The Experience of Social Isolation and Loneliness Among Older Men in Manitoba

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REPORT PREPARED FOR VETERANS AFFAIRS CANADA

January 2003

Aging in Manitoba
1971 to 2001

ACKNOWLEDGEMENTS

This study was funded by Veterans Affairs Canada, through the Prairie Region Office, Winnipeg, Manitoba (Contract No. 51019-007035/001CB). The views expressed herein do not necessarily repesent the views of Veterans Affairs Canada.

The authors acknowledge the support of Veterans Affairs Canada, the administrative support of the Department of Community Health Sciences, University of Manitoba, and the assistance of H. Dyck, S. Marshall, Y. Hosain and C. Nicholson in various aspects of the study.

Executive Summary

Social isolation (the lack of personal contacts with others) and social loneliness (the expression of dissatisfaction with a the lack of social contacts) are regarded to be challenging problems associated with growing older. Previous research has identified certain personal and situational aspects that affect an older person's experience of isolation and loneliness. However, a comprehensive analysis of the factors related to isolation and loneliness, along with the identification of measures to alleviate this problem for older persons are lacking. In particular, gerontological research has not addressed how older men and women differentially experience social isolation and loneliness. This study, conducted by Aging in Manitoba researchers and funded by Veterans Affairs Canada, provided a forum that linked researchers, community groups and individuals in a participatory research process to explore issues surrounding isolation and loneliness for older men, as well as the relationships among isolation, loneliness and health.

The goal of our study was to define the experience of isolation and loneliness for older men in Manitoba, as well as to identify ways to alleviate situations of isolation and loneliness that negatively influence health and well-being. The objectives were:

1. to explore the degree of social isolation and social loneliness among older men;
2. to explore the relationships among isolation, loneliness and health and well being of older men;
3. to explore the meaning of isolation and loneliness among older men;
4. to develop recommendations for policies and programs to address situations of social isolation and social loneliness.

Data from the 1996 panel wave of the Aging in Manitoba (AIM) Study were used to address objectives 1 and 2. AIM uses personal interview data and linked health utilization data to provide information on the socio-demographic and health characteristics of the sample, as well as social isolation, measured by the number of social contacts, and loneliness, measured by the Loneliness Scale.

The analyses revealed that the degree to which an older man feels lonely is influenced by widowhood, poor life satisfaction, chronic illnesses and negative perceptions of the treatment seniors receive. In addition, it was found that limited social contacts for older men are influenced by the lack of participation in leisure activities and vision problems. The results of the analyses also identified specific characteristics of older men that were associated with greater incidence of social isolation and loneliness. Older men who were isolated and lonely were more likely to be older, widowed and living alone. They were also less satisfied with life and had fewer visits from friends and family while participating in fewer social activities. In addition, the analysis evaluated the relationships among isolation, loneliness and poor health. It was found that poor health increases levels of loneliness, while loneliness negatively affects health both in the short term and over a longer period

as evidenced by the use of home care services one year later. Social isolation was not found to be as influential on poor health, but fewer social contacts did increase the risk of functional restriction.

To address objectives 3 and 4, eleven community discussion groups were conducted that involved older men, their caregivers and formal service providers. The discussions at the meetings revealed important insights regarding the factors associated with isolation and loneliness for older people. These factors include: a change in the social support network; chronic health problems; housing and transportation issues; economic hardship; and a change in role identity. Through the discussions, it was determined that older men are particularly vulnerable to isolation and loneliness when they experience difficulties adjusting to changes in role identity associated with retirement, as well as to changes in social networks, especially widowhood. In addition, the meetings provided important information regarding the relationships among poor health and social isolation and loneliness. Of particular note were the examples provided to illustrate that improvements in social interaction can have a significant impact on the well-being of an older person.

