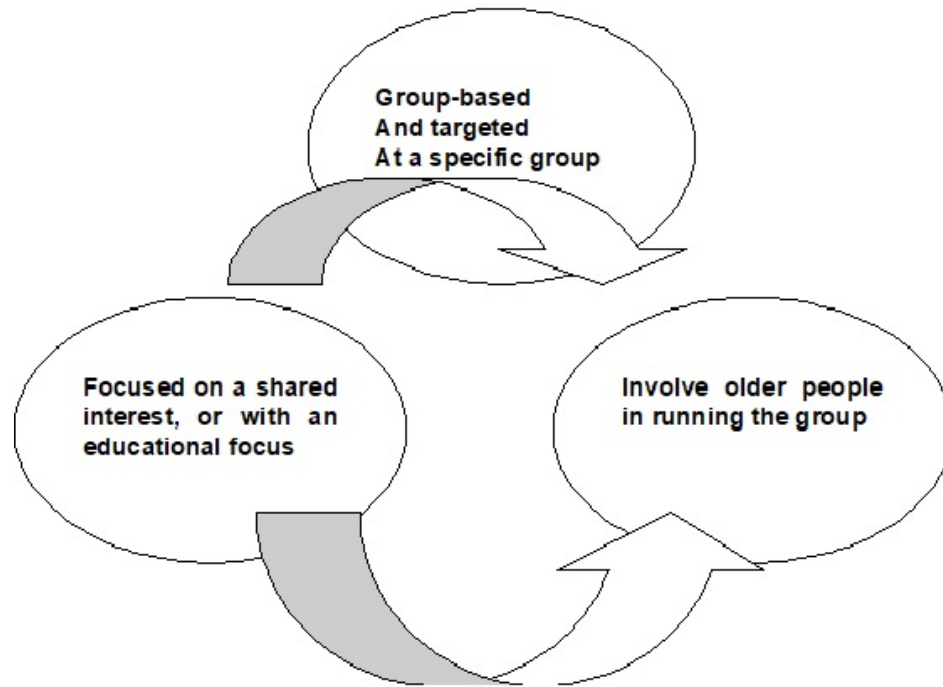


Figure 2: Group based shared interest intervention according to Cattan, (2009)

One-on-one friendships provide solutions to loneliness and social isolation by eliminating practical physical and psychological barriers that inhibit some of the residents in care institution to connect with the wider community. The most common initiative is the “befriending” services’ where by an elderly person is matched with a worker or volunteer who keeps close contact with the elderly on a regularly bases.

However, a systematic review of loneliness interventions by (Cattan, M 2005) concluded that the evidence on one-to-one befriending was too weak to be

able to state that these initiatives are effective in reducing loneliness. However Mima Cattan noted that such services were highly vital. Other studies before and since, has made different conclusions. One-to-one befriending services however, are believed to play a vital and positive role to elderly people whom practical barriers such as disability limits their contact with the wider community.

7.2.3 Psychological approaches

Psychological approaches are direct interventions that focus on supporting people to change their thinking about their relationships. A meta-analysis of loneliness interventions by Masi et al. (2010), found that greatest effect on loneliness was seen in interventions that addressed maladaptive social cognition. These are psychological approaches to loneliness based on system such as cognitive Behavior therapy and mindfulness.

Cognitive Behavioral therapy and mindfulness are traditionally recommended for use among individuals suffering from depression. However there is adequate evidence of their efficacy in addressing loneliness. Psychological services are rarely offered by organizations as a loneliness intervention approach. There is a room for further consideration of the potential psychological interventions might play among lonely and social isolated individuals. Psychological interventions have great potential to impact on elderly people's wellbeing and quality of life (Jarvis et al 2019).

