



Seniors: Loneliness and Social Isolation

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Introduction

Ageing is the gradual process of growing old. In Canada, the term 'old age' and senior is defined as an individual who is over the age of 65. Old age is described as a transitional period where older adults encounter changes in both his or her physical health and social roles (e.g., retirement, children becoming adults); these transitional changes are significant because older adults who adjust to later life transitions by being socially active tend to live a happier and healthier life than those who do not (Cornwell, Laumann, and Schumm 2008).

According to Statistics Canada (2015a), the senior age group experienced a 29.1% increase, indicating to us that the senior population is the fastest growing population in the country. Canada's senior population will continue to increase in the upcoming years as well (Statistics Canada 2004). In fact, according to Statistic Canada's (2015b) annual demographic estimates, the country's senior population has outnumbered children between the ages 0 to 14 for the first time in history. By 2036, it is estimated that the proportion of seniors in the overall population will range somewhere between 23 to 25 per cent (Statistic Canada 2015c). This strongly accentuates the need to grasp an understanding of the ageing population's precise needs, as well as the need to increase and improve social services in the ageing field.

According to the Mississauga Halton Local Health Integration Networks' (LHIN) report, Meeting Senior Care Needs Now and in the Future (2015), people aged 75 and older in this region will increase to approximately 55 per cent in the next decade. In addition, 44.3 per cent of the Mississauga Halton region identified themselves as immigrants, while the province's percentage of identified immigrants is at 28.5 per cent (Mississauga Halton Health Integration Network 2016). While the senior population in the Central West region is presently low, it is estimated by the Central West LHIN Population Profile (2015) to increase by 64 per cent by the year 2021. More than half of the local residents living in the Central West region belong to people of colour, racialized, or marginalized groups (Central West LHIN Population Profile 2015). Approximately 47 per cent of its population identifies as an immigrant with 13 per cent of its residents being newcomers to Canada (Central West LHIN Population Profile 2015). This highlights the need to employ regional-level programs, policies and strategies that will assist in creating an environment that will allow for active ageing.

On average, Canada's ageing population is found to live a more active, healthy and financially stable life than those from previous generations. However, seniors today are at an increased risk of being diagnosed with a chronic condition, disability and/or mental health illness (Canada's National Seniors Council 2014a). Seniors are also at a greater risk of becoming lonely or socially isolated. According to a 2012 International Federation of Aging report commissioned by the Employment and Social Development Canada (ESDC), the most prominent emerging issue seniors are facing is finding means to become, or remain, socially included and connected to their community. Knowledge and data on the effects of loneliness

and social isolation on Canada's senior population is limited. However, the findings do suggest that older Canadians are at a high risk of becoming socially isolated.

Lack of social relationships, discontent with the quality of such relationships, or low levels of social engagement and participation, have damaging effects on the quality of life for Canadian seniors (Victor, Scambler, Bowling, and Bond 2005, 358). In Statistics Canada's 2008/09 Canadian Community Health survey, it was found that 19 per cent of seniors lacked companionship and felt left out or isolated from others (Canada's National Seniors Council 2014a). Additionally, 24 per cent of seniors also reported the wish to participate in more social activities during that year (Statistics Canada 2015d). In a meta-analysis of 148 studies, Holt-Lunstad, Smith and Layton (2010, 4) found that individuals who have adequate relationships versus individuals who did not, had a 50 per cent greater likelihood of survival. This emphasises the importance of addressing loneliness and social isolation in the senior population immediately as well as demonstrates the high need to create and implement innovative intervention strategies to respond to this growing issue.

Defining Loneliness and Social Isolation

While there is some commonality between loneliness and social isolation, it is crucial to note that not all intersections between these two concepts are entirely clear, and therefore, these terms should not be used interchangeably (Victor et al. 2005). Loneliness can be defined and viewed in multiple ways:

...scholars from other disciplines have identified both negative and positive aspects of loneliness. For example, philosophers view loneliness as a vital element of human existence and as a motivating force for achieving a new connection, truth, and meaning and for discovering new possibilities (Rosedale, 2007). Although psychological scholars differ on whether loneliness is unidimensional or multidimensional, they agree that loneliness is an experience of separation that is associated with dissatisfaction and emotional distress and might arise during childhood and continue throughout life. Like philosophers, psychological scholars view loneliness as a motivational force for finding meaning, developing connections, and realizing one's fullest potential (Rosedale, 2007). Thus, the interpretation of the meaning of loneliness can be very subjective, and it can differ from one elder to the next. (Bekhet and Zauszniewski 2012, 215).

According to Victor (2012), "loneliness is a dynamic state that varies across the life course and is influenced by the resources available to individuals and their socio-environmental context as well as individual personality traits" (638). Loneliness is a difficult term to define due to its variability. There are numerous directions loneliness can take depending on its context. In order to properly determine loneliness, one must examine an individual's values, needs, wishes and feelings, as loneliness is both a subjective and negative emotion (Jopling

2015). Loneliness “reflects an individual’s subjective evaluation of his or her social participation or social isolation and is the outcome of the cognitive evaluation of having a mismatch between the quantity and quality of existing relationships on the one hand and relationship standards on the other” (de Jong Gierveld, Fokkema, and van Tilburg 2011, 41-42). Loneliness is an inevitable condition of existence, and therefore, it is crucial to recognize that the feeling of loneliness is not something which can be entirely solved or cured (Bekhet & Zauszniewski 2012).

However, due to loneliness being unavoidable, we should examine the various types of loneliness and acknowledge the need for different interventions to interrupt these varying types of loneliness. Past literature categorizes loneliness into five groups: emotional loneliness, social loneliness, intense loneliness, short-term loneliness, long-term loneliness.