The public discussion groups were asked to provide suggestions that would assist in addressing the problem of social isolation and loneliness for the older population. The recommendations obtained from these discussions are summarized below:

For Individuals

- Make regular contact with older family members, neighbors and friends
- Ensure older people feel needed and valued
- Include older friends, family and neighbors in social gatherings
- Assist older individuals to maintain or initiate social activities by providing transportation and accompanying them to activities
- Allow service providers/volunteers to spend extra time with homebound individuals that are at risk of isolation
- Maintain relationships with persons in personal care homes and assist them in getting out into the community

For Local Community and Groups

- Recognize that social needs are as important as medical needs
- Increase awareness and availability of seniors programs and services
- Improve information and access to seniors supports
- Increase the accessibility of resources through low-cost transportation and barrier-free access
- Establish/enhance availability of low-cost leisure and educational activities
- Provide affordable congregate meal programs
- Encourage intergenerational activities
- Establish inter-service referrals and community networks of service providers to improve and support programs

- Establish home visiting programs for those seniors unable/unwilling to participate in community programs
- Target programs for healthy, as well as more frail seniors
- Increase financial funding to provide paid staff and enhance programming for service organizations
- Involve seniors in all levels of planning
- Retirement information should include social changes, not only financial changes

For Program Planners and Policy Makers

- Involve seniors in all levels of planning programs and services
- Increase affordable housing options that facilitate social interaction and wellness
- Ensure provision of affordable transportation and barrier-free access
- Establish mechanisms to eliminate ageism
- Increase opportunities for social interaction with programming that addresses the needs of all seniors and is comprehensive throughout the week
- Enhance communication/cooperation among all levels of government to foster or improve links among social services, health and education
- Improve availability of resources for rural and northern communities (programming, transportation, etc.)
- Provide recognition for the work of community agencies and volunteers
- Increase awareness of resources
- Provide resources for continuing research on issues of isolation and loneliness

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I. INTRODUCTION

The experience of loneliness is different for men and women, and changes occur throughout the life cycle. In particular, social isolation and social loneliness are often considered as challenging problems associated with growing older. Previous research has demonstrated that these two components are the result of the interaction of personal factors and situational constraints (Rokach, 2000).[1]

Old age is characterized by multiple losses for older persons that precipitate isolation and loneliness (Ryan & Patterson, 1987). An older person, for instance, may experience a reduction in their social network through the death of family and friends, as well as their own inability to maintain social ties. As an individual grows older, loneliness and social isolation may become more prevalent as changing experiences in employment, marital status, living arrangements, social networks and health are encountered. Some researchers suggest that social isolation and loneliness result from a number of factors working in combination, including gender, widowhood and living alone (Weiss, 1973; Mullins & Dugan, 1990; Hall & Havens, 1999). It has been noted that a strong association exists among isolation, loneliness and the health and well being of older people. There has been little research to date, however, which has fully investigated the factors that influence isolation and loneliness.

This report documents research conducted by the Aging in Manitoba (AIM) Study from the spring of 2001 through the fall of 2002 to explore the issues of isolation and loneliness for older men. It follows previous research that looked at the influence of gender on isolation and loneliness, with particular emphasis on the experiences of older women (Hall and Havens, 1999). The present study involved analysis of data from the 1996 AIM survey, with input from members of the public at a series of meetings held across Manitoba to gain insight about the experiences of older men, and to provide recommendations for ways to address isolation and loneliness.

[1] A detailed review of the current literature about social isolation and loneliness, with a particular emphasis on gender differences, can be found in Appendix A.

II. STUDY OBJECTIVES AND METHODS

The goal of our study was to define the experience of isolation and loneliness for older men in Manitoba, and to suggest ways to alleviate situations of isolation and loneliness that negatively influence health and well-being. The definitions used in the study are as follows:

Social Isolation: a small number of regular contacts with other people

Social Loneliness: the expression of *dissatisfaction* with a small number of regular social contacts

Our specific objectives were:

1. to explore the degree of social isolation and social loneliness among older men;
2. to explore the relationships among isolation, loneliness and health and well being of older men;
3. to explore the meaning of isolation and loneliness among older men;
4. to develop recommendations for policies and programs to address situations of social isolation and social loneliness.

To address **objectives 1 and 2**, the study uses data from the 1996 panel wave of the Aging in Manitoba (AIM) Study. Aging in Manitoba is unique in that it is the longest continuous study of aging in Canada, one of the largest population-based studies of aging in existence, and the only longitudinal study of aging that merges personal interview data with complete health utilization data. (The sample is described in section III, and the results of the data analyses are reported in section IV).