8 RESEARCH METHODS

This is a qualitative study using interviews as a method of data collection. The data from interviews was analyzed by content analysis. Qualitative method of research was best applicable in this study as it allowed for exploration of loneliness as a social and human problem. The purpose of the various types of qualitative research involves the description and interpretation of human experience so that social situations or human experience can be better understood (John, 2016; 3). The method facilitated the study process based on distinct methodological traditions of inquiry. The literature and data collection methods used were relevant to the research topic in order to get answers to the research question. In qualitative research, the inquirer starts with a problem that needs to be solved, and then formulates a question that if answered, will help address the problem.

Qualitative research concerns individual experiences and the uniqueness of each individual's responses. Similarly, in social services, clients have individual needs and ideally should have an individualized plan of support. The data is collected from people in their own environment, taking into consideration their own social and cultural situation. Moreover, it seeks to understand an individual's perspectives and daily life (Creswell, 2016; 3).

8.1 Informants and Data Collection

The process of qualitative data collection involved several steps that stretched from selection of the site to designing forms for recording information. In this study, the process of selecting participants for the project was done by purposeful sampling. This process involved recruiting participants who could help inform the central phenomenon in this study (Creswell 2016; 104, 109).

The informants in this study were staff at a nursing home; they were care givers who had close and personal access to the elderly on daily basis and they come from a multicultural background; Russia, Nepal, Thailand, Somalia, Finland and Vietnam. The method of gathering data was done through

one-on-one interviews. A total of six respondents participated in the interview. The respondents agreed to audio recording which made the data collection process more convenient. The interview questions were phrased in the manner that allowed the respondents to expand more on loneliness and quality of life in elderly institution. Each respondent gave an average of 45 minutes of record time, with an average total of recorded time of 270 minutes.

The nursing home has two wards, in which one has 14 residents and the other nineteen. The residents consist of both partially independent while others are on wheelchairs and bed ridden. To further validate the study, the interviewees based their experiences on all the residents whose cognition ability allowed for them to share with the respondents.

The interviews were conducted referring from Open-ended questions I had prepared beforehand. Open ended questions are those that elicit answers which the interviewer cannot anticipate and are usually lengthier to get a description of the phenomenon of interest in a condensed and general form. This allows the respondents to answer the questions giving a lot of information without limit. This form of data collection was successful and the language used in the interview was English and Finnish.

A written permission for collecting data through interview was obtained and signed by the nursing home administrator. The objectives of the study had being agreed in writing between the work life partner and the thesis supervisor and my-self before starting. The administrator directed me to the members of the staff who were willing to participate in the research. The interviews were given to the staff and enough time was provided to describe as much as possible about their views on social isolation.

Data collection is a process of collecting information from all relevant sources to find answers to the research problem, and evaluate the outcomes. There are two categories of data collection methods; primary methods of data collection and secondary methods of data collection. This study has in-

cooperated both primary and secondary data collection methods to answer the research question.

Primary data is, data collected by a researcher from first hand sources using methods that include surveys, interviews or experiments. The data is collected directly from primary sources. Secondary data collection method on the other hand, relies on data obtained from pre-existing scientific research materials. Application of appropriate criteria to select secondary data to be used in this study was important in order to ensure high levels of research validity and reliability.

8.2 Data analysis

Content analysis is the process in which the researcher simplifies the data and formulates the categories in a way that describes the phenomena in a reliable way. It is important that the researcher is capable of providing link between the result of the analysis and the original data for validity of the analysis. The process of data analysis begun by sorting out all information and writing it down, getting acquainted with the data, naming the subcategories after reading and rereading the data and finally naming the main categories (Kumar, 2014).

The data is analyzed by using a qualitative method. In this study, an inductive content analysis is found to be a reliable way possible to present the findings. In this approach the concepts are derived from the data, Inductive techniques use it-self to derive the structure of the analysis. Specific techniques are then used to determine the categories, which are used to analyze the data. Once these categories have been identified, they can be validated against previous research and theoretical knowledge (JELTAL 2015).

