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Persuade of Coping with Loneliness on Quality of life of Elderly

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Abstracts

Loneliness have long been identified as problems associated with old age (Sheldon 1948; Halmos 1952). Loneliness denotes a "lack of… quantity and quality of social contacts"(Delisle, 1988). It is a state in which one experiences a powerful feeling of emptiness and isolation, a feeling of wanting company or wanting to do something with another person. Loneliness is a very complex, multidimensional phenomenon; it may be regarded as a 'geriatric giant', leading to impaired quality of life. (Libret S ,et al.), so coping with loneliness is very important for better Quality of life.The purpose of the study is to explore the coping strategies for loneliness of elderly male and female staying in family setting in Kolkata & to explore the effect of dimensions of coping with loneliness on quality of life of elderly. The study was conducted on 100 subjects purposely selected from family setting in Kolkata. The investigation was conducted with the help of coping with loneliness scale by Rokack & Brock (1998) & WHOQOL BREF questionnaire (1996). Findings suggested that elderly female cope in better way with loneliness in terms of social support networks and religion & faith and their QOL also better but elderly male cope in better way with loneliness in terms of reflection & acceptance; self development & understanding; distancing and denial & increased activity and having better QOL than female elderly.

Key words: Elderly, loneliness, coping with loneliness, quality of life

Introduction

Feeling of loneliness occurs among all age groups. Though, the most vulnerable seems to be the elderly people. (Killeen 1998) Donaldson and Watson (1996) claim that more attention should be pay to elderly because they are at risk of social isolation due to reducing contacts with other people. In average, one third of elderly population suffers from loneliness at least sometimes (Victor et al. 2005; Savikko 2008; Theeke 2009). Illness, death of a spouse, busy life of their children, shrinking of the social network, lack of friends etc.(Victor et al. 2005, Theeke 2009) are the most common causes of loneliness (Savikko 2008).

Loneliness is associated with increasing age. However, it has been found that after age of eighty-five, loneliness does not play a significant role in elderly people's lives (Tiikkainen, & Heikkinen 2005, 529; Victor et al. 2005, 371). In this age, not amount of social contact but a quality of relationship is more important (Holmén & Furukawa 2002, 269). Another explanation of decreased perception of loneliness in this age group may be "survivor effect and adaptive response" (Victor et al. 2005, 371). Lonely people either die or move from community to institutional care or they overcome the bereavement process and adjust to new circumstances. (Tijhuis, De Jong-Gierveld, Feskens & Kromhout 1999, 494; Holmén & Furukawa 2002, 271; Victor et al. 2005, 371; Tilvis, Laitala, Routasalo & Pitkälä 2011.)

Qualitative studies focus on elderly people's perception of loneliness and their coping strategies. In Pettigrew and Roberts' study (2008), loneliness was thought, by most of elderly Australians, to be a natural part of aging and older age as a result of

decreased participation in social activities due to health problems, death of friends and busy life of their children. On the other hand, many of the participants felt that loneliness can be decreased by constructive free-time activities, like reading, gardening or taking part in voluntary work. (Pettigrew & Roberts 2008, 304)

Unlike in the Australian study, Hauge and Kirkevold (2009) explored elderly people's understanding of loneliness more deeply. Their findings confirmed that loneliness is highly subjective. Differences of loneliness description were found between "not lonely" and "lonely" group, by lonely people giving more comprehensive description. What more, loneliness was seen negatively and was stigmatized. The group of "not lonely" reported loneliness to be one's own fault connected to one's personality and passive attitude to life. (Hauge & Kirkevold 2009.)

LONELINESS, DESPITE ITS PERVASIVENESS, can be successfully addressed and its pain reduced. If one subscribes to the belief that loneliness is as natural and integral, a part of being human as are joy, hunger, and sorrow, it stands to reason that the aims of the approaches and strategies enumerated in the present paper are to control rather than prevent loneliness.