Initial measures used in data analyses included the following:

To define Social Isolation: (based on previous work by Havens, 1989)

- Demographics
  - Marital status (widowed)
  - Perceived financial security (difficulties) at present
  - Perceived financial security (difficulties) in the future
- Social Network
  - Living arrangements (alone)
  - Proximity to nearest relatives
  - Life Space Score (Cumming and Henry 1961)
- Life Changes
  - Recent housing moves (less than 3 years)
  - Distance moved (more than 1 day away)
  - Length of time in present community (less than 5 years)

Life Satisfaction
- Perception of role of older people (not active in the community)
- Perception of treatment of older people (little respect)
- General Life Satisfaction (low score)

Health
- Recent health problems (4 or more in past year)
- Recent hospitalizations (more than 1 month in past year)
- Cognitive functioning (low Mental Status score)

To define Social Loneliness:

Aging in Manitoba has devised a Loneliness Index, which is a composite of the Loneliness Scale developed by de Jong-Gierveld and van Tilburg (1999) and two single items loneliness questions from the Netherlands NESTOR studies on aging.[2]

The Loneliness Scale is comprised of 11 items, 5 of which measure feelings of belongingness or sociability (positively scored), and 6 items measuring aspects of missing relationships (negatively scored). The items ask respondents to agree or disagree with the following statements:

- There is always someone that I can talk to about day-to-day problems.
- I miss having a really close friend.
- I experience a general sense of emptiness.
- There are plenty of people I can lean on in case of trouble.
- I miss the pleasure of the company of others.
- I feel my circle of friends and acquaintances is too limited.
- There are many people that I can count on completely.
- There are enough people that I feel close to.
- I miss having people around.
- Often, I feel rejected.
- I can call on friends whenever I need them.

The single item questions ask

- Do you consider yourself to be: not lonely/ moderately lonely/ severely lonely / extremely lonely?
- Do you sometimes feel lonely? Yes/ no/ more or less

To address **objectives 3 and 4**, we conducted eleven community discussion groups involving older men, their caregivers, and formal service providers. The schedule and location of the groups (see Appendix D) was determined in conjunction with the Prairie Region Office of Veterans Affairs Canada. All sessions were documented and audio taped, with full information provided to participants concerning their voluntary participation. The results of these sessions are reported in section V. In addition, a presentation of selected results from this and previous AIM work on

[2] See Hall and Havens (1999, pp 22-23) regarding the validity of the Loneliness Index.

isolation and loneliness was made to the Annual Support Services to Seniors Conference held in Winnipeg on September 26, 2002. Participants were asked to discuss the same issues as those in the public sessions. Their comments are included in the compilation of discussion results.

III. AGING IN MANITOBA STUDY SAMPLE

Data are drawn from the 1996 panel wave of the Aging in Manitoba Study. The study included interview data and data on health service use for all participants. Participants were originally interviewed in 1971, 1976 or 1983, and all were selected at random on the basis of age, gender, and area of residence in the province of Manitoba in each of the original study years (see Hall and Havens 1997 for details).

Each survey has collected a core of identical information on sociodemographic characteristics, health and social networks, with measures of social loneliness added in 1996. All interviews were conducted in person, in the respondent's usual place of residence. Attempts were made to obtain information from all survivors, in some cases necessitating the use of a proxy individual when the respondent was unable to hear the questions or answer competently because of severe physical illness or reduced cognitive ability.

The 1996 wave of the study included 1,868 individuals, whose ages ranged from 72 to 104. Forty percent of the sample (745 individuals) were men, typical of the gender distribution of this age group in Manitoba at the time of the interview. Thirty-five percent of the men lived in Winnipeg, the major urban centre of Manitoba, with only 8% of the men in total residing in personal care homes.

Many of the measures of social isolation used in this study require a factual response only. Examples would be a person's age and marital status, or the number of individuals a person interacts with on a regular basis which forms the Life Space score. These questions could be answered by proxy individuals on behalf of the respondent. Only study participants themselves, however, can provide answers to questions measuring thoughts and feelings, such as those included in the questions used in the study to measure social loneliness. Therefore, the total number of responses available for analysis differs depending on the type of measure used. For example, 13% of the interviews were conducted entirely with proxy individuals, and another 11% of respondents required at least some assistance by a proxy. Typically then, we have 745 responses available for analysis with most measures of social isolation, and approximately 580 responses available for analysis with measures of loneliness.[3] This number allows for sufficient statistical power with this representative sample of older Manitoba men.

