

LONELINESS AMONG OLDER ADULTS AND
PROPOSED STRATEGIC PROGRAM
FOR INTERVENTION

by

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An Abstract

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ABSTRACT

by

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The issue of loneliness is of great concern in the lives of the older adults. Few studies have examined the enormous impact of loneliness in the life of the older adults residing in long-term care facilities (LTCFs) in the American Midwest, as well as the programs established to alleviate loneliness. This study examined the programs that address the issues of loneliness in the life of the older adults residing in LTCF in the Midwest. Data was collected from seven LTCFs through semi-structured qualitative interviews, and was analyzed using phenomenon-based thematic analysis. Findings revealed that none of the facilities have any specific constructive strategic program to alleviate loneliness besides the use of companion animals by their residents. Conclusions from this study indicated that caregivers working with the older adults in LTCFs should embark in setting up meaningful strategic programs such as music, humor, and reminiscence therapy; social support programs; animal assisted therapy and the use of robotic companion animals; elders-helping-elders programs; recreational therapy; Information and communication technology (ICT); and Eden Alternative (AE) program, which will help in combating loneliness among the older adults.

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CHAPTER 1

NATURE AND SCOPE OF THE STUDY

Loneliness is a subjective and usually excruciating and disturbing sense of being psychosocially secluded (Weiss, Riesman & Bowlby, 1973). Loneliness is an unwanted and a subjective disposition, because what is deemed by an individual as loneliness may be cherished by another as a blissful episode. Some older adults have experienced loneliness while they have people around them, while others do not. Also, living alone for some older adults is a catalyst for loneliness, while for others it is very productive and enhances their sense of satisfaction (Routasalo & Pitkala, 2003; Grenade & Boldy, 2008).

Loneliness can be exacerbated by a lack of a family support system and cumulative losses including loss of finances, health, friends, and economic status, and most importantly, the loss of a spouse (Akinbohun & Quartaroli, 2012). Old age is associated with loneliness due to the various losses experienced by older adults (Aebischer, 2008).

Due to the improvement in lifestyles and advancing technology in health care, older adults are living longer than ever before. Ironically, they are living longer with a growing range of chronic diseases resulting in the increased need for long-term care services and facilities at some point in their life trajectories (Steele, 1986).

Loneliness is an especially common occurrence among the older adults residing in long-term care facilities (LTCFs), and is associated with numerous losses experienced by LTCF residents. These losses include loss of family, friends and significant others, as well as loss of freedom, autonomy, and a sense of identity (Butler, 1995; Tjihuis, De Jong-Gierveld, Feskens, & Kromhout, 1999). Additionally, older adults who live in LTCFs often have many chronic illnesses such as diabetes, strokes, dementia, and other physical and cognitive impairments that

may deter them from socializing with other people (Butler, 1995; Tijhuis, De Jong-Gierveld, Feskens, & Kromhout, 1999; McGilton 2002). The issue of loneliness among older adult LTCF residents is therefore an important issue to discuss as they transition to the crucial last stages in their life courses.

Purpose of the Study

Many studies have shown that loneliness is associated with both physiological and mental ailments (e. g., Caioppo, Hughes, Waite, Hawkley, & Thisted, 2006; Hawkley, Masi, Berry, & Cacioppo, 2006). On the other hand, few studies have examined the magnitude of the impact of loneliness in the life of older adults residing in LTCFs and the programs designed to mitigate and allay loneliness in these individuals.

This study examined the use and effectiveness of strategic programs to combat loneliness among residents of LTCFs. The data obtained during the study was utilized to analyze the different kinds of programs, their success rate, as well as assess the need to suggest other strategic programs to combat and prevent the problems of loneliness in LTCFs.

Thesis of the Study

The lives of typical older adults in LTCFs are characterized by loneliness in part because there may be no effective strategic programs or interventions that are designed to address the issues of loneliness. Loneliness among LTCF residents may be effectively mitigated through strategic programs.

Key Words

Strategic Programs: These are evidence based loneliness intervention programs that have been researched and demonstrated to be effective in mitigating loneliness.

EA: Eden Alternative

CTRS: Certified Therapeutic Recreation Specialist

ICT: Information and communication technology

SCP: Senior Companion Program

AAT: Animal-Assisted Therapy

LTCFs: Long-Term Care Facilities

CHAPTER 2

REVIEW OF LITERATURE

Loneliness is an insidious problem in the lives of older adults that has been underrated and has not been given sufficient attention by the research community. Some studies have revealed that loneliness is associated with both physiological and mental ailments (Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006; Hawkley, Masi, Berry, & Cacioppo, 2006). Loneliness can affect both physical and emotional well-being in older adults; it has been connected with high blood pressure, sleep disorders, pain, depression, and anxiety (Cacioppo & Patrick, 2008; Cacioppo & Hawkley, 2009).

Other studies have indicated that a decline in social support and the non-existence of social integration are negative factors that increase the likelihood of loneliness (Pinquart, 2003; Eshbaugh, 2009). Friendship plays a significant role in preventing loneliness among older adults, as friends make available a substantial source of support, particularly for single, never-married, and widowed older adults (Eshbaugh, 2009).

Notwithstanding the staggering increase in population of the older adults, and the growing diversity of that population, the public view of them is that of an overwhelmingly lonely group of people (Victor, Scambler, Bond & Bowling, 2005). The present generation of older adults are aging and having a different later-life experience than older adults of earlier generations (Federal Interagency Forum on Aging-Related Statistics, 2010). However, old age is usually associated with loneliness by way of some older adults retiring from the jobs and living longer than their spouses and friends (Nicolaisen & Thorsen, 2012).

In this chapter, the following topics will be addressed: What is loneliness; the causes, signs, and effects of loneliness in older adults; the types of loneliness; loneliness in LTCFs; and

interventions to reduce loneliness in older adults in LTCFs. The purpose of this literature review is to set the stage for the study that is the subject of this thesis.

What is Loneliness?

In 1939, Sigmund Freud used the term loneliness when describing the innermost structure of an individual that could be wholly altered after an experience of loneliness (Weigert, 1960). Later in 1953, Sullivan expounded on Freud's depiction of loneliness, and suggested that human beings are communal animals that have a dire need for companionship, and that loneliness is the consequence of this unsatisfied need (Copel, 1988; Sullivan, 1953). Loneliness is therefore an inimical experience that transpires when an individual's web of social connections is lacking, either qualitatively or quantitatively (Ryan & Patterson, 1987).

Victor, Scambler, Bond, and Bowling (2005) have described loneliness as the paucity of social contact, the absence of people available or eager to share social and emotional experiences. In other words, loneliness is the condition whereby a person has the ability to network with others, but is not doing so because of an incongruity between the actual and desired dealings with others. Loneliness also may be described as the unpleasant experience that emerges when a person's web of relationships is undersupplied in some significant way (de Jong Gierveld, 1987; Peplau and Perlman, 1982).

Forbes (1996) defined loneliness as an undesirable feeling of deficiency or absence of friendship, or the sad feeling that one is isolated. Routasalo & Pitkala (2003) considered loneliness as a "geriatric giant" (p. 303) that may lead to a diminished quality of life resulting in an ever-growing need for formal care and increased likelihood of death. Also, Western Daily Press (2011) has avowed that loneliness is a "hidden killer" (p. 14) of older adults. Therefore,

loneliness can be defined in many ways. It can be defined as a state of being alone or solitude. It can as well be defined as a feeling of disengagement or separation.

In the end, loneliness is basically unwelcome and it may have consequences for the health and well-being of the person going through the experience. A condition that has resulted in loneliness in one person can be a source of contentment for another person (Forbes, 1996). Succinctly, the feeling of loneliness is unique for every person (Austin, 1989).

Causes, Signs and Effects of Loneliness in Older Adults

Loneliness has become a gerontological public health issue, because it has a significant impact on the quality of life among older adults (Chalise, Saito, & Kai, 2007; Theeke, 2009; Thurston & Kubzansky, 2009). It has been linked with old age in part because many biological, social, and other changes and losses are involved in growing old (Aebischer, 2008). Further, various studies have shown that loneliness is associated with both physiological and mental ailments (e.g., Cacioppo, Hughes, Waite, Hawkley, & Thisted, 2006; Hawkley, Masi, Berry, & Cacioppo, 2006).

Aging can lead to a variety of losses in the life of the older adults, including the loss of freedom, autonomy, friends, spouse, health, transportation, and sense of individuality, resulting in older adults' feeling exasperated, abandoned, isolated, and desolate (Fry & Debats, 2002). As older adults encounter difficulties in communicating with family members and friends as a result of age-related disabilities, they may begin disengaging from their social relationships, thus increasing the danger of loneliness-related functional decline and mortality (Akinbohun & Quartaroli, 2012).

Loneliness is an unwanted and highly subjective mood state. What one person may enjoy as an acceptable seclusion may be viewed or interpreted by another as a tormenting or

destructive mental state (Forbes, 1996). Loneliness can be intensified by a lack of social network; further, the lack of financial resources experienced by many older adults (and especially immigrants, widows, and widowers) also may exacerbate their experiences of loneliness. Older adults with physical disabilities are in particular danger of experiencing loneliness (Akinbohun & Quartaroli, 2012). Older adult immigrants, who have no family to connect to, and who also may be struggling to grasp the niceties of American culture and language, as well as understanding their grandchildren, are especially prone to develop loneliness (Ponizovsky & Ritsner, 2004).

Older adults vary in their reactions or responses to different external conditions. Loneliness cannot be regarded as a simple direct result of external social circumstances: rather, it is a personal response to such situations, which is different for every older adult (Perlman & Peplau, 1981). Loneliness may also have a drastic and damaging adverse effect on the health and well-being of older adults. Decreases in social support as well as deficiencies in social integration among older adults are also considered to be catalysts for loneliness (Forbes, 1996).

Forbes (1996) has stated that the possible signs of loneliness are verbal expression, holding onto one's arm for a protracted length of time, crossing one's arms very tight, having a defeated appearance, and wearing dirty clothing. Moreover, loneliness and social isolation are two different concepts that are most often confused by people as having the same meaning (Havens, Hall, Sylvestre, & Jivan, 2004). Some researchers have described loneliness as a person's subjective feelings or experience of the absence of meaningful relationship with loved ones and friends. One person may be secluded and be well and happy, while another individual can be surrounded by lots of people and still feel very lonely. The feeling of loneliness is

therefore a subjective feeling and experience, since it is individually determined and defined (Pitkala & Routasalo, 2003).

Taylor (2009) specified that various studies have indicated that the feeling of loneliness is rampant among older adults over 75 years old (Taylor, 2009). Loneliness also is directly related to poor living conditions, illiteracy, living in institutional facilities, and relocation to a different state, city or neighborhood (Singh & Misra, 2009). Furthermore, loneliness is connected with the feelings of desperation, hollowness, wretchedness, misery and silent suffering. It is also concomitant with poor vision, hearing impairment, sleep disorders and other related health issues. Loneliness may lead to increased morbidity, which often results in a higher demand for social and health care services (Pitkala & Routasalo, 2003).

Loneliness can be best described as an insidious near-epidemic condition that has always been associated with old age, due to the propensity for older adults to experience all kinds of losses, including the loss of spouses, health, social status, and friends (Fry & Debats, 2002). Together, these losses may be catalysts for loneliness among older adults. Loneliness may also be displayed through tiredness, tension, withdrawal, and hollowness; these symptoms can be very difficult to discern if an older adult is actually lonely or exhausted (Strutte, 1996). Moreover, as older adults' age, they often are confronted with a wide range of stressors that may trigger loneliness.