Current literature discusses social loneliness and emotional loneliness in extensive detail. Robert Weiss (1973) discusses the ‘differentiated emotional loneliness’ and explains that emotional loneliness is due to the lack of an intimate figure (e.g., such as a spouse or a best friend) in an individual’s life. For social loneliness, Weiss believes it to be about the absence of an engaging social network of friends, co-workers, and members of their community (de Jong Gierveld, Fokkema, and van Tilburg 2011). Weiss (1973) also writes that emotional and social loneliness can co-exist or occur independently. It is also believed that personality and an individual’s network groups contribute to the development of emotional and social loneliness (Havens et al. 2004). Lack or low levels of social relationships, discontent with the quality of such relationships, or low levels of social engagement and participation are all linked to having damaging effects on the quality of life for Canada’s seniors (Victor et al. 2005).

Intense loneliness is found to be more frequent in divorces, widows or widowers, individuals who are living alone or in deprived areas, or those threatened with deteriorating health (de Jong Gierveld, Fokkema, and van Tilburg 2011). Long term loneliness increases one’s risk of developing severe health risks such as depression. In fact, “depression is one of the most common psychiatric disturbances in later life and can have devastating consequences on the quality of life and functioning and has been associated with mortality” (as cited by Pronk et al. 2011, 887). Long-term loneliness refers to individuals who have experienced lifelong loneliness, while short-term loneliness refers to loneliness as a new experience:

“...there are different types of loneliness typology and trajectories in later life; we can differentiate those who are consistently lonely; those whose loneliness increases; those for whom loneliness decreases; and those who are never lonely, along with a further group of the ‘fluctuating’ lonely who moved into and out of loneliness over time...” (Victor 2012, 644).

In addition, there is an inadequate amount of research on topics of loneliness such as loss of an adult child or the loss of a loved one through war. More evidence research is needed to

establish whether or not these topics can be placed in their own category of loneliness or if they can be placed in one of the categories discussed above. While it is evident that there are distinct differences in types of loneliness, we treat the experience of loneliness as homogeneous and implement universal interventions in attempt to ‘combat’ loneliness. This is seen as problematic; instead we must recognize that loneliness is a subjective and unique experience that should not be treated as a ‘one size fits all’ in its solutions to interrupt it.

Unlike loneliness, social isolation is an objective state that can be defined as a lack of social belongingness, the perception of missing relationships, or a lack of lasting interpersonal relationships (de Jong Gierveld and Kamphus 1985). Similar to loneliness, “social isolation is multidimensional. It encompasses physical dimensions, mental health and psychological dimensions, and social dimensions. It can be more or less severe, and has a temporal dimension; that is, it could be permanent, periodic, or episodic if related to life cycles or life transition phases” (Keefe et al. 2006, 1). Nicholson (2009) also defines social isolation as “a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling quality relationships” (1346).

Isolation can be split into two distinct categories. The first is emotional isolation, which is a type of desolation felt by the loss of someone close or an attachment figure (Hagan, Manktelow, Taylor and Mallett 2014). The second category is social isolation, which this review will endeavour to discuss in more detail, refers to a lack of engagement with others (Hagan, et al. 2014). More specifically, it focuses on the quantity of social relationship one has. To summarize, “social isolation is an objective measure of contacts with other people, while loneliness is considered to be the subjective expression of dissatisfaction with the level of social contact” (as cited by Havens, Hall, Sylvestre and Jivan 2009, 130). Both concepts are seen as significant issues that are closely associated with Canada’s aging population and are strongly believed to be determining factors of health and well-being in seniors (as cited by Havens, et al. 2004).

Although social isolation is often linked with loneliness, it is crucial to recognize that social isolation is not always the sole cause of loneliness (Havens, et al. 2004). An individual may feel lonely despite having many interactions with their different social networks, and therefore lonely individuals may not necessarily be socially isolated. It is also important to recognize that living in a communal setting still leaves older adults at risk of becoming socially isolated. For instance, the prevalence of social isolation in community-dwelling older adults (individuals who live in collective dwellings such as residences for senior citizens, long term care homes, retirement or health care and related facilities) is estimated to range from 10 per cent to as high as 43 per cent (as cited by Nicholson 2012).

In some cases, social isolation can be referred to as solitude and can be a personal choice (e.g., someone who is an extrovert) (Havens, et al. 2004). However, this should not be used as the lone argument to describe why seniors are lonely or isolated, for it not only individualizes the problem and places blame on the ageing population, but it also discounts

the numerous structural barriers that are both influencing and producing these substantial rates of loneliness and isolation in seniors. There is not a clear reason which explains why some older people with low levels of social support do not become lonely nor is there enough research to expound on precisely why those with high levels of support do (Victor 2012).

Prevalence of Loneliness and Social Isolation in Seniors

While loneliness and social isolation can occur at any point in life, research finds that loneliness is most common among older seniors and adolescents (Nummela, Seppänen and Uutela 2011). Therefore, it can be said that loneliness has a U-shaped distribution against age (Nummela, Seppänen and Uutela 2011). In a study conducted in the Netherlands, it was found that 20 per cent of its older population was mildly lonely and that 8 to 10 per cent of its seniors were experiencing intense loneliness (de Jong Gierveld et al. 2011). In the UK, it is believed that 5 to 16 per cent of seniors are lonely (as cited by Canada's National Seniors Council 2014b). In addition, it is estimated that 10 per cent of the population in the UK that is over the age of 65 experience chronic loneliness or experience loneliness for a prolonged period of time (as cited in Canada's National Seniors Council 2014b). Another study in the UK also found that "the prevalence of severe loneliness among older people living in care homes is at least double that of community-dwelling populations" (Victor 2012, 637).