[3] A greater number of the study participants living in personal care homes (PCH) required proxy assistance than did those living in the community. Thus, analyses with measures of social isolation typically include 8% of responses from those in PCH, while analyses with loneliness includes only 2% of responses from those in PCH.

IV. DATA ANALYSES

(A) **Univariate analyses** were conducted to describe the Aging in Manitoba (AIM) men in terms of isolation and loneliness.

Social isolation was measured using 15 components derived from interview responses (Havens 1989). The results are indicated in Table 1, with a comparison between the AIM men and women in 1996.

Table 1

COMPONENTS OF SOCIAL ISOLATION

	% Male	*% Female*
Demographics		
Widowed	22.8	65.6
Difficulty with finances now	11.4	13.1
Difficulty with finances in future	20.1	24.2
Social Network		
Live Alone	30.8	65.7
Nearest relatives more than 1 day away	1.9	3.8
Life Space Index = extremely isolated	12.1	19.1
Life Changes		
Lived in present house less than 3 years	14.5	19.9
Moved to present house from more than 1 day away	3.7	2.9
Lived in present community less than 5 yrs	9.2	10.9
Life Satisfaction		
Feel older people are seldom active in the Community	17.8	16.5
Feel community shows little respect to Older people	1.1	1.6
Low Life Satisfaction Scale score	3.6	3.3
Health		
4 or more health problems in last year	54.0	61.7
Spent more than 1 month in hospital In last year	13.7	17.4
Generally weak or unsteady state of mind	3.5	6.9

In terms of demographics, almost one-quarter of the men in the sample were widowed, compared to two-thirds of the women. While only slightly over 10% of both gender were experiencing financial difficulties at the time of interview, 20% of the men and 24% of the women felt they would be experiencing difficulties financially in the future.

Close to one-third of the men lived alone, but again were not as disadvantaged in this respect as the women. Few of either gender reported their nearest relative as living more than one day away. While only 12% of the men were found to be extremely isolated as measured by the Life Space score, another 69% were in the next lowest category. For the women, while 19% were extremely isolated, another 70% were in the next lowest category. Consistent with the theory of disengagement on which the Life Space score is based, we found, then, that most of our sample of older Manitobans had few contacts overall with other people.

More than half of the men and close of two-thirds of the women experienced four or more chronic health problems from a list of 22 conditions including things like heart conditions, arthritis, diabetes, high blood pressure, respiratory problems, and cancer. Only 14% of the men and 17% of the women, however, had required hospitalization in the year preceding the interview.

Social Loneliness was measured using the Loneliness Index. Figure 1 shows the distribution of loneliness for the full AIM 1996 sample, and Figure 2 depicts the scores for men according to the categories used in this study. We found that the proportion expressing any degree of loneliness was similar for men (82%) and women (85%), but there were about 10% more women in the loneliest groups. The results for the men show that only 18% expressed no degree of social loneliness (described as 0 on the loneliness index), 43% can be defined as somewhat lonely (levels 2 and 3 on the index), and 39% as lonely (levels 3 – 8, as seen after the mid-point on the curve in Fig. 1).

Figure 1

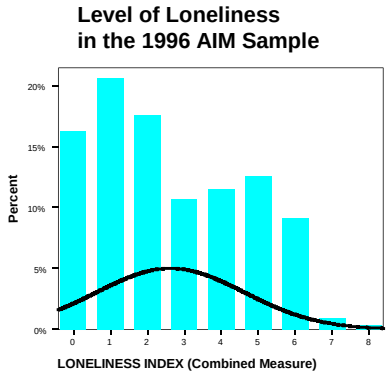
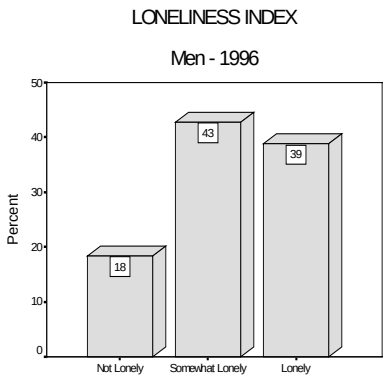