For instance, some older adults may be faced with the challenges of deteriorating muscle mass and other kinds of losses that will prevent them from being involved in meaningful activities that could keep them whole and hearty and alleviate the feelings of loneliness. Other older adults lose the ability to drive, participate in voluntary work, spend quality time with friends, and move around freely at will (Akinbohun & Quartaroli, 2012). These cumulative

losses can exacerbate loneliness because some of the older adults have led active lives, but as a result of their debilitating illnesses and other infirmities, they now reside in LTCFs, where they are deprived of doing some of the things they love to do.

Yet other older adults would rather shut themselves away from the hassling business of life, and have chosen to live solitary, and often lonely, lives. Some of them may feel that they are defeated in life and would rather not bother or be a burden to anyone around them (Singh & Misra, 2009).

Loneliness also has been associated with a variety of physical and social conditions. These conditions include high blood pressure, cognitive decline, depression and anxiety, and loss of transportation, job, and spouse. Also, issues such as impaired mobility and declining sensory capabilities can deter the older adults from sustaining meaningful social connections with other persons, which may increase the incidence of loneliness (Singh & Misra, 2009). Loneliness is a substantial issue in the lives of older adults and can have substantial negative impacts on their physical health and overall well-being. In addition to other related losses that trigger loneliness, hearing and vision loss is a great deterrent to older adults' ability to communicate and associate with others, often resulting in self-isolation and loneliness (Dugan & Kivett, 1994).

Unfortunately, many older adults do not seek screening for hearing loss due to the stigma attached to hearing impairment. Also, some older adults have denied their hearing loss, and have refused to wear hearing aids that could alleviate their hearing loss, thereby increasing the risk that they will experience loneliness (Fook & Morgan, 2000).

In our society, older adults are more likely to feel the profound sting of loneliness more than any other age group. Although there is no single cause of loneliness, loneliness often results in people feeling empty, helpless, and undesirable. These feelings frequently occur in older

adults in LTCFs who do not have self-confidence and who have the notion that they are undeserving of the responsiveness or respect of other people. Loneliness among institutionalized older adults is not a one-dimensional phenomenon; rather, it is a complicated and multifarious experience that affects these older adults physically, emotionally, socially and otherwise.

Types of Loneliness

Loneliness can be subdivided into two categories known as emotional and social loneliness. These two types of loneliness can occur independently or concurrently (Havens et al. 2004). Social loneliness arises through seclusion and is due to lack of social assimilation and connection to meaningful others (Weis, 1973). This form of loneliness can also be triggered by relocation to an unfamiliar environment. Making new friends and keeping in touch with meaningful others, can go a long way to curtail this form of loneliness (Akinbohun & Quartaroli, 2012).

Dykstra and de Jong Gierveld (2004) have stated that social loneliness is characterized by the absence of integration and may be related to a number of contributory factors, which may include insecurity, irregular contact with friends, children and siblings, the absence of involvement in social groups, and a deterioration in health.

Considering gender in relation to social loneliness among older adults, Dykstra and de Jong Gierveld (2004) have suggested that the social network size, compassionate interactions, and frequently attending church were contrariwise linked with a decrease in social loneliness among both older adult men and women. In contrast, dynamic involvement in charitable organizations, sports clubs, civic and political activities, and senior citizens' associations could render older adult men less susceptible to social loneliness; on the contrary, these activities

produced no significant decrease in social loneliness among older adult women (Dykstra & de Jong Gierveld, 2004)..

In contrast, emotional loneliness occurs as a result of the loss or absence of dependable attachment figures (Weis, 1973). Korporaal, van Groenou, and van Tilburg (2008) have asserted that emotional loneliness is the absence of a specific close relationship. It can be characterized by extreme feelings of anguish and rejection. It also can be linked with high quality or shortfalls in couple relationships, and it is most likely that emotional loneliness appears to be more correlated with marital contentment and psychosomatic despair than social loneliness (Drennan et al., 2008).

Emotional loneliness could also be described as the feelings of the absence of others in one's surroundings as well as the feelings of hollowness. Thus, the role of close significant others can act as a bulwark in warding off loneliness among the at risk older adults in LTCFs (Drennan et al., 2008). Both emotional and social loneliness are prevalent among older adults, because they are more prone to lose their friends and significant others due to old age (Akinbohun & Quartaroli, 2012).

For example, Salimi (2011) found that emotional loneliness is a stronger negative indicator of life satisfaction as opposed to social loneliness. In contrast, Dykstra and de Jong Gierveld (2004) found that older adult women who were frequently visited by their children were less socially and emotionally lonely compared to older adult women who were not visited by their children frequently. They also found that older adult childless women were less socially and emotionally lonely compared to older adult women who were not visited by their children frequently (Dykstra & de Jong Gierveldm 2004). Generally, older adult residents in LTCFs are most likely to experience both kinds of loneliness

Loneliness in LTCFs

LTCFs offer various forms of medical and personal care services to individuals who are unable to take care of their daily needs without depending on others in the community. Long-term care services are offered in several kinds of institutions, including assisted living facilities, nursing homes, and skilled nursing facilities. Most residents in these facilities are older adults who have serious, ongoing health and social conditions that negatively impact their independence and mobility (Angel & Angel, 1999). Unfortunately, the need for long-term care can surface unexpectedly without adequate notice or preparation on the part of the individual or his/her family. For instance, the complications after an acute myocardial infarction (heart attack) or the chronic sequence of a progressive stroke impact may result in the urgent need for long-term care. In these circumstances, many older adults enter LTCFs, where they will be provided with assistance with their activities of daily living and other medical and personal care services (Kane, Kane & Ladd, 1998).

As the older adult population in the United States continues to grow, an increasing number of older Americans likely will spend some time in LTCFs. Regrettably most of these facilities have discouraged their residents from bringing many of their personal possessions, including their pets. As a consequence, loneliness has become rampant in these facilities (Butler, 1995; Ebersole & Hess, 1990; Hogstel, 1995). Hogstel (1995) has found the rate of loneliness in older adults in LTCFs is between 12 and 40 percent. Also, Savishinsky (1985) and Arkow (1992) have noted that many LTCFs have limited their residents' choices in terms of daily activities, which can serve to dampen the residents' quality of life. For example, residents often have limited access to their personal possessions, including household pets. The loss of personal property and family- and community-centered social relationships has had a negative impact on

many residents' overall life satisfaction (Peplau, & Perlman, 1982). These limitations can lead to dejection, isolation, and a sense of hopelessness on the part of LTCF residents.

Very recent research has confirmed the negative impact of loneliness on lives and well-being of older adults. According to Goll, Charlesworth, Scior, and Stott (2015), lonely older adults have the propensity to experience increased poor health and early deaths. Similarly, Gerst-Emerson and Jayawardhana (2015) have found that lonely older adults may visit their health care providers more often than their more socially connected peers. These studies, among others, help to confirm that loneliness in later life is well-acknowledged as a crucial public health issue by the public health practitioners. Fortunately, programs designed to confront loneliness, and to enhance the welfare and life satisfaction of the older adults, are gaining more acknowledgment in worldwide social policy and in some nationwide health policies as well (World Health Organization, 2002).

For these reasons, social gerontologists and other health and social service professionals working in LTCFs have designed and implemented a variety of interventions to eradicate loneliness among their residents. These interventions include music, humor, and reminiscence therapy; social support programs; the Eden Alternative and other forms of animal-assisted therapy; information and communication technology and elder-helping-elder programs, to tackle loneliness in their facilities. The next section of this chapter addresses these interventions in further detail.

Interventions to Reduce Loneliness among Older Adults in LTCFs

Many group and individual activities for older adults in LTCFs can help with mood improvement, maintenance of functional skills, and preservation of mental state. These activities also may well lessen depression resulting in the improvement of quality of life for some of the residents in LTCFs (Nauert & Johnson, 2010).

In LTCFs, activity directors are primarily responsible for designing and implementing strategic programs that address resident loneliness; they aim to assure that the programs will be attractive enough for the residents to be willing to participate and enjoy. Unfortunately, most LTCFs do not give much attention to, or provide adequate funding for, these programs; as a result, many activity directors are left with limited resources to plan or implement activities for the residents (Nauert & Johnson, 2010). Fortunately, some of these programs require limited capital investment, and may be implemented with a minimal expenditure of creativity and time.

Music, Humor, and Reminiscence Therapy

Currently, there are various mediations for loneliness such as music therapy, humor therapy, and reminiscence therapy, which have been effectively utilized in some LTCFs to reduce loneliness among their older adult residents. It is imperative that LTCF personnel be knowledgeable of these therapeutic methods of mitigating loneliness as well as being devoted to employing them in their facilities to reduce or eliminate loneliness (Banks & Banks, 2005).

Hays and Minichiello (2005) have stated that music is relational to positive aging, because it creates avenues for individuals to maintain self-worth, sense of capability, autonomous, and combat the feelings of seclusion or loneliness. There is need for LTCFs personnel to be knowledgeable about how music can ease and sustain older adults' well-being.

Similarly, Tse, Lo, Cheng, Chan, Chan, and Chung (2010) have observed that humor therapy program is effective in relieving chronic pain, increasing happiness and life satisfaction, and reducing loneliness among older adults with chronic pain. Hence, using generationally- and ethnically sensitive humor therapy program in LTCFs may be an effective non-medical intervention.

Additionally, reminiscence therapy has shown to be very helpful and effective in improving the older adults' feelings of loneliness (Chiang et al., 2010). Reminiscence therapy helps to reduce feelings of loneliness by giving older adults an opportunity to share memories about their lives, experiences, and beliefs (Liu et al., 2007). Although Chiang et al. (2010) found that more research is needed to fully understand the relationship between reminiscence and loneliness, some studies have confirmed a decline in the feeling of loneliness when reminiscence therapy was employed for one to three times per week for at least one hour, occurring between ten and thirteen periods. According to these study results, reminiscence significantly reduced feelings of loneliness among the older adults, with the mean score of the UCLA Loneliness Scale falling from 44.9–54.2 to 35.5–40.4 ($p < .05$) (McDougall et al., 1997; Liu and Guo, 2007). The UCLA Loneliness Scale is generally used for measuring loneliness. The name UCLA originates from the University of California, Los Angeles where it was developed and first published in 1978 by Russell, D., Peplau, L.A., and Ferguson, M.L., and was revised in 1980 and 1996. UCLA Loneliness Scale is a 20-item scale designed for measuring someone's personal feelings of loneliness along with the feelings of social isolation (Russell, 1996).

According to Chiang et al. (2010), reminiscence therapy with older adults has been successful because it eased hopelessness, improved psychosomatic well-being, and alleviated feelings of loneliness in the older adult subjects. For these reasons, the authors recommended that healthcare workers should be providing fitting reminiscent activities in LTCFs, centered on the characteristics of the older adult residents because these activities could improve their psychosomatic well-being.

Social Support Programs

Walters, Cattan, Speller, and Stuckelberger (1999) have asserted that health programs that are designed to mitigate social seclusion and solitude among older people have played a significant role in assisting older adults to develop, nurture, and maintain their social networks and their mental health. Various interventions have been established to alleviate loneliness in communities where the ultimate goal is in decreasing loneliness as opposed to preventing it. Interventions at the community level could take the form of making friends through the phone, internet, or face-to-face meetings (Cattan, White, Bond, & Learmouth, 2005; Dickens, Richards, Greaves & Campbell, 2011; Masi, Chen, Hawkey, & Cacioppo, 2010).