Canada lacks statistics on the prevalence of loneliness in its ageing population. In Winnipeg, Manitoba, the prevalence of loneliness ranges anywhere from 10 to 90 per cent depending on what definition and population is used (as cited by Canada's National Seniors Council 2014b). In a report conducted by the Centre for Addiction and Mental Health, it is estimated that loneliness affects 10 per cent of older adults and is seen to be associated with depression and suicide (as cited by Canada's National Seniors Council 2014b). Given the range of various sampling methods, the lack of studies measuring social isolation, and the vague definitions and research methodologies used, these studies can only provide us with a very elementary view of the effects loneliness and social isolation has on Canada's senior population. However, despite having limited research on this topic, it is abundantly clear that loneliness and social isolation in Canada's ageing population is on the rise and will continue to grow unless proper interventions are initiated.

The literature discusses that Aboriginal seniors, newcomers, immigrants, caregivers, lesbian, gay, bisexual, or transgendered seniors are all at an increased risk of becoming lonely and/or socially isolated (Canada's National Senior Council 2014b). It is believed that those who experience language barriers are also at an increased risk of experiencing loneliness and/or social isolation (Canada's National Seniors Council 2014b). Older immigrants, minority ethnic groups, and lower income seniors are at a higher risk of becoming lonely as they have fewer social interactions due to language barriers, literacy, and discrimination. These individuals are also more likely to have fewer social interactions and lack a sense of belongingness to their community (Canada's National Seniors Council 2014b).

Aboriginal Peoples

Aboriginal people who are seniors may face barriers with practicing culture and language, as well as socio-economic disadvantages and regional differences as they might live in rural or more remote areas such as reserves (Canada's National Seniors Council 2015b). Aboriginal seniors who live in remote areas with specific health issues are also at an increased risk of becoming social isolation when they have to move to receive health treatments (Canada's National Seniors Council 2015a). Older Aboriginal people are also still healing from the effects of the intergenerational trauma that has stemmed from colonization (e.g., residential schools and the 60s Scoop). This historical oppression is still very much entrenched in today's institutions, and as a result, this population may possibly feel resentment and unwilling to reach out for services to help ease their loneliness and/or social isolation. There is a high need for new means to develop ways to incorporate Indigenous worldviews into future interventions.

Lesbian, Gay, Bi, Transgender Groups

Although research on this group is severely limited, UK research has reported that 41 per cent of LGBT people over the age of 55 live alone while only 28 per cent of older adults who identify as heterosexual live alone (Guasp 2011). Older adults who identify as lesbian, gay or bisexual are also more likely to have smaller social networks, see their family less often, consume more alcohol or drugs, have higher rates of mental illness, and face more barriers for necessary health care (Canada's National Seniors Council 2014b). Additional research expounds that loneliness can be acute among older lesbian and gay people as well (Jopling 2015), however due to there being gaps in literature on loneliness and social isolation in the LGBT community, additional evidence research must be collected to evaluate whether or not mainstream interventions are adequate in meeting the needs of older adults in the LGBT community (Jopling 2015).

Visible Minorities – People of Colour

Approximately 7 per cent of Canada's ageing population consists of visible minority group members (Acharya and Northcott 2007). Research shows that some, but not all, older adults from visible minority communities have higher rates of loneliness than non-minority groups (Jopling 2015). In addition, levels of loneliness amongst newcomers and immigrants "may be influenced by 'country level' factors such as discrimination and racism against particular migrant [immigrant] groups" (Victor et al. 2012, 67). This may be because "the experience of growing old in a 'foreign land' where cultural norms and values concerning social engagement and social relationships may be very different and where social networks maybe confined to immediate kin" (Victor et al. 2012, 67). Ethnically diverse older adults are under-represented in all areas of research across North America and it is unknown whether or not community-specific interventions would be the most effective way to address loneliness among minority ethnic groups (Jopling 2015).

Immigrants and Newcomers

Immigrating to Canada presents many life changes and psychological stress which can be furthered challenged by language barriers, loss of status, disrupted and smaller social networks, conflicted family values and cultural differences from their host society (Hossen 2012). Due to immigrants who migrate later in life, their social networks tend to be much more limited (Hossen 2012). Due to their “recent arrival, unfamiliar social environment, poverty, poor health and communication problems, it is difficult for them [immigrants and newcomers] to participate effectively in the economic, social, political, and cultural life” (Hossen 2012, 1). With language barriers present, older immigrants may also face difficulties reading newspapers and magazines, understanding news reports and the media, face challenges with using public transportation -- which increases an individual’s risk of becoming lonely or socially isolated (Maiter 2003).

Some immigrants and newcomers may also experience the same nature of issues as those who are part of visible minority groups. Many older immigrants reside in multigenerational households (e.g., their adult children’s houses) where they can become inhibited and their feelings of loneliness exacerbated (Hossen 2012). Older immigrants may also be given the responsibility of acting as a caregiver to their grandchildren, which can be exhausting both physically and mentally (Canada’s National Seniors Council 2014b). Research also suggests that high levels of caregiving can cause an older person to disconnect from others, increase stress, and exacerbate their feelings of social isolation (Canada’s National Seniors Council 2014b). However, some reports show that “...multigenerational households can reduce loneliness and stress levels and facilitate adjustment to a new society... while other studies show that multigenerational living is likely to increase stress and conflict and cause dissatisfaction” (Hossen 2012, 1).

Risk Factors

There are many risk factors that can significantly increase an older person’s likelihood of experiencing loneliness and/or social isolation. Some of the risk factors work interchangeably together and therefore are difficult to place into distinct categories; this indicates that the risk factors for loneliness and social isolation are both complex and multifaceted.

There are four sets of factors that are shown to be linked to loneliness and social isolation: socio-demographic attributes, the socio-environment, health status and health resources, and life transitions.

Socio-Demographics and Social Contexts

Commonly seen as one of the key risk factors for the development of loneliness and/or social isolation in older adults is living and suitable housing arrangements. When older adults reach the age of 85 years and older, the most common living arrangement shifts from living as a couple to living alone. This is said to be a significant risk factor for an older adult to experience loneliness and/or social isolation. Living arrangements influences socialization

patterns and therefore individuals may be less likely to participate in activities outside the comfort of their home due to the absence of a ready companion (Havens 2004).