Figure 2



(B) **Bivariate analyses** were conducted to explore the association between the Loneliness Index and the individual measures of Social Isolation for the AIM men in 1996. Bar charts depicting many of the associations are found in Appendix C, and a description of the results is in Table 2, below. Chi square measures of association determined the statistical significance of the loneliness index with variables in each area that measures social isolation. Based on our review of recent literature and the public discussions, we also included some additional variables in each group. As well, we looked at the association of these variables with the Life Space score, as a single proxy measure for social isolation.[4]

Demographics:
The AIM 1996 men who expressed the highest levels of loneliness were more likely to be age 85 or over. Forty-eight percent of those age 85-89 and 60% of those aged 90 and over expressed the highest levels of loneliness (compared to an average of 35% of those age 72-84.) In terms of the Life Space score, the majority of all men, regardless of age, had few social contacts. However, 93% of those age 90 and over had few contacts compared to 74% of those in their 70's.

As suggested by the univariate analyses, nearly 70% of the AIM men were married. Only 7% were single or divorced, and the remaining 23% were widowed. As might be expected, the highest levels of loneliness were expressed by those who were widowed (65%), followed by those who were single (52.5%) and those who were divorced (43%). Neither the length of marriage for those who were married, nor the length of widowhood for the widowers was significantly associated with either the Loneliness Index nor the Life Space score. This finding was contrary to the research of Dykstra (1995) who found that loneliness was greater among those who were recently widowed.

The greatest portion of all widowers were in the loneliest group; however, 85% of those widowed one year or less were lonely, compared to 61% of those who had been widowed for more than three years. None of the married men had been married for less than 1 year at the time of the interview, and only one individual had been married for less than three years.

Regardless of marital status, childlessness was also not found to be significantly associated to either loneliness or life space, though those who expressed the highest levels of loneliness were slightly more likely than those who were not lonely to report having no living children. Therefore, the findings of Zhang & Hayward (2001), that older childless men were at greater risk of loneliness and isolation were not supported by our research on the 1996 AIM men.

[4] As seen in Table 2, the association between the Loneliness Index and the Life Space Score is not statistically significant. While the association between these variables was previously found to be significant for women in the 1996 AIM sample, it is not for the men. This is because those with the lowest number of contracts overall are women (62% compared to 38% men).

Table 2: Chi Square Analysis – AIM 1996 Men
(associations ≤ .05 are reported)

	Loneliness Index	Life Space Score
Demographics		
Age	.016	.002
Marital status	.000	---
Length of widowhood	---	---
Length of marriage	---	---
Have/don't have children	---	---
Present financial security	.025	---
Future financial security	.044	---
Social Network		
Living alone	.000	.000
Proximity to nearest relative	.000	.019
Life Space score	---	
Visits with relatives	.003	.000
Visits with friends	.007	.004
Who helps	---	.029
No. of everyday leisure activities	.000	.000
Life Changes		
Years in present household	.003	---
Moves of more than 1 day away	---	---
Length of time in community	---	---
Transportation problems	---	---
Life Satisfaction		
Satisfaction with Life	.000	.021
Perceived role of seniors	.004	.003
Perceived treatment of seniors	.000	---
Health		
Self-perceived health status	.000	.011
4+ chronic illnesses	.000	.007
No. of days in hospital	---	---
Cognitive status (MSQ)	---	---
Functioning (ADLs)	.000	.002
Functioning (IADLs)	---	.015
Physician visits	---	---
Home care service	.007	---
Vision problems	---	.013
Hearing problems	.036	---

Present and future financial security were found to be significantly associated with loneliness, but not with life space. More of those in the loneliest category felt their income was not sufficient to meet present needs (56% compared to 37% who felt their income was adequate). Similarly, more of those who were in the loneliest category felt their income would not be sufficient to meet future needs (49% compared to 36% who felt their income was adequate). Only 6% of the not-lonely groups felt their present income was inadequate, and only 11% felt their future income would not meet future needs.