Hawkey, Hughes, Waite, Masi, Thisted, and Cacioppo (2008) have found that the interventions that improved social support are the relational and companionship interventions, such as the one used for the bereaved and older adults who have relocated, and as a result, have their personal networks disrupted. This suggests that when older adults have increased opportunities for social interaction, they may experience a reduction in loneliness.

The Eden Alternative

Another innovative program is the Eden Alternative. Founded by William (“Bill”) Thomas, MD, in 1994, the Eden Alternative, a non-profit organization committed to innovating quality of life solutions for older adults and their caregivers, regardless of their living environments (Thomas, 1994). Thomas’s goal in establishing the Eden Alternative was to eliminate or mitigate the three plagues of older adulthood; namely, loneliness, helplessness, and boredom (Brune, 2011; Duncan, 2007; Sampsell, 2003; Tavormina, 1999; Thomas, 1994). Thomas’s ideas were grounded in his personal experiences of loneliness, which led to his goal to Eden-like long-term care environments filled with plants, companion animals, and children to

improve the lives of older adults, especially those who lived in institutionalized settings (Eden Alternative, n.d.; Thomas, 1994).

The Eden Alternative views old age as an energetic segment in the life course, whereby a person should be able to have access to, and the chances for, continuous learning, individual development, and a sense of self-worth and expression, primarily through easy access to human and animal companionship (Eden Alternative, n.d.). Advocates of the Eden Alternative have claimed that the program assuages feelings of monotony, aloneness and powerlessness among the older adults who reside in LTCFs by encouraging autonomy, friendship, and mutuality in the circumstance of caring relationships, maintaining individual traits and a sense of meaning in life, and encouraging a sense of self-worth (Barba, Tesh, & Courts, 2002; Sampsell, 2003; Bergman-Evans, 2004).

Several authorities have asserted that the uniqueness of EA programs is contingent on the premise that decision making is resident centered, which ensures that their needs and aspirations are esteemed and appreciated (Bergman-Evans (2004); Barba, Tesh, and Courts (2002); Hamilton and Tesh (2002); Sampsell (2003); Thomas (1994) and Thomas and Stermer (1999)). These studies have revealed that some Eden Alternative programs have led to a decrease in the number of different kinds of medication taken by residents; a decrease in the level of infection amongst residents, enhanced rates of friendliness among residents, and reduction in the levels of loneliness among residents (Bergman-Evans (2004); Barba, Tesh, and Courts (2002); Hamilton and Tesh (2002); Sampsell (2003); Thomas (1994) and Thomas and Stermer (1999)).

Unfortunately, other research has raised questions about the purportedly positive effects of the Eden Alternative on loneliness among older LTCF residents. For example, Bergman-Evans (2004) conducted a study that utilized plants and companion animals' homelike

environment; the study utilized Geriatric Depression Scale (GDS) a 30-item scale personality-report assessment that is used to identify depression in the older adults. GDS was first developed in 1982 by J.A. Yesavage and his associates. The GDS may generally be used on older adults who are healthy or medically ill. GDS has been used widely in long-term care settings. And it has demonstrated to be a useful screening tool in the clinical setting to assist in the assessment of depression in older adults (Kurlowicz & Greenberg, 2007). Also, the UCLA Loneliness Scale was used to measure levels of loneliness, boredom and helplessness among residents residing in Eden Alternative facilities. Bergman-Evans (2004) compared them with residents living in the regular nursing homes. The measurement tool was used to compare the respective residents' health status, both emotional and mental states. The results revealed no substantial decline in feelings of loneliness among residents from the Eden Alternative (EA) facilities when compared to other non-EA facilities. These results strongly suggest the need for more quantitative and qualitative research about the relationships between the Eden Alternative model and older adult loneliness.

Among the many successes of EA are some challenges in the implementation of EA programs. For example large size facilities are having difficulties in training enough personnel on the EA concepts. For the Eden Alternative principles to be fully operational in any facility, however, all personnel must be trained and certified. Certified nursing assistants, nutritional workers, activity assistance employees, transportation staff, or management, all must receive at least the initial hands-on, face-to-face training concerning the process of EA (Sampsell, 2003).

According to Sampsell (2003), to be effective, EA facilities must be willing to invest in, and adhere to the principles and practices of the Eden Alternative philosophy. Furthermore,

doing so will take time, commitment, and a readiness to be familiar with and learn from their mistakes in order to attain the objectives of the philosophy of care.

Animal-Assisted Therapy

Companion animals—primarily household pets—have played a vital role in the lives of many older adults, including those who reside in LTCFs. For instance, older adults have the tendency to rely on their companion animals to keep them company when there is a decline in their social network connections. Lonely older adults often use companion animals as a means of warmth, friendliness, encouragement, and a sense of self-worth. According to Baun, Oetting, and Bergstrom (1991), companion animals may enable older adults to reduce stress, improve sense of self-worth, low blood pressure and heart rate, and alleviate loneliness. The use of companion animals may play a significant role in keeping the older adults company in the later life, which may result to reduction of loneliness in institutionalized facilities.

Some studies have indicated that animal-assisted therapy (AAT) may mitigate loneliness among older adults. As noted by Banks and Banks (2005), AAT is one of the programs presently used to enhance communication with, and to address loneliness in, older adults. AAT is a tool designed to stimulate friendly communication among the older adults and companion animals such as dogs, cats, and parrots, within a variety of residential and communal settings, including LTCFs. Researchers from different field of studies have dedicated enormous amount of time in conducting studies on ATT (e.g., Banks, Willoughby, & Banks, 2008; Goldmeier, 1986; Odendaal, 2000). At present, however, there are too few studies about the benefits of the use of companion animals by older adults residing in LTCFs (e.g., Banks & Banks, 2005). Perhaps as a consequence, nurses and other LTCF personnel have dedicated little or no time in collecting

information that may guide them on to make AAT available for the older adult residents in their facilities.

Banks and Banks (2005) have concluded that AAT is effective in lessening loneliness among older adults in LTCFs. However, the key benefits originate from human-to-animal relations, and not from using human-to-human relations. According to Odendaal (2000), the healing role of companion animals is generally well-known among the frailer people in society, such as the older adults residing in LTCFs. The success of AAT is contingent on the older adults' ability to provide nourishment, accommodation, and upkeep of the animal. On the other hand, companion animals can also be used for service and security purposes. This makes available an environment in which the two parties—human and animal—can relate positively on the emotional level because the physical aspects of the relationship are not intimidating to either party.

Banks, Willoughby, and Banks (2008) revealed that the use of automated and live animals for AAT may reduce loneliness among older adults in LTCFs. In their research of AAT and loneliness in LTCFs, the investigators used robotic and living dogs. The comparison was based on the capability of a live dog and a robotic dog to mitigate loneliness among the older adult residents in LTCFs. A control group that did not receive AAT was also used for the study. The study results showed that, compared with the control group, both groups that received AAT had a substantial reduction in their levels of loneliness. The investigators also discovered from the study that robotic dogs that have the apparent ability to interact are effectual in reducing loneliness among residents residing in LTCFs. These results appear to suggest that LTCF residents who may not have access to living pets may benefit from the companionship of robotic dogs.

Information and Communication Technology

The use of information and communication technology (ICT) is another beneficial program for decreasing loneliness and increasing social contact among older adults in LTCFs (Cotten, Anderson, & McCullough, 2013). As people age, they frequently lose contact with their families and friends because of retirement, death of friends and family, and relocation of families and friends (Havens, Hall, Sylvestre, & Jivan, 2004), or it becomes difficult for them to communicate as a result of time or distance. These changes often produce declines in the socioemotional status of older adults in LTCFs. For example, an older woman who recently has lost her spouse and has relocated away from other members of the family and friends due to health problems, and now resides in an LTCF may have the propensity to feel socially isolated and lonely as a result of these life-altering changes. ICT use can help improve socioemotional effects by helping older adults in LTCFs overcome time and distance and to create or maintain social relationships, which may result into decrease in social isolation and loneliness (Cotten, Anderson, & McCullough, 2013).

Communication with the people outside the facility is vital and a necessity for older adults' well-being in LTCFs. Sadly, LTCFs rarely offer ICTs to their residents. Personal computers, including cell phones and tablets, may offer the older adults in LTCFs direct lines of communication with friends and relatives who are outside the facility. These tools provide older adults with online purchasing, game interaction, chatting online, and e-mail access. Hence, older adults in LTCFs can make use of many benefits ICT offer without leaving their primary residence (Namazi & McClintic, 2003).

Elder-Helping-Elder Programs

Elder-helping-elder programs may be another means of helping to mitigate loneliness among older adults who reside in LTCFs. In these programs, both the older adult volunteers and the older adults they assist receive incredible social and health benefits (Butler, 2006). An example of this type of program is the Senior Companion Program (SCP), which is a national older adult volunteer program wherein elders assist other older adults that have special needs maintain their style of independent living. The SCP also provides a post-retirement opportunity for limited-income adults ages 55 and above to assist other older adults who need person-to-person support because of loneliness or other infirmities. As the volunteer renders service, he/she receive a tax-exempt stipend, which by federal law it is not considered to be taxable income. There are other benefits that accompany the stipend, including mileage reimbursement and a meal on days volunteered, enabling them to serve at no cost. The SCP is a program that benefits the volunteer, client and the community, but it is not addressed by existing health and service programs (Butler, 2006). The volunteers make weekly visits during which they provide companionship and assistance to the older adult. They are encouraged to use reminiscence therapy by telling and hearing extraordinary stories, which may help reduce loneliness among both storytellers and listeners.

Chapter Summary

This chapter reviewed the literature on: 1) the meaning of loneliness, 2) causes, signs and effects of loneliness in older adults, 3) types of loneliness, 4) loneliness in LTCFs, and 5) interventions to reduce loneliness among older adults in LTCFs. The chapter also included a summary of the literature relating to the strategic programs used for mitigating loneliness among older adults in LTCFs.

CHAPTER 3

METHODOLOGY

Research Design – Qualitative Phenomenology

The method of analysis used in this study was the theme-based approach analysis (Goll et al., 2015), which is also referred to as phenomenology thematic analysis (Giorgi, 1970, 2009; Moussakas, 1994; Smith, Flowers, & Larkin, 2009). The researcher used this approach because it allowed her to go beyond calculating clearly developed words or expressions and to concentrate on recognizing and labeling both implied and unambiguous ideas within the data collected. Hence, the researcher combined, classified, itemized, categorizes, and gave instances of the answers of the subjects. As stated by Strauss and Corbin (1998), “an analyst is coding for explanations and to gain an understanding of phenomena” (p. 129). Those phenomena were then positioned into groups compelled by the participants’ responses, which were then considered for additional analysis such as arranging the data in a tabular format (see Appendix A) and/or using a bar chart to represent the trend of the data (see Appendix C).

The researcher initiated the analysis by listening and transcribing each of the participants’ recorded interviews, and noting the distinct ideas of the participants’ responses to the interview. Units were developed and from those units, key words were recognized to plan the form and structure of the categories (Strauss & Corbin, 1998).

The researcher prepared a table of categories and unit (Appendix A), and went further to learn about the various categories and five different labels were formed from these categories: 1) the symptoms and indicators of loneliness; 2) the challenges confronting residents who are lonely; 3) the LTCFs strategic loneliness program, if any; 4) the program designed specifically to educate family members; and 5) the use of AAT by lonely residents. Next, the researcher

designated and plotted each applicable data into the table of categories in themes and unit (see Appendices A and B).