Rationale

This empirical observation is done because I wanted to see gender differences in perception of coping with loneliness and how that affects their quality of life. Much of the previous research and theorizing into loneliness has focused on the causes of loneliness and the associations of loneliness to other behavioral and emotional problems such as depression, self-esteem, and suicide. Not as much theorizing and research have been done on coping strategies and their relationship to loneliness, especially on cross-cultural and developmental levels. Even a lesser amount of research has attempted to collect and categorize people's subjective descriptions of loneliness and how they cope with it and how coping with loneliness can change the QOL of elderly.

Objectives

The objectives of the present paper were as follows-

1) to assess the socio-demographic status of elderly people living in family setting in kolkata
2) to explore the coping strategies for loneliness of elderly male and female staying in family setting in Kolkata
3) to explore the effect of dimensions of coping with loneliness on quality of life of elderly
4)

Method

Variables:

Loneliness denotes a "lack of… quantity and quality of social contacts" (Delisle, 1988). It is a state in which one experiences a powerful feeling of emptiness and isolation, a feeling of wanting company or wanting to do something with another person.In other words it is a situation involving few social roles and associations as well as an absence of mutually rewarding relationships with other people. Such loneliness occurs at three levels micro (individual), meso (community) and macro (society) (Delisle 1988, Delisle, 2005), they contribute to the marginalization of the elderly, reducing them to collective solitude and danger of imminently becoming individually alone with minimal sociability. deJong-Gierveid (1987) suggests that lack of social support and exclusion from the social network of existence become the host for welcoming loneliness. Loneliness is therefore unwilling solitude. (Ginter, et al. 1994).

Coping with loneliness: cope with loneliness is to try to reduce the loneliness**.**

Quality of life: An elderly person's Quality of life is the degree of well-being felt by the individual. Lawton. (1991), states that Quality of life is the multi-dimensional evaluation, by both intrapersonal and social normative criteria of the person environment system of an individual in time past, current and anticipated.

World Health Organization conceptualized **quality of life** in cross- cultural terms. **Quality of life** was defined as: An individual's perception of his/her position in life, in the context of the culture and value systems in which they live, and in relation to their goals, expectations, standards, and concerns. It is a broad ranging concept, affected in a complex way by the person's physical health, psychological state, and level of independence, social relationships, and their relationship to salient features of their environment. (WHOQOL group 1993,)

Area: - 10(ten) words within the jurisdiction of Kolkata municipal corporation.
Sample: - 100 (50 male and 50 female) within the jurisdiction of Kolkata[1]. Purposive sampling was done to meet the needs of the study.

[1]**Kolkata Metropolitan Area (KMA),** the largest urban agglomeration in eastern India, extends over 1851.41 sq. km. and envelopes 3 Municipal Corporations including Kolkata Municipal Corporation, 38 Municipalities and 24 Panchayat Samitis. KMA holds a population of 14.72 million, according to 2001 Census, as against the total urban population of West Bengal of 22.5 million. (source: http://www.kmdaonline.org/html/about-us.html; accessed 21.09.12)

Sample selection criteria

Selection of Respondents

i) Minimum 65 years of age in both the sub groups.
ii) Elderly who are capable of Activities of Daily Living. * (ADLs) in both sub groups.
iii) Elderly who was government employee

*In Gerontological literature Activities of Daily Living (ADL'S) are operationalized as personal-care activities such as Ambulating (walking), Transferring (getting up from a chair), Dressing, Eating, Drinking, Personal Hygiene (bathing, using the toilet) and Taking medication etc. (Raju, 2002; Dunlop, et al. 1997; Everard et al. 2000).

Tools used: -

1) General information schedule (containing both open ended and close ended question on socio-economic status, formal and informal care, intra-generational interpersonal relationship)

2) Coping with loneliness scale by Rokack & Brock (1998)

3) WHOQOL BREF questionnaire (1997)

Measures:

Coping with loneliness scale by Rokack & Brock (1998) was used to assess Coping with loneliness among elderly male and females. The scale consisted of 24 items with five alternative responses ranging from strongly agree to strongly disagree.