Social Network:
Living alone was significantly associated with both the Loneliness Index and the Life Space score. Specifically, those who lived alone were more likely to be lonely (60% lonely vs 10% not-lonely) and to have fewer social contacts (86% few contacts vs 14% many contacts). Proximity to close relatives was also significant, in that those men whose nearest relation was more than one day away were more likely to be lonely (59%). This was also true of the men who nearest relatives lived in the same community (53%), but not in the same household. Only those who nearest relative lived in the same household expressed less than the highest levels of loneliness; i.e., 29% expressed the highest level of loneliness and 23% expressed no social loneliness. The remaining 48% of the men whose nearest relative was in the same household were in the somewhat-lonely group.

We also analyzed the association for weekly visits with family members and friends. Those who had no visits with family members in the week prior to the interview were more than four times as likely to be in the loneliest category (52%) compared to those in the not lonely category (11%). This finding supports previous research that regular contact with family members protects against loneliness. As well, 50% of those who had had no visits with friends in the week prior to the interview were in the loneliest category compared to only 9% who were in the not lonely category.

Almost all (97%) of the AIM 1996 men stated they had someone to call on if they needed help. The greatest source of help was from adult children first, and friends or neighbors second. (Because the men were more likely than the women in the sample to be married and living with their spouse, the third source of help for them was their wife, while for the women the third source was other relatives.) The association between source of help and loneliness was not significant for the AIM men. The association was significant for the life space score, but only because the vase majority of the men had few contacts overall, regardless of the source of help.

Significant associations were found for both loneliness and life space with the overall number of leisure activities that the respondent participated in within a week[5], a measure that has been used to describe how active a person is generally, and that has been found to be related to various outcome measures (Menec & Chipperfield, 1997). As might be expected, those who participated in five or fewer leisure activities per week were more likely to be lonely (62% lonely vs 7% not lonely).

Life Changes:
The only variable measuring life changes that was significant was the number of years in the present household, and it was significant only with loneliness. Essentially, the men in the study who were lonely were more likely to have moved to a new household. Fifty-seven percent of those in their present household for less than three years were lonely, compared to 36% of the somewhat-lonely group and

[5] The AIM interview asks about respondent participation in 21 different leisure activities, including those that are social in nature and those that are solitary, those that can be done in the home and those done outside of the home.

only 8% of those who expressed no loneliness. This trend was also found among those men who had lived in their present household for 3 to 5 years, where 49% were lonely compared to 35% in the somewhat-lonely group and 16% who were not-lonely.

Life Satisfaction:
All of the three measures of life satisfaction were found to be significantly associated with loneliness, and two were also significantly associated with the life space score.

AIM uses a general measure of well-being, which asks for a rating of the present level of satisfaction with life. Sixty-three percent of the AIM men who described their satisfaction with life as poor were in the loneliest group, as were 96% of those with few social contacts. None of the men in the not-lonely group rated their satisfaction as less than fair.

We also ask study participants for their impressions of the image of seniors in their community. The first asks if they feel seniors play an active role in their community, and the second asks if they feel seniors are treated with respect. The results of our analyses with these measures showed that both were significantly associated with loneliness, and the impressions of an active role for seniors was also significantly associated with the life space score. The men who felt seniors were not active in the community were most likely to be in the loneliest group (53% vs 9% in the not-lonely group), and were most likely to have few rather than many social contacts (81% vs 19% many contacts). As well, 80% of the men who felt seniors were treated with much disrespect were in the loneliest group, compared to 20% in the somewhat-lonely group, and none in the not-lonely group.

Health
Three measures of health had previously been defined as contributing to social isolation: having 4 or more chronic illnesses, spending more than a month in hospital, and evidence of cognitive decline. Neither of the latter two measures was significantly associated with either loneliness or life space, but the chronic illness measure was significantly associated with both. Most of the men who experienced four or more chronic illness were in the loneliest category (48% vs 13% in the not-lonely group) and had few social contacts (85% vs 15% with many contacts). The men in the study were also asked to rate their general health status compared to others of their age. With this measure we found that significantly more of those who rated their health as poor, rather than fair or good, were in the loneliest group (56% compared to 10% in the not-lonely group), and were likely to have few social contacts (96% compared to 4% with many social contacts).

Analyses with two individual chronic health problems that tend to restrict interaction, vision and hearing, found that vision was significantly related to the life space score in that 86% of those with eye problems had few contacts, and that hearing was significantly related to the loneliness index because 44% of those with hearing problems were in the loneliest group.