Participants and Sampling

The participants in this study consisted of six administrators and one social worker (the latter was referred to the researcher by the administrator of the facility for the interview) in seven LTCFs in the Midwest. The participants were recruited through convenience sampling. To participate in the study, the participants needed to be an administrator, director of nursing, or registered nurse working in a LTCF (or proxy, per the social worker participant mentioned above). All participants were provided with a brief description of the research project, contact information for the researchers, and contact information for the University of Central Missouri's Human Subjects Review Committee.

Data Collection

Data were gathered through semi-structured qualitative interviews, whereby the researcher used an interview guide (see Appendix E) to gently direct participants through in-person conversational discussions. Interviews took place at the participants' facilities and six of the interviews were audio recorded and one was handwritten because the participant did not want the interview recorded. Written consent (see sample in Appendix D) was obtained from all participants and verbal consent was obtained to record or write each interview. Each interview lasted between ten and thirty minutes. Data were collected between February 12, 2015 and February 19, 2015.

All participants were assigned a pseudonym to ensure confidentiality. The recorded interviews were reviewed several times and the unedited transcripts were reviewed using phenomenal-based thematic analysis as defined by Giorgi (1970, 2009), Moustakas, (1994), and

Smith, Flowers, and Larkin, (2009). Participants were asked questions designed to ascertain the symptoms and indicators of loneliness among residents in the LTCF; the strategic programs put in place to mitigate the problems of loneliness among residents; the challenges confronting residents who were lonely; the programs designed specifically to educate family members on the dangers of their loved ones being lonely after moving to the facility; and the use of AAT by lonely residents to relieve some of the problems of loneliness.

Chapter Summary

This chapter focused on the research methods and procedures that the researcher used for this study. In this chapter, the researcher addressed specific procedures that she followed during the study, including informant selection, informed consent, and confidentiality; data collection; data analysis, comparison, and interpretation as well as the data and researcher's credibility.

CHAPTER 4

ANALYSIS AND FINDINGS

In the analysis, phenomena were placed into theme categories driven by the participants' responses to the questions asked during their interviews (Strauss & Corbin, 1998). The themes were described and illustrated with the participants' statements which were labeled and unitized in a tabular format as they positively responded. For ease of reading, repeated phrases and irrelevant words were deleted from quotes, and redundant fragments were replaced with an ellipsis (. . .). Participants were identified by their pseudonyms as noted in Appendices A and B.

The researcher examined the use and effectiveness of strategic programs to combat loneliness among residents of LTCFs. The data obtained during the study was utilized to analyze the different kinds of programs, their success rate, as well as assess the need to suggest other strategic programs to combat and prevent the problems of loneliness in LTCFs. The data collected revealed that none of the facilities had any program that was designed specifically to educate the residents' family members on the issues of loneliness. Three of the administrators seem not to be aware of challenges of loneliness faced by their residents. For example, the administrator of LTCF 7 seemed not to understand the symptoms of loneliness exhibited by the residents. All the facilities approved the use of companion animals (household pets) on their premises. Four of the facilities indicated that they used some kinds of programs to address resident loneliness (see Appendix C for a bar chart of these findings).

The following five major themes will be discussed below: 1) the symptoms and indicators of loneliness, 2) the challenges confronting residents who are lonely, 3) the strategic

programs put in place, 4) the program designed specifically to educate family members, and 5) the use of companion animals by lonely residents.

Theme 1: The Symptoms and Indicators of Loneliness

The consequences of loneliness are both from a psychological and physical health perspective. Unfortunately, these loneliness problems have not been given undivided attention in medical literature. Loneliness is really an inimical feeling of hollowness or unhappiness that creeps in and cause suffering to people at any age. But it can be exclusively devastating to older adults and may lead to severe health problems and even death.

Questions on symptoms and indicators of loneliness were asked to ascertain the level of understanding of the signs of loneliness of the participants. Among the participants that were interviewed, six out of seven participants responded positively with key words that are related to this theme category: [not interact, isolation, sad, crying, not socializing, stay in their rooms, leave me alone, withdrawing, come out, depressed, and not hanging out] (see Appendix A).

P. Bliss, the administrator in one of the facilities said that part of the warning signs of loneliness is, “when they do not interact or don’t want to come out for any meal and if when aids or nurses check on them or knock on their door and they just kind of say I am ok leave me alone” (P. Bliss, personal communication, February 17, 2015). R. Adam, an administrator of an LTCF, said it could be “isolation for one, [and] sometimes behavior; [those are] probably [the] two main things” (R. Adam, personal communication, February 12, 2015). I. Smith, the administrator of a different facility, said that when residents tend to “stay in their rooms for meals, they don’t come out for activities, these are definitely the signs . . . in the [residents’] faces right away [indicating that] they are lonely, depressed and sad” (I. Smith, personal communication, February 17, 2015). B. Frank, a social worker at one of the facilities said “depression, probably withdrawing from

activities and socializing and hanging out more in the room, depressed withdrawing from group activities and that indicates to us that may be more depressed” (B. Frank, personal communication, February 17, 2015).

M. Steve, another administrator in one of the facilities, said that lonely residents often manifest “crying and spending lots of time in their rooms by themselves” (M. Steve, personal communication, February 18, 2015). R. Sperry, an administrator in one of the LTCFs said that residents at her facility may manifest symptoms of loneliness by “isolating themselves in their room, by not eating; not coming out for activities; [and] not even wanting to participate in their own daily care” (R. Sperry, personal communication, February 19, 2015).

Loneliness can be aggravated due to the absence of significant individual in the life of the older adults (Korporaal, van Groenou, & van Tilburg, 2008). Hence, infrequent or no visits by family members is a catalyst to loneliness (Drennan et al. 2008; Pinquart, 2003). And loneliness, which may lead to anguish, and purposeless life in older adults, may be associated with a variety of diseases and chronic conditions. A lonely individual experiences the feelings of being low-slung, destitute, disconnected, or victimized, and may find it very difficult to socialize and carry on conversations with others. They also have a sense of dejection and rejection (Tiwari, 2013).

The common symptoms of loneliness among residents in the LTCFs include being discontented with social or family interactions, having negative outlooks about life, being angry about life, experiencing a deficiency of self-motivation, failure to establish social contact, experiencing feelings of hollowness and being very much alone, having few or no friends, feeling insignificant, abandoned, defenseless and feeling alienated from other people (Chen 1994; Flett, Harcourt, & Alpass, 1994; Keele-Card, Foxall, & Barron, 1993).

Theme 2: The Challenges Confronting Residents who are Lonely

Regarding this theme, the researcher asked the participants about the challenges confronting residents who are lonely in their facilities. Only four out of seven participants responded positively with key words that are related to this theme category: [participate, to open up, to help you, loss of independence, feel uncomfortable, and family support] (see Appendix A). For example, P. Bliss had the following to say concerning the challenges confronting lonely residents in his facility:

I think trying to get them to participate in activities, or trying to realize people have to help you get over that loneliness, especially when they are new, they feel uncomfortable. It is a new facility, new people, and new place. The best we can do is to make them feel comfortable and happy; this is their home but you still try to get them to open up. This generation is very private trying to get them to open up. . . . [W]e just ask them about things they like to do or eat or see. It is challenging to get them to open up on what they like to do. (P. Bliss, personal communication, February 17, 2015)

B. Frank, a social worker, responded by saying that the older adults in her facility often “don’t have family support and I think that’s where the loneliness comes from, because we do offer them some activities to try to get them to interact with each other but, [lack of] family support is the biggest challenge” (B. Frank, personal communication, February 17, 2015).

According to Cacioppo and Patrick (2008), the first challenge is that loneliness makes it difficult for individuals to adapt to their circumstances, which can result in critical behavior such as suicide. Evidently from Frank’s response, the lack of family support can lead to loneliness, which in turn may lead to self-harming thoughts and actions. R. Sperry, an administrator of one

of the facilities, responded to the question about the challenges confronting lonely residents in her facility by saying that, residents' "adjusting to living in a new situation, and being constrained not to bring many of their belonging to the facility, can produce a loss of independence on their parts" (R. Sperry, personal communication, February 19, 2015).

Disappointingly, most facilities discouraged their resident's from bringing most of their personal possessions, including their pets (Butler, 1995; Ebersole & Hess, 1990; Hogstel, 1995). R.

Adam's response to the question of challenges confronting residents who are lonely is that:

Our facility doesn't have a lot of family contacts, so I think our residents have little bit high potential for [loneliness] probably, and some we just try to keep them busy interacting with each other and activities and whatever, they kind of like to do. We kind of like to incorporate [activities] in their daily lives, [which] kind of helpful to some of them. (R. Adams, personal communication, February 12, 2015)

Adam's comment is another confirmation that the lack of family support systems may be an important risk factor for the development of loneliness in older adult residents of LTCFs. The significance of activities of daily living and social contact to combat loneliness among the residents in LTCFs cannot be overemphasized, but it can be very challenging.

In sum, the data has revealed that the major challenge that the participants faced is getting lonely residents out of their rooms to participate in the daily activities as well as lack of family support network, which appear to be essential for combating the issue of loneliness in the lives of these residents. A significant difficulty in measuring loneliness in this context is the propensity for those that are lonely to be in denial and refuse to acknowledge that they are indeed lonely (Wenger 1983). There are many challenges that LTCF administrators, nurses, social workers, and other caregivers face when they care for older adults and they need to have the capability to

identify the signs and symptoms of loneliness and to design and implement appropriate interventions that address these signs and symptoms.

Theme 3: The Strategic Programs to Address Loneliness

Forbes (1996), stated that it is imperative for the lonely individuals to be given the occasion to make a positive impact in the lives of the people around them. When they are actively involved and engaged in activities, as opposed to remaining physically and emotionally inert, the result is a reduction in loneliness. Hence, there is need for LTCFs to have programs of activities for their lonely residents. Victor et al. (2000a; 2000b) has indicated that it can be challenging to come up with policies and plans for combating loneliness as a result of negative attitude by both the caregivers and residents towards the issue.

When the researcher asked about the strategic programs put in place to mitigate the problems of loneliness among residents, only four of the seven participants responded positively with key words that are related to this theme category: [activities, program, therapist, socialize, companion animals, counselor, psychiatrist, social worker, online training system, watch movies, psychologist, human companion, reminisce, get involved, computer, assessment, topics, training, daily activities, interventions, learning, and bingo] (see Appendix A). For example, I. Smith answered the question about strategic loneliness programs as follows:

Some of the simple things we have in place are just that we do have the activities program obviously, [which] is just a normal program that we have to get people out and about to interact with each other. Now some things we have for people who might be more kind of a severe case of loneliness is we do have licensed social worker [who] comes out like a counselor and she can come out and just visit once a week with them to

do more like counseling without prescribing medication or anything like that with them.

(I. Smith, personal communication, February 17, 2015)

Smith's response has revealed that this facility has a program to engage the residents with, although it has not developed or implemented a specific program to combat loneliness. However, to its credit, the facility had employed the services of a licensed social worker to counsel the residents who are deemed to have severe cases of loneliness.

In contrast, P. Bliss has the following to say concerning the programs in his facility:

We have an activities director and social services. When [the activities director] first meets [the residents, the director tries to get a] background like family social history and also hobbies and also things they like to do, [including] foods they like. Second, they develop a program they might like to do. . . . [T]hen activities director [comes] in [and] she tries to have different things for all the groups, and then she designs it on one-on-one[.] Some [residents] like to watch movies, some like to sit and have talk, and reminisce about things, so we try to make programs kind of gear[ed] towards what they like to do. (P. Bliss, personal communication, February 17, 2015)

Unlike Smith's facility, Bliss's facility had programmatic activities in place for both the residents that are lonely and those that are not.