The scale assesses Coping with loneliness arising from the six dimensions:

1. Reflection and acceptance

2. Self Development and understanding

3. Social support Network

4. Distancing and denial

5. Increased Activity

1. Reflection and Acceptance factor highlighting the benefit of solitary reflection on one's feelings, thoughts, and alienation from others and increased awareness and acceptance of one's loneliness, and a consequent cognitive restructuring of the situation via the discovery and actualization of one's resources.

2.Self-Development and Understanding factor highlights the strength and belief in oneself and one's worth and increased understanding of one's self and situation that may be gained from newly acquired acquaintances and friends or as a result of counseling or therapy with a member of the clergy or medical health profession.
3. Social Support Network, focuses on increased social involvement and interaction with others via renewal of old friendships, attendance at social functions, written correspondence and telephone contact, and seeking romantic connections.
4.Distancing and Denial factor depicting unhealthy behaviors such as exaggerated consumption of medication, alcohol and drug abuse, self-induced isolation, attempting suicide, turning to crime, or denying loneliness altogether.
5. Religion and Faith, focuses on the feeling of belonging and community commonly felt when people attend religious services and the strength and comfort that humans receive through a faith in God or a higher power.
6.Increased Activity factor include devoting more of one's self to work as well as taking on extracurricular activities to make one's solitary time more pleasant, productive, and meaningful, or alternatively, to perhaps enhance one's social contacts and relationships.

This research was based on a phenomenologically derived model of coping with loneliness that was composed of six factors (Rokach & Brock, 1998): (a) Reflection and Acceptance (which included items highlighting the benefits of solitary reflection on one's feelings and thoughts and the increased awareness and acceptance of one's loneliness), (b) Self-Development and Understanding (which highlighted the increased understanding of one's self that may result from newly acquired friends or as a result of counseling), (c) Social Support Network (which focused on in- creased social involvement and interaction with others), (d) Distancing and Denial (which depicted unhealthy behaviors, such as exaggerated consumption of medication, alcohol and drug abuse, self-induced isolation, or denial of loneliness), (e) Religion and Faith (which focused on the feelings of belonging and community that people commonly feel when they attend religious services), and (f) Increased Activity (which addressed the devotion of oneself to work as well as taking on extracurricular activities to make one's solitary time more pleasant, productive, and meaningful)

The **WHOQOL-BREF** instrument comprises 26 items, which measure the following broad domains: physical health, psychological health, social relationships, and environment. Each domain consists of various items which were rated on a five point scale. The raw score for each domain was calculated and then transferred into a range between 0-100. Higher scores suggest higher quality of life

Quality of life of the respondents was measured using **WHOQOL-BREF (1996)**. This scale has four domains of multiple items. The physical domain has 7 items which include; pain and discomfort, dependence on medication, energy and fatigue, mobility, sleep and rest, activities of daily living and working capacity.

The psychological wellbeing domain has 6 items which include; positive feelings, negative feelings, spirituality, thinking, learning, memory and concentration, body image and self-esteem. The social domain has 3 items including; personal relationship, sexual activity and social support. And the environment domain has 8 items including; physical safety and security, physical environment, financial resources, information and skills, recreational and leisure, home environment, access to health and social care and transport. Each item was rated on a five point scale. The raw score for each domain was calculated and then transferred into a range between 0-100. Higher scores suggest higher quality of life

Data Collection: - Face to face interview by visiting the respondents in their old age homes.

Statistical test: - Mean, t-test,Co-relation.