Coding played a significant role in data analysis by providing structure and overview to what was rather extensive interview data. Inductive coding involves marking of content with a code to identify themes. In this study, I coded the content of recorded interview by writing down relevant words,

phrases or sentences to develop categories that emerged to identify themes (Raymond 1992). The data collected was broken down, examined and comparisons made. This was followed by conceptualizing and categorizing the data (Kvale & Brinkmann, 2009, 201-217).

Familiarization involves questionnaires that has been re-read with the aim of becoming immersed in the data. This is an essential stage in qualitative analysis. According to qualitative researchers, it enhances the researchers' awareness of the respondents' reality. Making a draft categories of answers that seem to belong together and code them with a key word. The information obtain will be summarized in discussion (John W. Creswell 2016).

Inductive manner is a way of developing conclusions and generalization from specific observations. The researcher observes the emerging patterns from the examinations of specific events. Inductive reasoning is used when specific ideas generate identifications of concepts that progress to theoretical propositions. The process of analytic induction in qualitative research involves the identification of variables that generate theory.

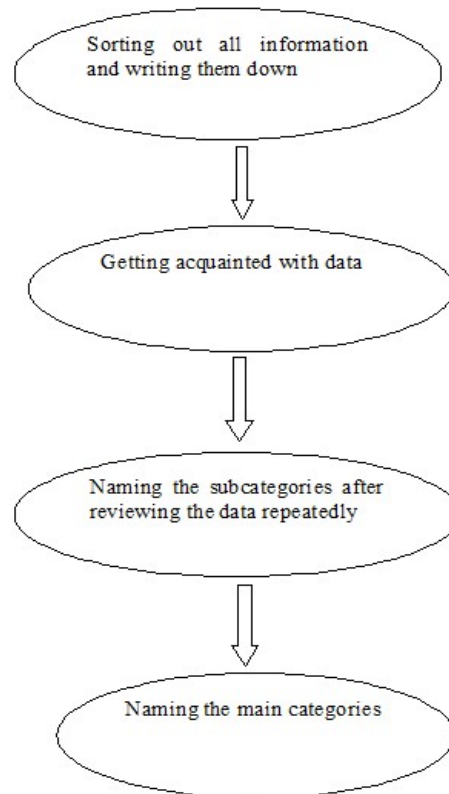


Figure 3: Data analysis process (Kumar 2014)

Understanding the data is the first step during the analysis part of the study. To achieve more clarity, reading and re-reading the data to come up with the real meaning is vital. During this step, data is sorted out carefully and written down to avoid information being left out thus maintaining the real meaning of the information from the respondents. While reading, writing down the impressions brought out by the data is done. This is followed by evaluating the data at each and every stage of reading to check for its meaning and how valuable it was as far as final analysis is concerned. It is vital for the researcher to continuously remind oneself about the topic, research question and the purpose of the study every time during the readings. This facilitates accuracy in the interpretation of the data. Data is organized by question and topic to look across respondents and their answers to specific questions. This helps a lot in checking for consistencies and differences of the data thus facilitating good focus of the analysis (Kumar, 2014).

After understanding the information, data is categorized as a code by using the old school method of printing transcripts, cut and used the snippets as codes. I used each piece of paper as a code. Defining coding unit was one of the most fundamental and important part for analysis. I developed categories from the data collected. The meaning of this phase was to find the similarities and differences of the simplified data.

When developing categories inductively from raw data, constant comparison method which not only is able to stimulate thoughts but also make differences between categories is used. The categories with similar content are then combined into larger components. In this phase, ideas, concepts interactions and terminology used helps to bring out the main categories whereby it is summarized to bring out the meaning to the data being analyzed.

A useful tool to use to make sub-categories is reflective thinking. Other themes are simply identified to make these sub-categories. Patterns formed from categories and sub-categories which later make it easy to draw conclusion and report the data effectively are identified.

Analytical procedures and processes are reported as truthfully as possible. Presenting research results from qualitative content analysis is challenging. Although it is a common practice to use typical quotations to justify conclusions, it is not always. The meaning of using quotations is to increase the validity of the report.