R. Sperry said the following about the loneliness-focused programs in her facility:

We have our daily activities that our activity director goes around to each room every morning and invite everybody out but we can't force them to come. . . . [If they try to] isolate themselves, we ask for a psychologist to come in or psychiatrist to come in and talk with them and see maybe [if it's] actual depression or just loneliness (R. Sperry, personal communication, February 18, 2015)

In Sperry's facility, it appears that the activity director engages the residents with daily activities every morning which may not be an activity of interest to someone that is lonely. In contrast, Bliss' facility has general and personalized activities designed to address the specific needs and desires of individual residents.

Likewise, B. Frank's response to the loneliness program question is that:

the activities department offer[s] activities to try and get the residents out of their rooms to socialize more, we offer [contract] counseling services[, which the residents pay [for] through insurance;,[after payment, the residents] can see a psychiatrist (personal communication, February 17, 2015)

Both Sperry and Frank responded with an indication that their facilities had general activity programs in place, but not strategic programs that is aimed at combating loneliness in their facilities. However, in Sperry's facility, there were general activities for everyone, and staff had no obligation to force anyone to participate in those activities. In contrast, Adam's facility had "nothing specific" in place for their lonely older adults (R. Adam, personal communication, February 12, 2015).

To evaluate the effectiveness of the strategic program, the researcher probed further to determine the success rate of the participants' programs, the programs' early intervention possibilities, and loneliness awareness and training among staff. The same thematic analysis was applied to the participants' responses during probing to categorize and unitize their words as they relate to the theme (see Appendix B).

When the researcher probed further to ask of those participants who have programs in their facilities, the percentage of residents that participate in the programs, I. Smith, an administrator of one of the facilities, said:

Probably, 70%, you know, some that may be passive participants, who might just be able to watch, some may [play] bingo, which you see in every nursing home. [We] have some [residents] who may be hard of hearing or confused, who might sit there with them and draw the number out [, because] they can't hear so help them (I. Smith, personal communication, February 17, 2015)

R. Sperry's response to the question is that "75% of [our residents] get involved in one activity or another. I mean they don't all come to everything the majority of them come to most of the activities" (R. Sperry, personal communication, February 19, 2015). Based on Smith's and Sperry's responses, over two-thirds of their residents have participated in loneliness programs. Although that may be a good showing (Krysick & Finn, 2013), it means that roughly one-third of the residents were not participating in such a program.

In contrast, P. Bliss's facility had a very high participation rate in her facility's loneliness programs, as noted by her answer to the strategic programs question:

[We have a 90 to 95% success rate [with these programs. Although, we ha[d] a couple [of residents who] were kind of upset that they were . . . here instead of [at] home, [and that] they and families couldn't take care of them. They ha[d] medical needs that were beyond the capabilities of the families, and all of us try to make it part of our day to say hi and see how they are doing, to kind of help bring them out a little bit once they get comfortable with us. (P. Bliss, personal communication, February 17, 2015)

The response rate in Bliss's facility is very encouraging because almost all the residents partook in the facility's loneliness program. In contrast, the participation in B. Frank's facility was very low, "probably 8 -10% [if] they are able to communicate; there are lots of them who are not able

to communicate. We don't know exactly how they are feeling because they are so far gone in[to] them[selves].” (B. Frank, personal communication, February 17, 2015).

Loneliness is related with numerous issues such as individual characteristics, demographic features, and the ability for an individual to deal with critical situation. Also, the lack of finances, family support system, illness, migration, the loss of significant others and retirement can be deterrents to combatting loneliness (Victor et al 2000a; 2000b). There are varieties of strategic interventions that can be embraced by the caregivers such as encouraging the lonely residents to be more engaged in physical and social activities as well as being intentional of what they choose to eat so as to be and remain healthy and strong (Barr, Kirkcaldy, Robinson, Poustie, & Capewell, 2005).

Lauder, Sharkey and Mummery (2004) have confirmed that caregivers in LTCFs can educate their lonely residents on the necessity for taking adequate care of themselves as well as the need for moderate exercise which has been proven to ward off loneliness to a reasonable extent. Participating in a moderate activity in a group setting may help lessen loneliness, anxiety, and depression among the residents (Morgan & Bath 1998; Estabrooks, Glasgow, & Dzewaltowski, 2003). Caregivers must endeavor to accentuate the advantages of moderate exercise to the older adults that are capable of undertaken exercises such as walking and gardening. Also, there is need for caregivers to initiate a cordial relationship between the older adults in their care and community at large as an indirect intervention to detect and avert loneliness (Lauder et al, 2004).

When the researcher further inquired of the participants about the early interventions they had put in place to curb or address the issues of loneliness in their facilities, the participants

revealed a variety of responses. For example, I. Smith, an administrator of one of the facilities, answered as follows:

There is initial assessment that is done when somebody comes newly in the facility and that is done by a nurse within seven days that they are here; it's kind of series of questions that are asked. . . . I feel like we are pretty good on catching . . . things [related to loneliness (I. Smith, personal communication, February 17, 2015)]

Smith's positive response is a good indicator that her facility has an effective program to detect and intervene promptly to the issues of loneliness in its early stage—even on admission to the facility—in the lives of the residents in their facility. This early intervention can go a long way to prevent the potential loneliness of residents from deteriorating into more serious conditions such as depression and other related health issues.

In like manner, other facilities also had put strategic programs in place to support their lonely residents and take prompt action to avoid an escalation of any resident's experience of loneliness. B. Frank a social worker from one of the facilities, responded by saying that:

As social workers, we do . . . a mood assessment [of each resident]; . . . [I]f they score on a mood assessment ,maybe we can talk to them about interventions. We also start a care plan so if they are on any medication for depression or if they already have a diagnosis of depression, so we know what interventions we [have] put in place (B. Frank, personal communication, February 17, 2015).

In this regard, P. Bliss an administrator of one of the facilities, said:

We do have contract with psychology[ists and], psychiatrist[s,] and they come around and talk with [our residents] and make recommendations. Medicine is last resort[; we

may] try some medicine to help with mood and that's really kind of the last resort.(P. Bliss, personal communication, February 17, 2015).

R. Sperry, an administrator of facility six similarly responded as follows:

We do an individual service plan upon admission and then review it often and our nurse assesses them for symptoms of depression or loneliness or anything that could cause them to start going downhill and so we catch up fairly early and able to develop a service plan to help them keep at the same level they are instead of declining. (R. Sperry, personal communication, February 19, 2015)

Some of the facilities have some form of early intervention program put in place to identify early signs of loneliness among the residents. For instance, in Smith's facility there is an initial assessment that is done within seven days of admitting a resident to identify signs and symptoms of loneliness. Also, in Frank's facility, a mood assessment is conducted to determine if the resident has signs and symptoms of loneliness or depression.

Joy, Carter and Smith (2000) have stressed that, although it is imperative for LTCFs to have a solid multi-disciplinary process of recognizing and taking care of the needs of the older adults, the education of medical and other personnel on loneliness can go a long way in helping them to detect the warning signs of loneliness in the older adults. Problems associated with loneliness must be thoroughly covered by staff and nursing (and other) students who are working with the older adult population. Lauder et al. (2004) has proclaimed that reactive interventions may be unproductive; proactive interventions are essential.

Staff shortages can severely impair LTCFs ability to proactively design and implement loneliness programs. For example, the nurses who work closely on a daily basis with the older adults often are so overwhelmed by their workloads and other activities that they have little or no

time to help in alleviating loneliness (Ebersole, 2002). Furthermore, Ekwall, Sivberg, and Hallberg (2005) have emphasized the crucial need for LTCFs to provide adequate training to their personnel about residents' loneliness, and how to identify the signs and symptoms of loneliness as well as the application of appropriate interventions.

The researcher probed the participants further on whether there is a training program among staff about loneliness and how it can be alleviated. I. Smith, an administrator of one of the facilities, responded by saying:

We do each month, or once a month we and all the staff in service train on different topics and the director of nursing will... usually [be] in charge of picking what topic we do every year. She kind of has a rundown of what we go over and usually we do hit those topics. (I. Smith, personal communication, February 17, 2015)

B. Frank, an administrator of one of the facilities,, answered the question by saying that “when staff are new here they learn about the activities for well-being, they cover a lot of different stuff so I am not sure if there is anything specific” (B. Frank, personal communication, February 17, 2015). P. Bliss said “we have online training system for the staff it include loneliness and stuff like depression” (P. Bliss, personal communication, February 17, 2015). Also, R. Sperry said that her facility had “an online training system that the staff has several modules to [address resident loneliness. [Each] month our company is very good about touching on loneliness, depression, dementia and all that is covered on that learning” (R. Sperry, personal communication, February 19, 2015).

Considering the participants' responses, some of the facilities have no effective training program for their staff to help mitigate loneliness among their residents. However, some of the facilities did a good job in training their staff on the issues of loneliness among the residents. For

instance, Sperry's and P. Bliss' facilities had online training system for their staff which includes loneliness. And, Frank's and I. Smith's facilities conducted monthly training of staff in various topics.

Theme 4: Loneliness Programs Designed Specifically to Educate Family Members

Educating the families of the residents in LTCFs about the danger of loneliness in the lives of older adults is vital to the health of the residents in LTCFs. There is need for them to know that they need to be visiting regularly, and the significant of keeping their older adults company. Educating the family members will go a long way to change the haphazard attitude of some of them to visiting their loved ones, which may lead to mitigating loneliness problems in the lives of the older adults residing in the facility (Wilkinson & Marmot, 2003).

None of the LTCFs in this study has a program designed specifically to educate family members on the dangers of their loved ones being lonely after moving to LTCF. R. Adam's answer to the question about family member loneliness education was:

We have like regular schedule, care plans for the residents and their guardians or their family members are invited to those care plan meetings, during that meeting that's when we discuss their overall every aspect of their care, so if there is issues with that loneliness, all those things are best discussed with them unless they want to be more involved and that's great. But most of them do not. (R. Adam, personal communication, February 12, 2015)

In this regard, I. Smith said, "You know it's a good question. Honestly, we don't have a good program for family members [regarding loneliness]. When a family comes in, the social worker will meet them and go over paper work" (I. Smith, personal communication, February 17, 2015). Also, P. Bliss said, "Usually that is kind of the social service person. . . . Some of [the family

members] comes visit anytime. If there is an issue, they can let us know; but as a formal program, not really” (personal communication, February 17, 2015).

All participants responded that there is no program in the facility to educate families on the danger of loneliness. However, the involvement of family members in the lives of the lonely older adults is very crucial in mitigating loneliness, most especially when there is a strong bonding between the older adult and the members of the family. There is tendency for the families not to be aware of their roles in mitigating loneliness in the lives of their aged relations in LTCFs. Hence, educating them will help them to be aware of the dangers of loneliness and the role they are expected in alleviating loneliness in the lives of their aged relations (Wilkinson & Marmot, 2003).

Theme 5: The Use of Companion Animals by Lonely Residents

Some studies have revealed that the possession of companion animals (usually household pets) by older adults is positively correlated to the older adults’ state of comfort and happiness (e.g., Banks & Banks, 2005; Banks, Willoughby, and Banks, 2008; Odendaal 2000). Also, the possession of (or access to) companion animals may be an effective tool for alleviating older adults’ loneliness. Even though there is a supposition that animal companionship is a protection against loneliness and not a solution to a long-lasting loneliness (Pikhartova, Bowling, & Victor, 2014). Hogarth-Scott, Salmon, Salmon, and Lavelle (1982) have stated that the positive outcome of the use of companion animals in dealing with some difficulties in the health issues of the older population cannot be discounted. Caregivers can go extra mile to encourage the older adults to own companion animals, or to make such animals accessible to facilities and residents.