In addition, some seniors are required to move into long term care facilities due to deteriorating health or other reasons. However, rates of severe loneliness for older people residing in care homes is estimated to be double of those who live in a community-dwelling (Victor, 2012). It is found that a change in residence or living alone may also increase one's risk of becoming socially isolated (Canada's National Seniors Council 2014b). In fact, 44 per cent of seniors in residential care have been diagnosed with depression or show symptoms of depression without diagnosis (Canada's National Seniors Council 2014b, 4). Senior men over the age of 80 also hold the highest suicide rates out of all age groups in Canada (Canada's National Seniors Council 2014b). In addition, the Centre for Addiction and Mental Health (2013) concludes that "social isolation and exclusion are important factors in suicidal behaviour among the elderly" (1).

As stated earlier, one can be among many social networks and still experience high rates of loneliness and/or social isolation. According to Canada's National Seniors Council (2014a), lack of publicly funded long-term care facilities for seniors imposes additional risks that may increase an individual's chance at experiencing loneliness and/or social isolation:

The shortage of publically funded long-term care beds, the cost of living in private facilities, and the discrepancies in regulations from one jurisdiction to another were some of the other housing concerns raised by participants [seniors]. Because of shortages or having few affordable options, some seniors may have to accept beds in facilities outside their home community, that don't accept pets, that may not offer services in the language of their choice or be sensitive to their cultural needs. (15).

An individual's psychological attributes, such as personality, is also thought to be a risk factor. Although research on this topic is limited, it is believed that traits such as self-efficacy and introversion or extroversion might increase or decrease the likelihood of an older adult becoming lonely and/or socially isolated (Victor 2012).

Although research is limited, some studies suggest that gender may be a risk factor for loneliness and social isolation. One study found that women are more likely to experience both emotional and social loneliness following the death of their partner (as cited by Havens, et al. 2004). It was also found that women are more vulnerable to experiencing severe loneliness and/or social isolation because they are more likely to live alone, become widowed, or experience longer periods of declining health (as cited by Havens, et al. 2004). It was found that only 14 per cent of older female seniors live with their spouse or partner compared to 53 per cent for male counterparts (Community Development Halton 2015a).

Senior women are also more likely to lose their drivers licence (mostly due to their longer life expectancy) than men counterparts (Community Development Halton 2015b). This not only impacts an older person's mobility and way of life, but also effects them emotionally as

well. The implications of inaccessible transportation for older adults will be discussed in more detail later on. While some research indicates that gender is a risk factor for loneliness and/or social isolation, other research has found that being a woman is not a predictor of being at an increased risk (Havens, et al. 2004). Therefore, more evidence research must be collected in order to determine whether or not gender can be considered as a risk factor for loneliness and/or social isolation in seniors.

The way in which a family is structured is also thought to be a risk factor for social isolation and/or loneliness in seniors. This includes younger family members migrating for work (Canada's National Seniors Council 2014b), having no children, having children who live far distances away, and the loss of siblings or other social networks (de Jong Gierveld et al. 2011). All these determinants can result in smaller social networks which can increase the likelihood of a senior experiencing loneliness and/or becoming socially isolated.

Another group that is at an increased risk of loneliness and/or social isolation is seniors who are caregivers for either their parents, siblings, children, grandchildren, or other relatives (as cited by Canada's National Seniors Council 2014b). Seniors who endure high levels of caregiving, such as working intense or long hours while dealing with their own physical or mental health, can result in seniors becoming isolated, stressed or depressed; all which are severe attributes and symptoms of social isolation (Canada's National Seniors Council 2014b). The literature on caregiving tends to focus on its relationship to social isolation and not on loneliness.

Limited education is also thought to be a risk factor for social isolation in seniors. In a report written by Cloutier-Fisher (2006) it was found that "socially isolated persons [are] more likely to have a high school education or less, and [are] not as likely to have post-secondary training" (30). Seniors income status, or rather having a low income status, is also thought to be a risk factor for loneliness and/or social isolation in seniors. The same study also found that "socially isolated persons are more likely to report their household income being lower than \$50,000 a year" (Cloutier-Fisher 2006, 30).

Poverty is thought to be a substantial risk factor for loneliness and social isolation in seniors as well. In a study that looked at the lived experience of lower-income individuals, it was found that poverty hindered one's ability to find affordable transportation to participate in social organizations and events that would allow one to feel accepted and as if they belong in a community (Stewart, Makwarimba, Reutter, Veenstra, Raphael and Love 2009). The study also found that living in poverty influenced perceptions and experiences of prejudice and stigma, which seems to increase the likelihood of an individual to become socially isolated as they are less likely to become involved in community activities and more likely to distance themselves through self-isolating behaviours (Stewart et al. 2009).

Socio-Environment

The built environment – whether there is an absence of affordable and suitable housing or lack of accessible and affordable transportation – will impact the prevalence of loneliness

and social isolation in older adults. This includes the built environment of a senior's neighbourhood, the local transport infrastructure, and material resources (Canada's National Seniors Council 2014a). For instance, if a long-term care facility does not have a bus stop directly outside of its building, older adults who live in that dwelling will face barriers with travelling to social events that allow them to become engaged with their community.

The cost of transportation is also a significant factor to consider, particularly because it is believed that older adults with lower incomes are at a higher risk of becoming lonely and/or socially isolated. For instance, older adults with a low income and living in a rural area with few transportation options may become isolated despite the fact that he or she wishes to become more engaged in their local community (Canada's National Seniors Council 2014b).

Accessibility of services or access to information for services also increases the likelihood of seniors becoming lonely or socially isolated. Gateway services such as transportation and technology, can be useful if an older adult knows how to use them. However, if they do not know how to use them or if they are inaccessible, then these gateway services not only act as a disabler, but puts these individuals at a higher risk of becoming lonely and/or socially isolated (Jopling 2015). The stigma surrounding loneliness and social isolation also limits older adults to seek help or even reveal what their needs are in the first place (Jopling 2015), which as a result, makes it difficult to create services and information that will accurately address the ageing population's needs.