8.3 Ethical considerations and Validity

In a qualitative study, a researcher needs to anticipate the types of ethical issues that will likely arise in his or her project and actively plan and write down how to address them when and if they arise. Ethical issues arise during different phases of the research process as well as during publishing and dissemination of a study. There is however an assumption that exist that ethical issue arises only during data collection.

Attention was paid to ethical issues and ethic consideration present in all phases of this study. In the beginning of any study, a researcher needs to

consider the informed consent that includes estimation of possible risks or benefits, from the interviewee's point of view (Creswell 2016; 50). The author has defined the study overall purpose, and clarified that the participants are volunteers and have the right to withdraw at any time. In this study, permission to carry on the study was asked from the nursing home administrator. The staff members agreed to participate in the study, no names were written down and the informants were informed about the purpose of the study in advance. If they wished to withdraw from participation they were free to do so at any time (Creswell 2016; 50, 51). In order to protect the participants, guaranteed anonymity and confidentiality has been given; special attention is to be paid when publishing the report.

Qualitative research is interpretive, where by the inquirer makes personal interpretation of information. A researcher needs to make sense of collected data, code and provide code labels that seem to characterize text of information. Since the use of open ended questions and analyzing the data requires a personal interpretation, it is important for the qualitative researcher to pay close attention in validating the findings. The conclusions of a study are more trustworthy, if they are accurate and resonate with the participants in the study.

In qualitative research, validity means that all good underlying measures are gathered, this includes; construct validity, content, statistical conclusion validity, consequential validity as well as external validity. Validity has to be sewed in more widely to cover a study's part through the researcher's self-reflection. In order to create trustworthiness, Careful consideration is needed in order to facilitate clear communication and to ensure mutual understanding (Creswell 2016; 190-191).

9 FINDINGS

This chapter presents the findings from the data collected. The data was collected by means of interviews from the elderly institution staff, conducted referring from prepared deliberated open ended questions. This enabled the respondents to answer the interview questions giving as much information as possible without limit. Important issues regarding social isolation and loneliness and how it relates to the quality of life in the elderly institution were raised. In their response to the factors that cause institutionalization, the respondents felt that, cognitive and functional disabilities were not the only risk factors. The need for long term care depends not only because of ageing population but also on prevalence and severity of chronic medical conditions, elderly people's income, housing conditions and spouse care.

One aspect of the study was to examine whether an individual's quality of life was affected depending whether an elderly is institutionalized or not, while taking health and income as constant. Regarding the determinants of institutionalization, existing bodies of knowledge indicated that, older, poorer, single and less healthy individuals are more likely to be institutionalized (Health 2000 in Finland).

Differences in the quality of life in between the modes of living for elderly people indicted that, while keeping health, demographic and income aspects into consideration, results showed that individuals living in elderly people's homes report higher levels of better quality life than those living at home. The explanation to this finding is that, it is possible that there are individuals living at home who are very frail and that they should be in actuality be living in an elderly institution, but because of long admission waiting list into the residences, they are forced to live at home and endure lower quality of life as a consequence

9.1 Chronic medical condition factors

Even though there is no extensive research showing how chronic medical conditions other than dementia relate to the risk of admission in the general

elderly population, analysis has identified chronic medical conditions to relate to quality of life, loneliness and cause of long term admission into institutions. Loneliness is known to be a major risk factor for multiple chronic conditions. On the other hand chronic diseases creates barriers to social engagement which in return isolates the elderly person, the isolation further exacerbates their loneliness. Research has consistently indicated great relation between loneliness and physical and mental health problems.

During the interview, a respondent gave an example of some residents who isolate themselves from others during meal time and from group activities due to their chronic physical or psychological conditions. In the respondents own words:

“We can easily notice them because they separate themselves from the group during food time, they tend to sit separated from others, and during summer time when we ask them to take some sun, they refuse and they just want to stay inside in their rooms” another respondent said “they just want to stay alone, they look depressed, easily irritated and sometimes they shout and don't want to eat”

Study has suggested that loneliness elicits a bodily stress response Theeke et al. (2016). Through this and other mechanisms, loneliness is linked to multiple chronic illnesses, including hypertension, depression and cardiovascular diseases. On the other hand, the illness factors increases the fear of becoming lonely. The fear of physical or psychological illnesses causes loneliness in every development stage of human life, more particular with elderly people.