Katcher and Friedmann (1980) also have pointed out that animal companions has the propensity to help reduce loneliness because they keep their human counterparts lively, agile and

the feeling of safety which in turn may be a great benefit to the health of a lonely older adult. Likewise, Mugford (1980) has observed that the major reason for the ownership of pet by older adults is to keep them company. Through their possession of pet, their need for physical closeness, friendly relations and a feeling of self-worth can be actualized. Moreover, one of the major problems associated with old age is the loss of companionship through the loss of a significant other, which can be, in some measure, alleviated through meaningful animal companionship.

Therefore, the use of companion animals by lonely residents of LTFCs may be a powerful tool in protecting them against loneliness. However, most residents do not have the ability to take care of these animals while they reside in LTCFs. There is therefore a growing need to direct such lonely residents to the use of technologically-based pets that are safe. The technologically-based pet has the ability to serve the same purpose as a living dog or cat, thereby giving the lonely residents an opportunity to bond with the pets, and feel less lonely (Saint Louis University, 2008).

In this study, when the researcher asked about the use of companion animals to combat loneliness among residents, all the participants positively responded with key words that are related to this theme category [pet therapy, companion animals, pet, cat, dog, and animal therapy] (see Appendix A).

For example, R. Adam, an administrator of one of the facilities, said, “we have a resident that has a cat, do I like it? Not really. But you know he has had this cat for years but you know, that means it is part of his family or so to speak” (R. Adam, personal communication, February 12, 2015). R. Adam’s negative reaction to the use of companion animals may be a form of bias

that can negatively influence the effectiveness of the use of companion animals to tackle loneliness in that facility.

In contrast, I. Smith responded by saying that:

We do allow them [family and friends] to come visit any time we do have families that will bring in dogs and we used to have a resident she is no longer with us that her daughter brought her cat on a leash it was so funny and we do have dog day on Friday we all can bring our dogs too we don't have pets that live here but any time people can bring in their pet to visit, (I. Smith, personal communication, February 17, 2015)

Similarly, B. Frank answered by saying:

We kind of have an activity they call pet therapy where they invite different people from the community to come in with their pets. [We have] different neighbors [here, some do not, while some,] you know like animals. We did have a dog a long time ago but it was a puppy so it's a little wilder, [we gave it out]. So we have been looking for [another dog], I guess an older dog. (B. Frank, personal communication, February 17, 2015).

P. Bliss also said, "We have a pet therapy [program] and if the family is bringing [in a family pet to visit?]. . . .We let their own pets come in [the facility]; we just required them to [offer] proof that [the pet] have been vaccinated" (P. Bliss, personal communication, February 17, 2015). M. Steve, an administrator of one of the facilities, responded affirmatively, "Yes, you know, they have to pay \$500.00 deposit to have a pet" (M. Steve, personal communication, February 18, 2015). And, R. Sperry said simply that residents "can bring their pets" to the facility (R. Sperry, personal communication, February 19, 2015). Last, R. Glade, the administrator from one of the facilities, responded positively on this one thing by saying that she "support [pets] through

hospice organization, dog therapy kind of dogs” (R. Glade, personal communication, February 18, 2015).

A companion pet is not a universal remedy for all the problems of old age. Although for older adults that are lonely it can enhance their daily activities and overall life satisfaction (Erickson, 1985). All the facilities in this study encouraged the use of companion animals without restrictive conditions, except Steve’s facility that mandated that residents pay \$500.00 deposit before they can be allowed to have an animal in the facility. Also some of the residents may not be able to afford the maintenance expenses which may include vaccinating the pet. Some residents who love to have their pet with them in this facility may be discouraged and disappointed as a result of not being able to afford the money. Nonetheless, most of the administrators reported that the use of pet was an antidote to battle against loneliness or the propensity to be lonely.

Chapter Summary

This chapter focused on the analysis and findings in the study. In this chapter, the researcher gave the description of the analysis and findings according to their theme categories. This include the symptoms and indicators of loneliness, the challenges confronting residents who are lonely, the strategic programs put in place, the program designed specifically to educate family members, and the use of companion animals by lonely residents.

CHAPTER 5

DISCUSSION

Russell, Cutrona, De La Mora, and Wallace (1997) have stressed that the issue of loneliness is a prevalent problem faced by the older adults residing in long-term care settings. Likewise, it is connected with a variety of physical and mental health consequences, including mortality (Hawkey & Cacioppo, 2010; Luanaigh & Lawlor, 2008), unhappiness (Cacioppo, Hawkey, & Thisted, 2010), high blood pressure (Hawkey, Thisted, Masi, & Cacioppo, 2010) and all kinds of destructive health conduct such as lack of physical fitness program, sedentary life styles, smoking, and binge drinking (Hawkey, Thisted, & Cacioppo, 2009; Lauder, Mummery, Jones, & Caperchione, 2006).

The Baby Boom generation is driving the most rapid growth of the older adult population in the history of United States, resulting in there being nearly 40 million individuals older than age 65. This number is projected to increase to approximately 88.5 million by 2050 (Crayson & Velkoff, 2010). With this demographic shift, it is inevitable that there will be a commensurate growth in the number of people in LTCFs; it follows that, without concerted focus, many of these people are likely to be lonely. Therefore, it is imperative for researchers, including social gerontologists, to conduct more studies to explore and have more insight into the factors that exacerbate loneliness, and strategic programs to mitigate and alleviate the problem of loneliness in the life of older adults residing in LTCFs.

Nonetheless, this study highlights the symptoms and indicators of loneliness among residents in the LTCFs, the challenges confronting residents who are lonely, the strategic programs put in place to mitigate the problems of loneliness among residents, the program designed specifically to educate family members on the dangers of their loved ones being lonely

after moving to the facility, and the use of companion animals by lonely residents to ameliorate the problems of loneliness.

Five main factors stand out in the literature that was reviewed in this study: a) lonely residents are more prone to social disconnection, loss of self-esteem, feelings of worthlessness and lackadaisical attitude to the core issues of life; b) lonely people have the propensity to live an unfulfilled life due to their despondent reaction to their immediate environment; c) loneliness of older adult immigrants is mostly as a result of cultural traditions, lack of close family ties, and language barriers; d) the use of strategic programs for residents and their families relating to loneliness could be a powerful tool for mitigating and alleviating the problem of loneliness in LTCFs; and last, e) the use of companion animals can also alleviate the feelings of loneliness among the residents who are comfortable with the use of animals.

Although most of the facilities represented in this study had a variety of social programs set up for their residents, but none of those programs were designed specifically to combat loneliness among the residents. With the growing awareness of the phenomenon of loneliness among older adults in LTCFs, and some evidence that strategic programs can be beneficial in this regard both at alleviating loneliness and reducing some of the adverse effects of loneliness,, there is need for more studies to be done in the areas of effective strategic programs to use in combating loneliness among older adults in LTCFs.

According to Rokach and Brock (1997), in the course of developing strategic programs for lonely older adult in LTCFs, various cultures must be taking into consideration during research. For example, Doherty, Hatfield, Thompson, and Choo (1994) have stated that it is vital for researchers to take cultural and ethnic differences into account most especially when designing research, so that the similarities and differences between individuals will be accurately

understood. If this kind of approach is applied to the study on the causes and interventions of loneliness in LTCFs, older adult immigrants will inevitably be considered. This approach will enable LTFC personnel to take into consideration people of different cultures that are resident in their facilities, thereby reflecting an understanding that the concept of loneliness is interpreted differently in various cultures (Rokach & Brock, 1997).

Long-term care administrators, nursing and medical staff, social workers, social gerontologists, and other professionals who are directly or indirectly involved in the care of the older adults in LTCF should partner with researchers and other long-term care practitioners to address and mitigate the problem of loneliness among older adults residing in LTCFs. Because inherent vulnerability of this cohort, programs that are designed to address the root conditions of social and emotional loneliness are warranted.

Based on the literature reviewed during this study, a wide range of strategic programs have been researched and proven to be effective in mitigating loneliness. These programs include activities that have evolved to combat the experiences of loneliness among older adults residing in LTCFs. These strategic programs include animal assisted therapy, and especially the use of robotic pets; elders-helping-elders programs; recreational therapy; information and communication technology; and the Eden Alternative program. The facilities included in this study did not use any of these programs for combating loneliness, except for the use of companion animals.

Most of the listed strategic programs above have been proven to be effective in combating both social and emotional loneliness. One of the goals of this study is to propose strategic programs for interventions that will effectively mitigate loneliness among older adults in LTCFs. Those programs are elaborated in the next section of this thesis.

Proposal of Strategic Programs for Loneliness Interventions

Loneliness is an insidious condition that commonly affects older adults in LTCFs.

Various programs for interventions have been proposed and tried to curb and ameliorate the feelings of loneliness among residents in LTCFs. Regrettably, none of the programs used by the facilities in this study have successfully curtailed or eradicated the problems of loneliness. In the researcher's estimation, it appears that the facilities were not aware of effective programs to mitigate loneliness among their residents. Hence, there is an urgent need for strategic programs to be initiated to ease the feelings of loneliness among residents in LTCFs (Luanaigh & Lawlor, 2008).

As a result of this study, and its accompanying literature review, the following strategic programs are proposed by the researcher for intervention in mitigating loneliness among older adults in LTCFs:

Animal assisted therapy and the use of robotic companion animals: The use of live companion animals such as dogs, cats, and birds for lonely residents who are pet lovers and have the ability to manage such pets is a useful tool for mitigating the issue of social loneliness. Goldmeier (1986) has asserted that animal-assisted therapy (AAT) is a useful tool for alleviating the problem of loneliness in long-term care settings, and older adults that own a pet are less likely to be lonely when compared to their counterparts who lack animal companionship. Banks and Banks (2002) discovered in their study that lonely residents in the LTCFs who received animal-assisted therapy as a strategic intervention improved dramatically due to the use of AAT. The residents in question had been pet-lovers throughout their life course trajectories. After moving into an LTCF, the separation from their beloved pets often left residents with a physical and emotional void, a vacuum caused by the unfulfilled deep desire to be with their beloved pets.

Clearly, the use of AAT as an early intervention to help these residents has proven to be useful in alleviating loneliness in LTCFs. As for residents who are incapable of handling live pets, the use of robotic pets is highly recommended, because robotic pets have proven to mitigate loneliness among residents as effectively as live pets (Banks, Willoughby & Banks, 2008).

Elders-helping-elders programs: Companionship is an essential constituent in friendship and it safeguards people from the hollowness and desolation associated with loneliness as well as plays a significant role in nourishing emotional well-being (Rook, 1987). This truth underlies much of the success of the burgeoning industry of elders-helping-elders programs. An example of one of these programs is the Senior Companion Program. This program is one of the most conventional and well-known friendly visitor programs in the country, it can be found in all 50 states and it is funded by both federal government and some private organizations. The program helps to connect older volunteers with frail elders needing companionship and assistance.

According to Butler (2006), helpful human relationships have increased physical and mental health among older adults and have enhanced their overall life satisfaction. Elders-helping-elders programs address older adults' human need for social integration and combats loneliness to which the frail older adults can be predominantly vulnerable. Butler (2006) also has asserted that volunteer visitor programs such as elders-helping-elders programs have a long history with remarkable results such as higher morale, better health, and better mental status of all older adults, both service providers and service recipients.