Lack of affordable or suitable housing is also said to increase the likelihood of an older adult in becoming lonely and/or socially isolated. As discussed earlier, the prevalence of social isolation in community-dwelling older adults is estimated to range anywhere from 10 per cent to as high as 43 per cent (Nicholson 2012). The likelihood of loneliness in older adults living in care homes is also found to be double that of older adults who live in community-dwellings (Victor 2012). Experts have suggested that care homes try to create an environment that promotes normal social interactions, such as arranging chairs into small groups, which would assist in encouraging people to interact with one another (Jopling 2015). However, there are additional barriers for people living with disabilities, as well as individuals living with cognitive impairments, to find suitable ways to socialize in these care home settings as well (Jopling 2015). Evident through these findings, suitable housing plays a substantial role in the prevalence of loneliness and social isolation. Despite many seniors residing in communal living, the ageing population is still experiencing high rates of loneliness and/or social isolation.

The literature has also gathered research to discover whether or not older adults living in an urban or rural area will increase the prevalence of becoming lonely and/or socially isolated. There is an assumption that older adults living in urban areas are more likely to experience loneliness than older adults living in rural areas (as cited by Burholt and Dobbs 2012). The reasoning behind this is because rural settings tend to be portrayed as being more socially integrated and is therefore more "supportive, friendly, and neighbourly" (as cited by Burholt and Dobbs 2012, 437). However, other literature believes loneliness in remote rural areas

may be hidden and therefore go unnoticed (as cited by Burholt and Dobbs 2012). Another study found that loneliness and social isolation in older adults is a significant issue regardless of geographic location (Havens, et al. 2004). Additional research must be collected in order to clearly establish whether or not geographic location play a role in the prevalence of loneliness and social isolation in the ageing population.

Another factor that may increase the likelihood of an older adult becoming lonely and/or socially isolated is the walkability and physical safety of their community (Canada's National Seniors Council 2014b). It was found that seniors feared leaving their dwelling and visiting public spaces because they were concerned for their physical safety "due to higher crime rate or perceived higher crime rates, lack of information or awareness to access community services and programs, or being reluctant to form new relationships, or not wanting to go alone to activities" (Canada's National Seniors Council 2014b, 6).

Health Status and Health Resources

Given that studies have found that a lack of adequate social networks is linked to a 60 per cent increase in dementia and cognitive decline, and that a more integrated lifestyle can act as a protector against dementia (as cited by the Canada's National Seniors Council 2014b), it is evident that health is a significant risk factor in becoming lonely and/or socially isolated.

Living with a compromised health status has been recognized as a possible risk factor for increased social isolation (Canada's National Seniors Council 2014b). This includes both physical and mental health. While we cannot claim that mental illness is the exclusive cause of loneliness and/or social isolation in older adults, "it is likely that mental health affects the likelihood of social isolation, and that persons experiencing social isolation are more prone to mental health issues" (Canada's National Seniors Council 2014b, 4). Canada's National Seniors Council's report on the Social Isolation of Seniors does an accurate job at describing the vicious cycle of dealing with social isolation and mental health needs: "isolated seniors can become depressed or develop other mental or physical health problems; seniors who have a mental illness or other health issues either refuse to or are unable to seek the help they need, become further isolated" (16). Older adults must also deal with the stigma associated with both mental illness and their old age.

Other "age-related disabling conditions such as incontinence, frailty, fear of falling when going to and from venues, or general loss of independence have also been identified as risk factors for social isolation" (Canada's National Seniors Council 2014b, 5). Loneliness and social isolation also tends to be a frequent companion of older adults living with chronic illnesses and has been "associated with a range of negative health outcomes including elevated mortality, chronic illness, psychological ill-health, health service use and negative health behaviors" (Victor 2012, 644). Limited access or inadequate primary health care services have also been identified as a potential risk factor for seniors to become lonely and/or socially isolated.

Life Transitions

The last category to be discussed is life transitions. Life transitions are unavoidable and can vary anywhere from the death of a spouse or partner, death of an adult child, death of a grandchild, death of friends, to the experience of a traumatic or negative life event, decreased functional competence or increasing incapacity in one's partner, divorce, and lastly, retirement (Canada's National Seniors Council 2014b). In one study, it was found that 60 per cent of widows and widowers experienced feelings of loneliness after the death of their partners (de Jong et al. 2011). However, nine months after their partner's death, only 40 per cent of the widowed and widowers were still lonely and only 20 per cent managed to recover from their loneliness (de Jong et al. 2011).

While these life events are inevitable, how older adults cope with transitions such as bereavement is inherently different and therefore puts this group at risk of experiencing short-term or long-term loneliness. Loneliness and social isolation is also said to be more apparent among older adults who have outlived their spouses or partners, family members and friends (Havens et al. 2004), and therefore makes those who fit into this category of life transitions to be at an increased risk of becoming lonely or socially isolated as well.

Due to the fact that these life transitions are fundamentally different and that older adults will be coping with these various life events and other risk factors in different ways, it is important to emphasise the need to not implement interventions that are 'universal' and seek to 'combat' loneliness and social isolation in seniors. Each of these life transitions are immensely complex and multi-layered and therefore its intervention cannot be treated as a one size fits all. Each of these life events will cause a different type of loneliness to form -- whether it be emotional, long-term, short-term, or intense -- and therefore will require different interventions to interrupt them.

To conclude, the more social demographics, socio-environment, health and health resources, or life transitions an older adult encounters, the more likely he or she is to experience loneliness and/or social isolation.

Consequences and Implications

The consequences of social isolation and loneliness is grouped under three different categories: economics, physical and mental health, and social.