It has being observed that the elderly people who suffer from chronic illness keep themselves isolated from the people who are emotionally healthy. Self reporting and other studies indicate that the elderly who define their state of health as good felt less loneliness, (Steven et al 2012). Chronic medical conditions in the elderly more often cause impairment of physical functioning and general poor health leading to dependency on the help of others and health care services in daily living, these factors are associated with loneliness.

9.2 Social economic factors

The respondents identified social and economic factors to having greater relation on health over time and were considered to be foundations to achieving long and healthy lives. Factors including but not limited to; income, education, employment, community safety and social supports were seen to affect an individual's ability to make healthy choices, afford medical care and housing as well as manage stress.

The respondents described how the residents who have had high level education and careers in the society seemed to generally cope and relate more easily within the nursing home. A respondent gave an example of a resident who likes to talk about his personal life and his career. In her own words, the respondent said:

“Resident X status in the society as prominent professional gives him the confidence to talk with the nurses and other residents. He enjoys talking about himself as a young professional and also about the politics of the day. He likes to volunteer during group activities and is generally a cheerful person”

The study found related results between education level and feeling of loneliness. The elderly with high education were observed to have a higher economic, intellectual, and social-cultural level than the elderly with low education level due to their increased opportunity to have more things to do and possibility to participate more in social and cultural activities. Low level of education and income were among the factors identified to expose elderly persons to loneliness Wee et al. (2019).

The relationship between age and loneliness is dependent on whether cross-sectional or longitudinal data are analyzed. By using both analysis (Jylhä, 2011) indicated that loneliness increases with age. The study suggested that age is confounded with widowhood and poor health such that loneliness in-

creases with old age, not because of age per se, but because of increasing disability and weakening social integration.

In regards to family ties and loneliness, there are discrepancies in results. As people enter old age, the event of losing a spouse becomes ever more common. The respondents identified differences in happiness levels between the elderly whom got social visits from spouses and children in comparison to those who did not. The study showed an increase in the elderly vulnerability to emotional and social isolation at the event of loss of spouse. The loss of a spouse may also mean losing social interactions that were facilitated by being part of a couple. Elderly people with a partner more often report lower levels of loneliness than those without a partner either caused by bereavement, divorce or singlehood. Although it is acknowledged that being alone does not inevitably lead to loneliness, living alone is a predictor of loneliness.

10 CRITICAL ANALYSIS

The process of preparing and completing this thesis gave me an opportunity to work in depth with a limited subject area independently. The process enabled me to demonstrate professional maturity as a student and the ability to formulate a topic, use relevant literature, process data, make analyses, apply methodologies and present answers to questions raised in the problem statement.

In the future research, the voice of the elderly could be heard. Data collected from Self-report will portray firsthand the elderly people's feelings of loneliness and how it affects them individually. Interviews were conducted from six nursing staff respondents. More respondents may have provided greater amount of data to analyze.

The study intended to focus on loneliness and quality of life in Finnish elderly institution. The literature review done was searched in English. There is a rich content of research that has been conducted in Finnish that was left unutilized, which might have provided more data to the study that is more relevant to Finnish institutions.

11 CONCLUSION

Loneliness is a distressful warning signal that an individual's social relations are deficient in some important ways. It is a deeply personal experience, unique to every person, with different causes and different consequences to a particular individual which ultimately makes addressing loneliness complex. For a growing number of people, loneliness defines and devastates their lives. It is however important to note that some elderly people choose isolation as a preferred lifestyle.