Additionally, there is significant proof that friends' support is more vital than family support to older adults' well-being (Butler, 2006). Elders-helping-elders programs can be beneficial to LTCFs, because one of the needs of lonely residents is to have genuine friends who

can give them their undivided time and attention, and who listen to their stories. In the process of talking to, and interactive with, other persons in a helping relationship, their lonely feelings can be alleviated, resulting in a positive outlook and positive attitude towards the issues of life, as well as improved health.

Recreational therapy: Generally, nurses in LTCFs are overwhelmed and overloaded with the day activities in taking care of the residents; their utmost priority is to be relentless in advocating for qualities services, medicine prescriptions, and other forms of treatment to ensure that the older adults in their care have a dignified quality of life (Buettner, 2001). One solution to this conundrum is the use of recreational therapy, under the guidance of Certified Therapeutic Recreation Specialists (CTRSs). Buettner, Kernan and Carroll, (1990) found that the fragile elderly in mental hospitals and nursing home settings that were involved in various CTRS based programs were more sociable and less lonely.

Regrettably, most long-term care training programs have failed in precisely defining and explaining the significant impact of recreational therapy in combating loneliness. There appears to be a lack of understanding as well as the use of recreational therapy, and the employment of CTRSs, in long-term care settings to reduce the incidence of loneliness among LTCF residents (Buettner, 2001).

Information and communication technology (ICT): Computers can be used by older adults as useful tool for warding off loneliness. The use of ICT has positive benefits for older adults living in LTCFs (Cotten, Anderson, & McCullough, 2013). Through the use of computers, older LTCF residents can network and interact with their friends and families through email, Facebook, voice and video calls, and do other useful online activities. They can conveniently do their shopping online without leaving the comfort of their homes to purchase different items.

Residents can hold chats with their family members and friends by using a variety of online media. Ultimately, older adults should be encouraged to learn how to use ICT for their own benefit, because of its social, emotional, and even financial benefits (Namazi & McClintic, 2003). According to Shapiro (1995), one of the greatest advantages of technology is in its ability to make the older adults more independent. Through the use of computers, older adults may be less susceptible to loneliness; even if their mobility is limited, they can take advantage of technology and socially connect with friends and families, which may reduce the risk that they will develop intractable loneliness. Other studies have revealed that the usage of computers can improve the older adults' self-worth, which in turn may reduce their feelings of loneliness (Danowski & Sacks, 1980; Cotten, Anderson, & McCullough, 2013). White et al. (1996) and Cotten, Anderson, and McCullough (2013) have discovered that older adults' use of email and other online tools is positively correlated to improved well-being of the older adults, as well as improvements in their ability to maintain their social network. Therefore, encouraging older adults in LTCFs to start using ICT to communicate with family members and friends and to complete other Internet transactions could help to enhance the older adults' social contacts and to decrease their overall experiences with loneliness.

Eden Alternative (AE) program: Another evidence-based program that has demonstrated to be effective in mitigating loneliness in LTCFs is the AE. This program is based on the premise that old age is an active segment in life trajectory, whereby the older adults should have a strong sense of dignity, personal development, and expression, and the opportunity for ongoing learning. Proponents of this program have confirmed that EA may alleviate feelings of boredom, loneliness and hopelessness among older adults residing in LCTFs by promoting independence, friendship, and sense of purpose in later life (Barba, Tosh, & Courts, 2002;

Sampsel, 2003; Bergman-Evans, 2004). The primary purpose of the EA program is the eradication of loneliness, hopelessness and boredom among LTCFs' older adult residents (Brune, 2011). With the EA, LTCFs will become homelike habitats for human beings instead of medicalized facilities for the frail older adults. By adopting EA philosophies, LTCFs may have fewer residents with chronic depression, reduced medication usage, lower staff turnover, and outstanding older adults and caregiver fulfillment.

There are a variety of other programs that have been proven to be effective mediations for loneliness. These programs include music therapy, humor therapy and reminiscence therapy (Hays & Minichiello, 2005; Tse, Lo, Cheng, Chan, Chan, & Chung, 2010; Chiang et al., 2010).

In this study, the researcher observed that none of the facilities' strategic programs proposed has demonstrated to be effective among lonely older adult immigrants in LTCFs. This outcome likely has occurred because none of the facilities had taken into account the cultural and ethnic backgrounds of their respective immigrant residents (Doherty, Hatfield, Thompson, & Choo, 1994).

Dong, Chang, Wong, and Simon, (2012) have suggested that strategic programs for addressing loneliness should be geared toward improving the social support of older adult immigrants. A typical way of enhancing their social support is through establishing community service centers with multilingual services, and providing opportunities for older adult immigrants to use and have access to these centers. Social workers may well play a crucial role in assisting older adult immigrants to establish sustainable ethnically- and culturally-sensitive social networks, thereby enriching the residents' supportive relationships, and physical and psychological well-being, which ideally will result in a drastic decline in their levels of loneliness. Also, social service agencies can be of great support in creating awareness. And

soliciting the involvement of the family members of older adult immigrants, thus prevent them experiencing unnecessary seclusion.

For these reasons, it is imperative that communities and governments play significant roles in decreasing older adults' social seclusion, and enhancing social networks and companionship opportunities for older adult immigrants. Also, there is need for social policy implementation that will help older adult immigrants and their family members to deal with fundamental issues such as loneliness in long-term care settings. Loneliness may be prevented if all of these supports are accessible to the older adult, regardless of their immigrant status.

Limitations and Suggestions for Future Research

Since this is a qualitative study utilizing a small, non-representative convenience sample of six administrators and one social worker in various LTCFs located in a small rural Midwestern town, it is not generalizable to other LTCFs across the nation. It would be useful to substantially increase the sample size to include multiple LTFCs in several states across the nation. The facilities in this study were all located in a rural setting. In future studies, if the participants' facilities are located in urban or suburban areas, the findings may indicate that different types of programs designed to address loneliness among older adults are warranted, beyond those suggested in this study. In other words, the geographic location of the LTCF, and the demographic characteristics of the facilities' residents, could be important factors for LTCF leaders to consider regarding the design use of strategic programs to alleviate loneliness among their residents.

The study design could be improved for future studies by using survey research design that will enable future researchers to cover wider geographical areas, and that will be relatively

easy and cost-effective to administer. For example, the survey could be administered remotely via online, mobile devices, mail, email, kiosk, or telephone.

Loneliness among older adult immigrants is an increasingly critical area of study, particularly with the rapid growth of older adult immigrants in American LTCFs. There is need for more research that will address the causes and intervention of loneliness in older adult immigrants residing in LTCFs, taking into consideration the unique aspects of their ethnicities and cultures. Moreover, a global comparative research on the issue of loneliness among older adults, as well as evidence-based programs for ameliorating loneliness in LTCFs, may be proper subjects for future research.

The educational background of the various administrators of LTCFs could also play a huge role. Hence, in future research, it may be advisable for researchers to ascertain if the administrators' educational backgrounds directly or indirectly impact the kinds of programs that they use to alleviate loneliness among their residents.

There are many possible paths for future research about loneliness among older adults in LTCFs. Work still needs to be done to combat older adult long-term care residents' social and emotional loneliness, with action taken through the design and implementation of strategic loneliness mitigation programs and otherwise. Another future research is the identification of common barriers to strategic programming to alleviate loneliness in LTCFs, which may include knowledge, perceptions, opportunities, and cost.

Conclusion

Being aware of loneliness in older adults is of critical importance for all health care providers, especially those in LTCFs. Caregivers of older adults in LTCFs need to be able to recognize the signs and symptoms of loneliness in their residents; more important, these

caregivers must be able to provide the appropriate interventions or strategic programs to mitigate these signs and symptoms.

This study complements the current body of knowledge by encouraging caregivers such as the administrators and nurses in LTCFs to recognize which older adult residents are at high risk for developing loneliness, and to be fully prepared to combat this largely avoidable scourge. These caregivers have a unique opportunity to listen avidly to their residents' stories and concerns about loneliness—and to do something constructive about it.

Caregivers employed by LTCFs—and the family members of LTCF residents—need to be educated about the predominance of loneliness in older adults residing in their facilities. One way in which LTCFs can do this is by employing any or all of the above-mentioned programs to recognize and address the behavior, beliefs, and characteristics of loneliness in their older adult residents.

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APPENDIX A

POSITIVE THEMATIC DATA ANALYSIS

Category	Theme	Theme Unit
1	<p>The Symptoms and Indicators of Loneliness</p> <p>Key Words: not interact, isolation, sad, crying, not socializing, stay in their rooms, leave me alone, withdrawing, come out, depressed, and not hanging out</p>	<p>P. Bliss: “when they do not interact or don’t want to come out for any meal and if when aids or nurses check on them or knock on their door and they just kind of say I am ok leave me alone”</p> <p>R. Adam: “isolation for one, sometimes behavior that’s probably two main things”</p> <p>I. Smith: “they do stay in their rooms for meals they don’t come out for activities, these are definitely the signs that will slap of in the face right away..., they are lonely, depressed and sad”</p> <p>B. Frank: “depression, probably withdrawing from activities and socializing and hanging out more in the room, depressed withdrawing from group activities and that indicate to us may be they are more depressed”</p> <p>M. Steve: said “crying and spending lots of time in their rooms by themselves”</p> <p>R. Sperry: “isolating themselves in their room not eating not coming out for activities not even wanting to participate in their own daily care”</p>
2	<p>The Challenges Confronting Residents who are Lonely</p> <p>Key Words: participate, to open up, to help you, loss of independence, feel uncomfortable, and family support</p>	<p>P. Bliss: “I think trying to get them to participate in activities, or trying to realize people have to help you get over that loneliness, especially when they are new, they feel uncomfortable. It is a new facility, new people, and new place. The</p>

		<p>best we can do is to make them feel comfortable and happy, this is their home but you still try to get them to open up. This generation is very private trying to get them to open up ...person we just ask them about things they like to do or eat or see. It is challenging to get them to open up on what they like to do”</p> <p>B. Frank: “they don’t have family support and I think that’s where the loneliness comes from, because we do offer them some activities to try to get them to interact with each other but, family support is the biggest challenge”</p> <p>R. Sperry: “Just adjusting to living their own home several of their belongings they can’t bring, you know it’s kind of a loss of independence to them.”</p> <p>R. Adam: “Our facility doesn’t have a lot of family contacts, so I think our residents have little bit high potential for that probably, and some we just try to keep them busy interacting with each other and activities and whatever, they kind of like to do, we kind of like to incorporate that in their daily lives, so you know it kind of helpful to some of them”</p>
3	<p>The Strategic Programs Put in Place</p> <p>Key Words: activities, program, therapist, socialize, companion animals, counselor, psychiatrist, social worker, online training system, watch movies, psychologist, human companion, reminisce, get involved, computer, assessment, topics, training, daily</p>	<p>I. Smith: “Some of the simple things we have in place are just that we do have the activities program obviously, that is just a normal program that we have to get people out and about to interact with each other, now some things we have for people who might be more kind of a severe case of loneliness is we do have licensed social worker that comes out</p>