Economic

The ageing population plays a significant role in the development and integration of a community through volunteering. However, volunteering decreases when seniors experience social isolation (Canada's National Seniors Council 2014b). The contributions older adults make to their communities hold great value and assist in making a community whole, especially in the social services field, and therefore should be considered both an issue and priority for the entire community to repair (Canada's National Seniors Council 2014b).

Seniors also make substantial contributions to Canada's paid economy (Canada's National Seniors Council 2014b). All age groups benefit from seniors involvement in the economy as we all profit from the continued engagement in the labour force (Canada's National Seniors Council 2014b). Some examples of the benefits seniors bring to the labour market are: "increased income, increased intergenerational learning opportunities, and retention of technical skills, leadership talent and corporate memory" (Canada's National Seniors Council 2014b, 6). Risk factors that are associated with social isolation and severe loneliness counter against labour force participation as it increases poor health, ageism, stigmas, and lack of information and awareness of opportunities (Canada's National Seniors Council 2014b).

Physical and Mental Health

The consequences for social isolation and loneliness in seniors is quite deleterious. This is because research finds that loneliness and social isolation are closely associated with negative physical health outcomes such as mortality, dementia, depression, and high blood pressure (Victor 2012). The implication of loneliness and social isolation can also lead to other negative health behaviours such as smoking, overconsumption of alcohol and a decrease in physical activity and exercise (Victor 2012). In addition, "the mortality differential between lonely and non-lonely individuals has been reported at 50 per cent... which is equivalent to the mortality differential between smokers and non-smokers" (Victor 2012, 638). Some additional physical and emotional consequences of social isolation are: "poor nutrition, decreased immunity, anxiety, fatigue, [and] premature institutionalization (Canada's National Seniors Council 2014b, 7).

The consequence of loneliness and social isolation can also lead to higher rates of dependency for health services. For instance, lonely individuals are three times more likely than individuals who are not lonely to consult with their general practitioner (Victor 2012). Lonely individuals also have 30 per cent higher hospital admission rates than their non-lonely counterparts (Victor 2012). According to Cloutier-Fisher (2006), the growing rates of social isolation in seniors might result in a financial burden on the healthcare system as isolated seniors are more likely to wait until they are older and in much poorer health to seek medical attention. In terms of loneliness, the weakening of social networks for seniors have been identified as "detrimental to older people's mental health and well-being" (Canada's National Senior Council 2014b, 7). Seniors who live alone and lack adequate social networks also have an increased risk of developing dementia (Canada's National Senior Council 2014b), which again could potentially place an additional burden on Canada's healthcare system.

Social

Evident through the discussion on how loneliness and social isolation in seniors will impact Canada's economy and health care system, it is very clear that it will also leave a negative mark on society. For instance, there could be a rise in inappropriate service usage, lack of social cohesion, and even a decrease in civic participation and contribution in community activities (Keefe et al. 2006). The consequence of this includes: "[lower] socio-economic

status, social inequalities, change in income and social status, [less] control over life situations, [decrease in] social supports, social networks, social engagements, social capital and social cohesion” (Keefe et al. 2006, 6).

It is important to recognize that Canada’s ageing problem will continue to grow, as baby boomers are actively ageing. Attempting to ignore and/or postpone proper interventions that will accurately address this large population’s needs will only further impede society. To conclude, the consequences of loneliness and social isolation in seniors is far too severe to overlook and discount any longer.

Interventions

The first portion of this section will discuss and examine the different interventions being suggested by Canada’s National Seniors Council. The report discusses interventions that will occur on both a federal and provincial level to assist in countering social isolation in seniors. The second half of this section will discuss alternative interventions and suggestions made by other literature.

Canada’s National Seniors Council’s Suggested Interventions

Future policies and practices should quickly aim to target and identify seniors who are at risk of becoming socially isolated (Canada’s National Senior Council 2014b). Individuals must be identified early with interventions before their health or quality of life grows worse (Canada’s National Senior Council 2014b). There is also a high need for the government to collaborate with the ageing population to create and implement these programs. Allowing for popular education to be a technique used in the collaborative process to redevelop interventions is imperative as it will allow seniors to identify important gaps in previous interventions, as well as discuss the factors that put them at risk of social isolation, as well as how to promote social inclusion in a meaningful way (Canada’s National Senior Council 2014b).

As noted by the British Columbia Ministry of Health (2004), present day interventions for older adults who are socially isolated are small programs that are population specific. Current interventions need to find innovative ways to learn about its target population and evaluate possible consequences of these different interventions (Canada’s National Senior Council 2014b). It is crucial to address various social problems that continue to be prominent in Canadian society, such as poverty, suitable and affordable housing, and substance abuse and depression in order to begin establishing interventions that will help alleviate seniors from being social isolated (Canada’s National Senior Council 2014b). Future interventions must also incorporate specific characteristics that have been successful in the past into new interventions (Canada’s National Senior Council 2014b).

The need to raise awareness among the ageing and general population, as well with health and social service providers, is crucial if the government wishes to alleviate social isolation in seniors. Establishing more awareness will allow the ageing population to identify the signs

and symptoms of mental health problems which can allow for early detection and assist in preventing social isolation all together (Canada's National Senior Council 2014b). Raising awareness can also assist in decreasing ageism, as well as educate the country's entire population on the reality of retirement. Many carry the belief that retirement is a time of luxury and relaxation for seniors, when in reality, that is not the case (Canada's National Senior Council 2014b). With ageism, lack of suitable housing, and other factors, the reality of retirement for the senior population has changed and is a new challenge many are struggle to cope with.

The federal government aims to work collaboratively with the provinces to promote the World Health Organization's Age-Friendly Communities Initiative that has the goal of developing communities so they can create a healthier and safer environment for Seniors to live in (Canada's National Senior Council 2014b). Some goals of this initiative include: creating affordable and accessible transportation, as well as improving access and opportunities for seniors to engage in civic, cultural, employment and volunteer activities in their communities (Canada's National Senior Council 2014b).