We also explored the association of functional health in terms of activities of daily living (ADLs), which was significant with both loneliness and life space, and instrumental activities of daily living (IADLs), which was significant with only life space. In general, the men who were most restricted in ADLs were in the loneliness category (70% vs 9% not-lonely) and had few social contacts (91%). Those who were restricted in terms of IADLs were also more likely to have few social contacts (84%).

In terms of health care use, neither hospitalizations nor physician visits were significantly associated with either loneliness or the life space score. The use of home care services, however, was significantly associated with loneliness. Basically, the men in the study who used home care were most likely to be lonely (53% compared to 10% in the not-lonely group and 37% in the somewhat-lonely group).

In summary, the results of our bivariate analyses suggest that the men in our study who were lonely were more likely than those who were not lonely to:

- be older
- be widowed
- be financially insecure
- be living alone
- have few visits with family members and friends
- have participated in few social activities
- have made recent moves, were less satisfied with life
- be in poorer health
- be functionally restricted
- use home care services

Likewise, those who could be described as isolated in that they had few social contacts, were more likely that those with many contacts to:

- be older
- be living alone
- have few visits with family and friends
- have participated in few social activities
- be less satisfied with their lives
- be in poorer health than those who were less isolated

(C) **Logistic regression** models were created to identify predictors of loneliness and isolation. All variables found to be significantly associated in the bivariate analyses were included in the models[6]. Thus, marital status, adequacy of current and future income, proximity to relatives, visits with family and friends, the number of leisure activities, the number of years in the present household, satisfaction with life, perception of the role of seniors in the community and the amount of respect they receive, perceived health status, number of chronic illnesses, activities of daily living, use of home care services, and hearing problems were all included as potential predictors of loneliness. The model to predict isolation used life space as the outcome, with proximity to relatives, visits with family and friends, source of help if needed, the number of leisure activities, perceived role of seniors in the community, perceived health status, number of chronic illnesses, instrumental activities of daily living, use of home care services, and vision problems. The results of the age-adjusted regression models are presented in Tables 3 and 4.

Table 3: **Logistic Regression with Loneliness as Dependent Variable[7]**
AIM 1996, Males

Predictor	Significance ($p < .05$)	Age-adjusted Odds Ratio	95% CI
Marital Status (widowed)	.000	4.504	2.888 - 7.023
Life Satisfaction (poor)	.000	2.920	1.816 – 4.695
Chronic Illness (4+)	.001	2.022	1.328 – 3.080
Treatment of Seniors (little respect)	.001	2.013	1.326 – 3.055

Table 4: Logistic Regression with Life Space as Dependent Variable
AIM 1996, Males

Predictor	Significance ($p < .05$)	Age-adjusted Odds Ratio	95% CI
No. of Leisure Activities (<8/wk)	.000	4.030	2.238 – 7.257
Eye Problems	.040	1.706	1.025 – 2.839

[6] The influence of living alone was eliminated from the regression models because it was found to be highly associated with other potential predictors, specifically marital status ($p \leq .000$) and proximity to other relatives ($p \leq .000$). It was therefore deemed to have a confounding effect on the overall model.
[7] Loneliness was dichotomized in the regression models; the lonely group was defined by the 39% depicted in the right-hand bar in Fig. 2 on page 5 (levels 3-8 on the loneliness index), and the not-lonely and somewhat lonely groups were combined, as depicted by the left and middle bars in Fig. 2. (levels 0 – 2 on the loneliness index).

Table 3 shows that widowhood, poor life satisfaction, 4 or more chronic illnesses, and feeling that seniors are not respected were all independently significant predictors of loneliness for the AIM men in 1996. In essence, a man who was widowed was 4½ times as likely as one who was not to express the highest levels of loneliness. Additionally, the men who described their satisfaction with life as poor were nearly 3 times more likely to be lonely. The experience of four or more chronic illnesses doubled the risk of loneliness, as did the opinion that seniors are treated with little respect. If an individual has more than one of these characteristics, the effects are increased. For example, a widower with four or more chronic illness would have a risk of loneliness 9 times greater than an older married man in better health; or, a man with many chronic health problems and a low level of life satisfaction, would be nearly 6 times more likely to be lonely than a man in better health who is more satisfied with life.