Results and discussion:

Table-I:- Distribution of elderly on the basis of their socio-demographic profile

Age	Male (N=50) No.(%)	Female(N=50) No.(%)	Total (N=100) No.(%)
65-69 year	14(28)	10(20)	24(24)
70-74 year	16(32)	18(36)	34(34)
75-79 year	12(24)	12(24)	24(24)
79 and above	8(16)	10(20)	18(18)
Educational Status			
Illiterate	2(4)	4(8)	6(6)
Primary	4(8)	8(16)	12(12)
Secondary	8(16)	18(36)	26(26)
Graduate	22(44)	16(32)	38(38)
Post Graduate	6(12)	4(8)	10(10)
Professional	8(16)	0	8(8)
Marital Status			
Married	30(60)	24(48)	56(56)
Unmarried	12(24)	4(8)	16(16)
Widow/widower	8(16)	20(40)	26(26)
Divorce/separated	0	2(4)	2(2)
Religion			
Hindu	50(100)	50(100)	100(100)
Muslim	0	0	0
Caste			
General	24(48)	28(56)	52(52)
SC	16(32)	14(28)	30(30)
ST	6(12)	6(12)	12(12)
OBC	4(8)	2(4)	6(6)
Family Type			
Nuclear	38(76)	35(70)	73(73)
Joint	12(24)	15(30)	27(27)

Table I shows the socio-demographic profile of elderly. In this study, 28%of male elderly and 20% of female elderly are within the age group of 65-69 year, 32%% of male and 36% female elderly are from 70-74 year old; 24% male and 24% female are from 75-79 year old group and 16% of male and 20% of female elderly are belonging to 79 and above age group. Thus most of the elderly male and female are from age group of 65-69 year.Study suggests most of male elderly (44%) are graduate and most of the female elderly (36%) having secondary education Most of the elderly (60% of male and 48% of female) are married; 24% of male and 8% of female are un married and 16% of male and 40% of female are widow/widower.100% of respondents are from Hindu community. Most of the elderly (48%of male and 56% of female) are belonging to general category. Most of the elderly(64% male & 56% female) are from nuclear family.

Table-II showing the Mean of coping with loneliness scale of male and female elderly

Dimensions of coping with loneliness	**Male**	**Female**
Reflection and Acceptance	14.99	14.65
Self Development and Understanding	12.14	11.48
Social Support Network	1.58	4.05
Distancing and Denial	5.90	4.21
Religion and Faith	10.85	14.05
Increased Activity	11.92	12.78
Total Mean	**57.38**	**61.62**

Table II is shown that the female elderly cope with loneliness on the basis of their social support network, Religion and faith and increased activity but Male elderly cope with loneliness on the basis of Reflection and Acceptance, Self Development and Understanding and Distancing and Denial.

The total mean score for coping with loneliness of elderly females living in family was 61.62 and the total mean score for coping with loneliness of elderly males was 57.38. So, female elderly cope in better way than their counterparts in family setting. Shukla.A and Pathak.S, (2011) study also supports this result.

Table-III showing the level of significance for coping with loneliness scale of male and female elderly living in family setting

Dimensions of coping with loneliness	t-value	Level of significance
Reflection and Acceptance	0.07	Non significant at 0.01 and 0.05 level
Self Development and Understanding	1.61	Non significant at 0.01 and 0.05 level
Social Support Network	2.78	Significant at 0.01 level
Distancing and Denial	2.75	Significant at 0.01 level
Religion and Faith	2.07	Significant at 0.05 level
Increased Activity	2.68	Significant at 0.01 level

Table-III indicates that female elderly cope in better way than male elderly. There was significant difference in coping with loneliness with reference to social support network, Distancing and denial, Religion and faith and Increased activities whereas there is no significant difference in coping with loneliness with reference to Reflection and acceptance and self development and understanding.

Having a social Support Network, which may be contracted in a variety of ways from attending impersonal social events to being involved in deeply personal relationships, provided a feeling that one belongs and is loved and valued (Blieszner (1998)). As women are commonly known to be able to make social contacts and relate others even on a superficial manner better than men (Shukla.A and Pathak.S,2011), they scored high on social support network.