As for the provinces and territories, their intervention to alleviate social isolation in seniors is to establish home visiting programs for seniors who are unable to engage in community programs (Canada's National Senior Council 2014b). It is also suggested that the provinces and territories also offer support to service workers and volunteers by training health staff and volunteers with the knowledge to understand social isolation and how to identify individuals who are at risk (Canada's National Senior Council 2014b). The provinces and territories should also encourage support service providers and volunteers to spend additional time with individuals who are unable to leave their home and who are at risk of becoming socially isolated (Canada's National Senior Council 2014b).

There is a growing need to examine the linkages between transportation and level of participation in social activities when addressing new ways to alleviate social isolation and loneliness. Access to public transit, taxis and carpools are immensely important for interventions as most seniors are less likely to hold a driver's license after the age of 85 (Canada's National Senior Council 2014b). Organizations that offer interventions to counter social isolation in seniors should offer accessible transportation options for those with limited mobility (Canada's National Senior Council 2014b). There is also a need for better access to information on resources and services. Interventions must also be sensitive to potential barriers such as literacy and communication impairments to assist in creating better access to community resources (Canada's National Senior Council 2014b).

Canada's National Seniors Council (2014b) also writes that interventions such as telephone befriending programs and the use of internet as a communication tool have been associated with decreased social loneliness in seniors. Canada's National Seniors Council (2014b) explains that these low-cost programs have allowed older adults to gain confidence, reengage with the community, and become socially active. However, the council did not discuss how technology also poses potential barriers to some older adults, and can further

exacerbate the exclusion of people (Jopling 2015). Technology can be effective in some cases but not all. It is important not to rely too heavily on technology as a main intervention to counter loneliness and social isolation as it will only be effective for individuals who are knowledgeable in operating new technology, and therefore not universally applicable to all seniors.

Canada's National Seniors Council's Report on the Social Isolation of Seniors (2014a) suggest four specific measures to counter social isolation:

1. Raise public awareness of the social isolation of seniors;
2. Promote improved access to information and services and programs for seniors;
3. Build the capacity of organizations to address isolation of seniors through social innovation;
4. Support research to better understand the issue of social isolation.

Other Suggested Interventions

Various literature has shed light on the fact that Canada's current interventions being used to counter social isolation and loneliness in seniors are ineffective (de Jong et al. 2011). To further this point, Canada's National Seniors Council's report only reviews social isolation in seniors and not loneliness. While these two terms are often associated together, they should not be used interchangeably. Current approaches with social isolation and loneliness in seniors are not specific activities or interventions, but rather services designed to address one or more of the key challenges faced in working with seniors who are lonely. The 3 key issues are: "reaching lonely individuals, understanding the nature of an individual's loneliness and developing a personalized response, and supporting lonely individuals access to appropriate services" (Jopling 2015, 9).

In order to create new interventions that are effective, commissioners and funders of services that work with the ageing population must be able to identify areas in the community that are in need (Jopling 2015). We also need to see an increase in support service providers who deliver these interventions. Additional research needs to be done so a more comprehensive understanding of loneliness and social isolation in Canada can be developed and addressed (Jopling 2015).

The problem with current interventions is that they are only beneficial if an older person who is socially isolated and/or lonely chooses it and if the intervention is well suited to their individual needs. New intervention must provide services that can first draw lonely or social isolated older adults out and then find ways to respond to their individual needs (Jopling 2015). This is because loneliness is a subjective experience that is based on a person's perceptions and attitudes towards the value of their social relationships (Jopling 2015). There is a high need to create spaces where seniors and service providers can "have in-depth dialogues on topics such as requirements for specialist support to overcome barriers to accessibility caused by mobility issues, sensory loss, or cognitive impairment" (Jopling 2015, 19).

Due to the fact that various interventions used currently are treated as a one-size fit all approach, it is evident that not every senior who is lonely and/or socially isolated are going to have their needs met by these current approaches. As mentioned previously, with the stigma attached to the word 'lonely', seniors are less likely to reach out for help and reveal what their specific needs are (Jopling 2015). Current approaches are promoted as holistic and person-centred services that assist in active ageing, building resilience, and supporting loneliness, however, these programs are arguably not framed as effective interventions to counter loneliness (Jopling 2015), and therefore new ways to interrupt loneliness and/or social isolation is needed. Instead of continuing to create interventions that have limited input from the ageing population, steps must be taken to ensure that new strategies are offered to those most likely impacted by loneliness, rather than having interventions being made as universally available (Jopling 2015).

This can be done in three ways. The first way requires one to use data and target action. This means using literature on the many risk factors of loneliness and social isolations in seniors to target services for that specific population who is at risk (Jopling 2015).

The second way is called 'eyes on the ground'; this requires a person to use individuals and professionals in specific communities who are most likely to be in contact with the community's older population (Jopling 2015). Once in contact with this group of people, proper training can be given so individuals and professionals are able to recognize the signs of loneliness and offer appropriate referrals and support (Jopling 2015).

The third and final way connects to health services and refers to the high need to link up the provision of loneliness and social isolation interventions to the health care services (Jopling 2015). This is crucial considering the strong linkage between mental health and social isolation and/or loneliness.

Another approach that experts discuss is the need for services that support older people through the process of reconnecting with their social networks and communities (Jopling 2015). These services include providing seniors who are lonely with a friend or a mentor. With their friend or mentor, the individual is able to develop a relationship with someone who offers practical and emotional support (Jopling 2015). This approach differs from the befriending relationship, as those approaches tend to be time sensitive and too heavily focused on the achievement of very specific goals that the lonely individual creates (Jopling 2015). By revamping this approach, it will allow for a long-term support structure or social connection to form in itself (Jopling 2015).