The distinction between loneliness and social isolation is often overlooked. Social isolation is an objective measure of the number of contacts that an individual has. Loneliness on the other hand is a subjective feeling about the gap between a person's desired levels of social contact and their actual level of social contact. Understanding the links and distinctions between the two concepts will help policy makers and researchers come up with more revolutionary measures to reduce elderly peoples feeling of loneliness.

Even though loneliness and social isolation cannot be eliminated from the repertoire of common human experience, prevention of transient episodes of loneliness evolving into conditions of severe and chronic loneliness is imperative. Persistent loneliness can set the stage for depression, increase chances of suicide and negatively affect well-being and general quality of life. It is crucial to put in place preventative measures to avoid serious psychological and physiological effects that persistent loneliness in the elderly will cause, rather than dealing with the aftermath. Primary preventative measures will encompass on explicit targeting of high risk groups within the community. The defining attributes of primary prevention measures are health building, proactive, mass-oriented and educational. Preventative measures will capitalize on an individual's naturally occurring interactions, such as interactions with health professionals as well as capitalize on existing social systems that are oriented towards elderly care.

Even though there is a universal assumption that make believe elderly people wants to live at home as long as there health can allow, there is a

reason to argue that institutionalization may actually increase an elderly persons quality of life. Subsidies provided to elderly homes through the tax system, ensures that a residence pay less than the true cost of living there. By admission to the institutions therefore, the elderly will receive increased utility from the government subsidies which consequently improves the quality of life.

In Finland, there is a clear gap between elderly needs and the actual provision of services by the local authorities. Finnish municipalities have great autonomy in deciding which criteria to follow in deciding who to offer institution care. Access to elderly homes residency is limited, which creates a vacuum in regards to finding places to elderly people living at home with equally fragile health status (Johansson, 2010). Social work practice is a privilege to work with elderly vulnerable persons, whom despite the assumptions made by society that elderly people are homogenous with common expectations, they are a diverse and varied group who suffer a similar fate of stereotyping imposed by the social construction of old age.

12 RECOMMENDATIONS

Knowledge about social isolation and loneliness has increased over time particularly in recent years. However critical gaps in the basic information about loneliness and isolation remain. Even though the existing research provides the epidemiological aspects of loneliness and social isolation, there is little knowledge about variance across ethnic or income groups. In Finland for example, studies that would include samples of people other than white ethnic Finns would be useful.

Although there is existing researches that have linked loneliness to poor mental health, findings in this area are not extensive. More research is required to determine the extent to which loneliness and deficient social relations contribute to psychopathology. Depression has been identified as a major consequence of loneliness. The sequence in which transient loneliness becomes a severe and chronic condition and induces depression is a phenomenon that requires more study in order to know more about the relationship between the two.

The debate in regards to differences in quality of life while living at home in comparison to elderly institutions is not straight forward. Loneliness is believed to be a common experience in long term care. However, the prevalence of loneliness among institutionalized elderly is less well documented.

A disconnect between research and policy making on loneliness and social isolation in the elderly is a hindrance to solving the epidemic. Research on loneliness is seldom used in a direct and instrumental way in the making of policy, but rather as one that just inspires to enlightenment. To enable policy makers raise and implement policies that well meets the needs of elderly population, further studies are required to facilitate deeper understanding in regards to whether quality of life in an elderly differ depending whether an individual is institutionalized or not while taking health and income into consideration.

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APPENDIX 1

Interview Questions

The interview questions were;

- How long have you worked in Elderly care institution? What is your role and Job title?
- In your view, what is social isolation and loneliness in elderly care institution?
- What are the causes of loneliness and social isolation in elderly care institution?
- How do you identify or recognize lonely and socially isolated elderly in care institution?
- How does social isolation and loneliness relate to the quality of life in an elderly care institution?
- What are the wider issues associated with social isolation in regards to elderly psychological and physical health?
- How can social inclusion in elderly care institution be improved?
- What is the framework on loneliness and social isolation interventions in elderly care institution?
- What is your view on the interventions that exist to address social isolation and loneliness in elderly care institution?