Moreover men are more prone to substance abuse in order to cope with loneliness than do females (Rokach and Orzeck, 2004). Substance abuse if a product of differential gender socialization (Krugman,1995)

Religion and Faith refers to religious beliefs and particularly beliefs about having a relationship with God and having a faith in supreme power. Elderly females engage more in religious activities because through affiliation with a religious group and participating, its faith one can gain strength, inner peace and a sense of community belonging (Rokach,1999)

Increased activity refers to devoting more of one's self to work as well as taking of extracurricular activities to make one's solitary time more pleasant, productive and meaningful. It may decrease their dependence on others foe experiencing, satisfaction and may consequently increase their sense of personal control. Moreover pleasurable and satisfying activities may aid in lifting the sadness or depression that often accompany loneliness (Rook and Peplau, 1982)

There was no significant difference found between male and female elderly with respect to Reflection and acceptance and self development and understanding may be the reason is that the most of the sample elderly belonging to age group of 70-74 year old . At this stage of life, elderly do accept that they are lonely.

Table-III showing the mean of QOL- BREF questionnaire of male and female elderly

Gender	Physical QOL	Psychological QOL	Social QOL	Environmental QOL	Overall QOL
Male	52.78	51.65	30.72	38.54	43.42
Female	49.14	53.24	32.69	42.9	44.49

Table III shown that female elderly had higher quality of life than the male elderly living in family setting. Only in case of physical QOL , male elderly had higher QOL but in other three domain i.e psychological QOL, social QOL and environmental QOL female elderly are having better QOL that their male counterparts.

So, It can be said that in case of coping with loneliness female elderly are much better and their QOL is also better than male elderly, Male elderly have less capacity to cope with loneliness so their overall QOL is also worse than female elderly. So, it can said that coping with loneliness is the important pre condition for having better QOL for elderly.

Table-IV Showing the Co-relation of quality of life and coping with loneliness dimensions

	Reflection and Acceptance	Self Development and Understanding	Social Support Network	Distancing and Denial	Religion and Faith	Increased Activity	Overall QOL
Reflection and Acceptance	1						
Self Development and Understanding	.389(**)	1					
Social Support Network	.540(**)	.393(**)	1				
Distancing and Denial	.397(**)	.421(**)	.238(*)	1			
Religion and Faith	.653(**)	.625(**)	.672(**)	.685(**)	1		
Increased Activity	.524(**)	.256(**)	.5929**)	.103(*)	.276(**)	1	
Overall QOL	.156(*)	(.458**)	.542(**)	.143(*)	.695(**)	.365(**)	1

** Correlation is significant at the 0.01 level (2-tailed).

* Correlation is significant at the 0.05 level (2-tailed).

Table-IV Showed there is significant co-relation between overall quality of life and various dimensions of coping with loneliness of elderly. Higher correlation is between social support network and QOL; religion & faith and QOL and between Increased activity and QOL. So, we can say if coping with loneliness will be better, then QOL will also become better.
Bradburn's theory of Self Perceived General Well Being (1969) and Levinson's theory of Developmental Periods (1978) show relation between individual's current general well-being and adaptation to retirement and coping with loneliness.

Conclusion

- Female elderly cope with loneliness on the basis of their social support network, Religion and faith and increased activity but Male elderly cope with loneliness on the basis of Reflection and Acceptance, Self Development and Understanding and Distancing and Denial.
- Female elderly cope with loneliness in better way than their counterparts in family setting. Shukla. A and Pathak.S, (2011) also found female elderly cope in better way than male elderly.
- There was significant difference in coping with loneliness with reference to social support network, Distancing and denial, Religion and faith and Increased activities whereas there is no significant difference in coping with loneliness with reference to Reflection and acceptance and self development and understanding
- Female elderly had higher quality of life than the male elderly living in family. Only in case of physical QOL , male elderly had higher QOL but in other three domain i.e in case of psychological QOL, social QOL and environmental QOL female elderly are having better QOL than their male counterparts
- It can be said that in case of coping with loneliness female elderly are much better and their QOL is also better than male elderly. Male elderly have less capacity to cope with loneliness so their overall QOL is also worse than female elderly. So, it can say that coping with loneliness is the important pre condition for having better QOL for elderly
- There is significant co-relation between overall quality of life and various dimensions of coping with loneliness of elderly
- So, we can say if coping with loneliness will be better, then QOL will also become better for elderly

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