Interventions to counter loneliness and social isolation in seniors must find strategies to create meaningful social contacts and connections. Two examples of this is group-based and one-to-one interventions. Group based approaches are targeted at a specific group, based on either a common interest or educational focus, and ultimately aims to involve older people in leading the groups (Jopling 2015). The literature surrounding group interventions appears to be quite mixed. Having older adults take control of these groups tends to be the deciding factor of the effectiveness of these groups (Hagan et al. 2014). It is also suggested

that the effectiveness of self-help groups in reducing grief, depression and loneliness may increase when group members maintain social contacts outside of the group (Hagan et al. 2014). Group members tend to see an increase in self-esteem, competencies and life satisfaction in these groups as well (Hagan et al. 2014).

The one-to-one approaches are geared towards older adults who are faced with practical barriers that prevent them from moving back into the wider community (Jopling 2015). However, it has been found that one-to-one befriending is too weak to be seen as an effective intervention in reducing loneliness (as cited by Jopling 2015). Instead, as discussed earlier, the traditional befriending model should be built upon and further developed in a range of ways to increase efficacy and offer older adults the opportunity to become involved by becoming befrienders themselves (Jopling 2015).

Given the connection literature has found between social isolation, loneliness and mental health, it is important to examine possible psychological approaches that can be used to counter social isolation and/or loneliness in the ageing population. Psychological approaches aim to support people in changing their way of thinking about their social relationships (Jopling 2015). Approaches such as Cognitive Behaviour Therapy (CBT) and mindfulness strategies is believed to be a prospective way to address the 'maladaptive social cognition' socially isolated and/or lonely older people face (Jopling 2015). However, these two approaches are generally used for individuals who are diagnosed with depression and is still in its early stages of research to determine its effectiveness in interrupting loneliness and/or social isolation.

Another intervention discussed in the literature was a variety of neighbourhood approaches. Neighbourhood approaches allow for us to deal with loneliness in older adults by breaking down different interventions into manageable chunks and promote more outreach efforts and initiatives (Jopling 2015). This includes asset based community development, volunteering, and age positive approaches (Jopling 2015). The asset based community development (ABCD) model functions by identifying and mobilizing individual and community assets, rather than concentrating on problems, needs, or discrepancies (Jopling 2015). This approach looks to base itself around citizen involvement; it holds discussions with local older people on what they want, and aims to be sustainable (Jopling 2015). The ABCD model is an effective approach because it develops the kind of groups, activities and services that research proves to be most effective in tackling loneliness (Jopling 2015).

The next approach to be discussed is volunteerism. Volunteering in the community is said to be an effective intervention to tackle loneliness as it not only helps alleviate it, but it also prevents loneliness too (Jopling 2015). Multiple studies done on volunteering emphasises the positive effects it has on an individual's ability to develop their social connections and well-being (Jopling 2015). However, there is limited evidence on the effects of volunteering as a possible intervention for loneliness and therefore more evidence is required.

The age positive approach has to do with demographic change. It involves around local authorities and other commissioners placing an emphasis on healthy and active ageing in

policy and practice, as well as rejecting stereotypes of later life and ageism (Jopling 2015). This approach assists in creating a positive mentality among a wide range of organizations and institutions within a community (Jopling 2015). This also encourages institutions to be more creative when thinking of new ways to ensure services and facilities allow for older adults to remain socially connected (Jopling 2015). This approach also needs additional research in order to evaluate its effectiveness, but seeing as ageism is said to be a potential barrier older people face, rejecting stereotypes on the ageing population would most likely assist in dismantling existing barriers and promote older adults to seek help for their loneliness and/or social isolation.

Gaps and Limitations

Interventions to reduce or prevent loneliness will not succeed until further research is conducted on social isolation and loneliness in the Canadian ageing population. Canada's current research and evidence-base does not keep up to date with the constantly changing dynamic of its ageing population and the diversity of groups who are growing older (Victor 2012). This includes older adults who are Aboriginal, individuals who identify as lesbian, gay, bisexual, transsexual, or those who are immigrants or newcomers to Canada.

There are substantial gaps in research for the ageing population who come from a minority background. To be specific, there is a lack of evidence based on the most effective ways to address loneliness and social isolation among minority ethnic groups. There is also a large gap in research surrounding the most effective way to meet the needs of LGBT older adults.

CBT, mindfulness therapy, neighbourhood approaches, volunteering, one-to-one settings, transportation to and from programs and the ABCD model are all underrepresented in research. It is recommended that additional research evidence is gathered to accurately examine whether or not the interventions discussed here can be effective in countering loneliness and/or social isolation in seniors. Although research is limited, there is a growing understanding that communal living is not an effective intervention to deal with loneliness. More research is desperately needed on finding new interventions that are suitable for older adults who live in communal living spaces. However, in order to develop interventions to counter loneliness in care home settings, research must first understand the extent of this issue and identify those who are at an increased risk (Victor et al. 2012).

The British Columbia Ministry of Health (2004) suggested the following for future research: “exploring the experiences of different ethnicities with loneliness and social isolation; examining the interaction of loneliness with poverty; focusing research on transportation; investigating the experience of caregivers of spouses who live with a disability; identifying direct linkages between social isolation and service usage; and exploring what elements of social support enhance health” (Canada's National Seniors Council 2014b, 11). Research evidence is crucial as it will assist in guiding programs, develop policies, and validate funding for program evaluations that guarantees that programs addressing loneliness and social isolation in older adults are able to demonstrate its efficiency, effectiveness and accountability (Canada's National Seniors Council 2014a).

More and more older Canadians are at an increased risk of becoming socially isolated and/or lonely because of factors such as unsuitable living arrangements, an increased risk of having a compromised health status, changing family structures, death of family members and more (Canada's National Seniors Council 2014a). Loneliness and social isolation in seniors is not a phenomenon that can be ignored any longer as its impact on Canada's ageing population is too severe. This literature review has identified that, while there is an extensive amount of knowledge referring to the causes, risks factors, consequences and interventions that seek to address loneliness and social isolation in seniors, numerous gaps remain.

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