	<p>activities, interventions, learning, and bingo</p>	<p>like a counselor and she can come out and just visit once a week with them to do more like counseling without prescribing medication or anything like that with them, but just do more counseling we do also have a psychiatrist which will be a more severe case of depression or things like that will be for medication if needed so we have those two things for severe cases We also have you know pastors that come in people anybody from their church familiar to can definitely come and speak to them as well probably the main things I can think of to kind of help with that-”</p> <p>P. Bliss: “We have an activities director and social services, when they first meet them, they try and give a background like family social history and also hobbies and also things they like to do, foods they like. Second, they develop a program they might like to do but then activities director brings in she tries to have different things for all the groups and then she designs it on one on one, some like to watch movies, some like to sit and have talk, and reminisce about things, so we try to make programs kind of gear towards what they like to do”</p> <p>R. Sperry: “We have our daily activities that our activity director goes around to each room every morning and invite everybody out but we can’t force them to come out and if To isolate themselves; we ask for a psychologist to come in or psychiatrist to come in and talk with them and see maybe is actual</p>
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		<p>depression or just loneliness”</p> <p>B. Frank: “The activities department they offer activities to try and get the residents out of their rooms to socialize more, we offer counselling service, it is contracted they have to pay through insurance but it’s down to normal then we can offer a service and they can see a psychiatrist”</p>
4	<p>The Program Designed Specifically to Educate Family Members</p> <p>Key Words: Family training, awareness program, loneliness, intervention, family support awareness</p>	None
5	<p>Use of Pets by Lonely Residents</p> <p>Key Words: pet therapy, companion animals, pet, cat, dog, and animal therapy</p>	<p>R. Adam, “we have a resident that has a cat, do I like it? Not really. But you know he has had this cat for years but you know, that means it is part of his family or so to speak”</p> <p>I. Smith: We do allow them to come visit any time we do have families that will bring in dogs and we used to have a resident she is no longer with us that her daughter brought her cat on a leach it was so funny and we do have dog day on Friday we all can bring our dogs too we don’t have pets that live here but any time people can bring in their pet to visit</p> <p>B. Frank: We kind of have an activity they call pet therapy where they invite different people from the community to come in with their pets different neighbors you know like animals. We did have a dog a long time ago but it was a puppy so it’s a little</p>

		<p>wilder so we have been looking for I guess an older dog</p> <p>P. Bliss: we have a pet therapy and if the family is bringingwe let their own pets come in we just required them to proof that they have been vaccinated” (personal communication</p> <p>R. Sperry: “they can bring their pets”</p> <p>M. Steve: “yes, you know, they have to pay \$500.00 deposit to have a pet”</p> <p>R. Glade: support through hospice organization, dog therapy kind of dogs</p>
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APPENDIX B

SUB-CATEGORY THEMATIC ANALYSIS
Strategic Program and Intervention Further Probing

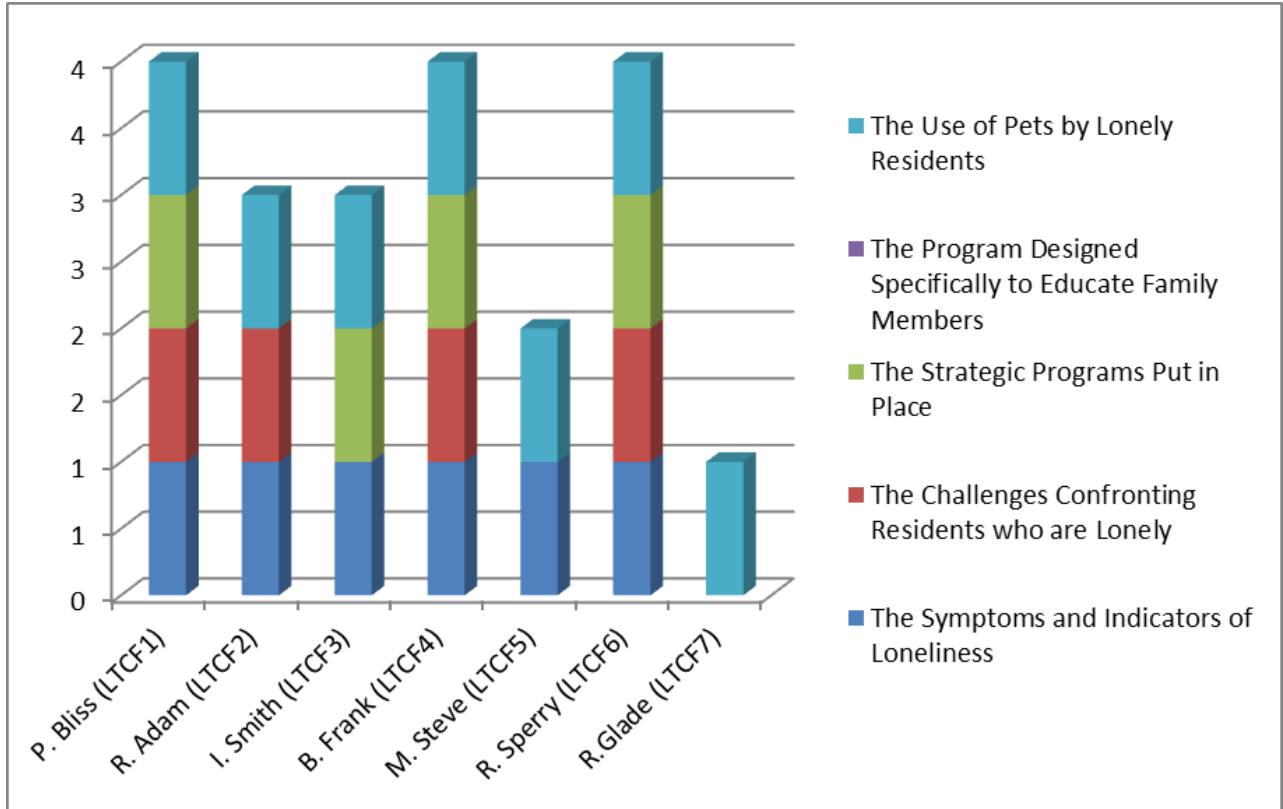
Sub-category	Theme	Theme Unit
1	Loneliness awareness programs for staffs	<p>I. Smith: We do each month, or once a month we and all the staff in service train on different topics and the director of nursing will... usually in charge of picking what topic we do every year she kind of have a rundown of what we go over and usually we do hit those topics</p> <p>B. Frank: when staff are new here they learn about the activities..... for wellbeing they cover a lot of different stuff so I am not sure if there is anything specific</p> <p>P. Bliss: we have online training system for the staff it include loneliness and stuff like depression</p> <p>R. Sperry: we have an online training system that the staff have several modules to each month our company is very good about touching on loneliness, depression, dementia and all that is covered on that learning</p>
2	Early intervention	<p>I. Smith: There is initial assessment that is done when somebody comes newly in the facility and that is done by a nurse and within seven days that they are here, it's kind of series of questions that are asked I feel like we are pretty good on catching those things.</p> <p>B. Frank: As social workers we do like a mood assessment to see and then if they score on a mood assessment maybe we can talk to them about interventions we also start a care plan so if they are on any</p>

		<p>medication for depression or if they already have a diagnosis of depression so we know what interventions we put in place</p> <p>P. Bliss: We do have contract with psychology, psychiatrist and they come around and talk with them and make recommendations, medicine is last resort try some medicine to help with mood and that's really kind of the last resort so we try to help them if our staff is labelled to let try and bring a professional if they are ok with their present state of mind they don't mind talking to them then we bring them in</p> <p>R. Sperry: We do an individual service plan upon admission and then review it often and our nurse assesses them for symptoms of depression or loneliness or anything that could cause them to start going downhill and so we catch up fairly early and able to develop a service plan to help them keep at the same level they are instead of declining</p>
3	Success rate of programs	<p>I. Smith: Probably, 70%, you know, some that may be passive participants, who might just be able to watch, some may be well think about bingo which you see in every nursing home and you have some who may be hard of hearing or confused, we do have people who might sit there with them and draw the number out they can't hear so help them</p> <p>B. Frank: probably 8-10% that will be if they are able to communicate there are lots of them who are not able to communicate. We don't know exactly how they are feeling because they are so far gone in them</p>

		<p>P. Bliss: 90-95% - Success rate, I say yes, we have a couple that were kind of upset that they were kind of here instead of home, they and families couldn't take care of them they have medical needs that was beyond the capabilities of the families and all of us try to make it part of our day to say hi and see how they are doing, to kind of help bring them out a little bit once they get comfortable with us one the person is very sweet like history I love history so much I will go and spend 10 minutes in a day at least and we talk about old TVs and movies or things they like to do and try to do fun things like that</p> <p>R. Sperry: 75% of them get involved in one activity or another. I mean they don't all come to everything the majority of them come to most of the activities</p>
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APPENDIX C

BAR CHART OF LTCFs THEMATIC TREND



APPENDIX D

Informed Consent to Participate in a Research Interview

Identification of Researchers: This research is being done by Patricia Akinbohun, a graduate student, and Dr. Musa Ilu, an Associate Professor. We are with the Sociology Department at University of Central Missouri.

Purpose of the Study: The purpose of this study is to examine the strategic programs and interventions put in place to address the issue of loneliness in the life of older adults residing in a long-term care facility (LTCF).

Request for Participation: We are inviting you to participate in a study on Loneliness among older adults and Strategic programs for intervention. It is up to you whether you would like to participate. If you decide not to participate, you will not be penalized in any way. You can also decide to stop at any time without penalty. If you do not wish to answer any of the questions during the interview, you may simply skip them. You can also decide to stop participating at any time.

Exclusions: You must be an administrator or a registered nurse in the facility to participate in this study.

Description of Research Method: This study involves an interview that will be digitally recorded and transcribed. The recording will be erased after transcription is completed. You can request that written notes be taken in place of the recording. The interview will take between 30 and 60 minutes to complete. You will be asked questions about loneliness and interventional programs currently in place in your facility.

Privacy: All of the information collected will be confidential. A false name will be assigned to you at the beginning of the interview. You will be given the name verbally so you can refer to it if you choose to withdraw your information from the study. All documents, except for this consent form, will not have your real name on them. This consent form will not be tied to the false name.

Explanation of Risks: The risks associated with participating in this study are similar to the risks of everyday life.

Explanation of Benefits: The benefit is having the satisfaction of participating in a research study that helps bring a greater understanding of loneliness among older adults in the facility and strategic programs for intervention.

Questions: If you have any questions about this study, please contact my research mentor Dr. Musa Ilu. He can be reached at ilu@ucmo.edu or at (660) 543-8533. If you have any questions about your rights as a research participant, please contact the Human Subjects Protection Program at (660) 543-4621.

If you would like to participate, please sign a copy of this letter and return it to me. The other copy is for you to keep.

I have read this letter and agree to participate.

Signature: _____

Date: _____

APPENDIX E

Interview Guide for Loneliness

I'd like to discuss with you the issue of loneliness among residents in LTC facilities.

What do you observe as the greatest challenge confronting residents who are lonely?

What in your perspective are the symptoms, and the greatest indicator of loneliness among residents?

Does your facility have any programs specifically designed to alleviate loneliness?

If yes:

What percentage of residents participates in the program(s)?

What is the success rate of the program or intervention?

- Probe for the most effective program(s) or intervention(s) for combating loneliness.
- Probe for whether there is early intervention in place to curb or address the issue of loneliness.
- Probe for whether there is an ongoing discussion among staff about how to improve the program (increase effectiveness, encourage higher participation, etc)

If no:

Have any programs to address this issue been discussed?

If yes:

Why haven't they been implemented? Probe.

If no:

- Probe for why not.
- Probe for whether the interview subject/staff believe there is a need for such a program.
- Probe to ascertain whether there are plans to discuss/design/implement such a program, etc.

Does your facility have any program designed specifically to educate family members on the dangers of their loved ones being lonely after being moved to the facility?

Does the facility allow the use of pets for residents who are lonely, and want to have a pet as a companion? Why or why not?