Table 4 highlights the influence of leisure activity participation on socialization. Specifically, those who participated in 8 or fewer activities per week were four times more likely to be restricted in social contacts. Vision problems were also found to independently predict a low number of social contacts by a factor of 1.7 times.

We also examined the influence of loneliness and isolation (by means of the life space variable) on health status and life satisfaction. In these models, loneliness and life space were used as potential predictors of health variables that were significantly associated with both, i.e., perceived health status (poor), chronic illness (4+), activities of daily living (restricted in seven or more), use of home care services, and life satisfaction. The age-adjusted results are shown in Tables 5 and 6.

Table 5: Logistic Regression with Health Status as Dependent Variable
AIM 1996, Males

Outcome	Predictors	Significance ($p < .05$)	Age-adjusted Odds Ratio	95% CI
Poor Perceived Health	Loneliness	.000	2.187	1.546 – 3.095
4+ Chronic Illnesses	Loneliness	.000	2.188	1.547 – 3.094
Restricted in ADLs	Loneliness	.005	2.147	1.264 – 3.647
	Life Space	.040	2.515	1.045 – 6.054
Use of Home Care	Loneliness	.037	1.657	1.031 – 2.664

Table 6: Logistic Regression with Life Satisfaction as Dependent Variable AIM 1996, Males

Outcome	Predictors	Significance ($p < .05$)	Age-adjusted Odds Ratio	95% CI
Poor Life Satisfaction	Loneliness	.000	3.131	2.040 – 4.805

As seen in Table 5, loneliness is a significant independent predictor of a poor self-rating of health and of poor life satisfaction. Life Space, the variable used to measure social isolation, was a significant predictor of only ADL restrictions. In other words, the men in the AIM 1996 sample who were lonely were more than twice as likely as those who were not lonely or only somewhat lonely to subjectively rate their health as poor, and more than twice as likely to have objectively poorer health in terms of chronic illnesses and functional restrictions. They were also 1.7 times as likely to use home care services.

Table 6 highlights the influences of loneliness on life satisfaction. We found that the AIM men who expressed the highest levels of loneliness were 3 times more likely than those who were not-lonely or only somewhat lonely to rate their satisfaction with life as poor rather than fair or good.

Finally, we explored the possibility that loneliness and/or isolation (low life space) might predict the use of health care services a year later. Hospitalizations, the use of physicians and prescription medications were not predicted by either loneliness or life space. Only the use of home care services was predicted by loneliness. As seen in Table 7, the AIM 1996 men who were lonely were 1.6 times more likely than the not-lonely or somewhat-lonely to be using home care one year later. In other words, the risk of home care use by the lonely AIM men remained nearly the same a year following the survey, as it did in the year when loneliness was measured.

Table 7: Logistic Regression with Home Care Use in 1997 as Dependent Variable AIM 1996, Males

Predictor	Significance ($p < .05$)	Age-adjusted Odds Ratio	95% CI
Loneliness	.036	1.568	1.030 – 2.387

Briefly, our analyses revealed the following:

- The odds of being lonely are significantly influenced by:
  - Widowhood
  - Poor life satisfaction
  - 4 or more chronic illnesses
  - Feeling that seniors are treated with little respect

- The odds of having few social contacts are significantly influenced by:
  - Participation in only a few leisure activities
  - Vision problems

- Loneliness predicts:
  - A poor self-rating of health
  - A greater number of chronic health problems (4+)
  - A higher number of functional restrictions
  - A poor self-rating of life satisfaction
  - Use of home care services, both at the time loneliness is measured and after one year

- Isolation (few social contacts) predicts:
  - A higher number of functional restrictions

Therefore, our findings from the regression analyses suggest that poor health can increase levels of loneliness for older men, *and* loneliness negatively affects older men's health both in the short term and over a longer time as evidenced by the use of home care services one year later. Isolation, as measured by the number of social contacts, did not prove to be as influential on poor health; however fewer social contacts did influence a greater restriction in functional tasks. We also found that the men who participated in fewer leisure activities, and those with vision problems, were more likely to be socially restricted.

V. PUBLIC MEETINGS TO DISCUSS ISOLATION AND LONLINESS FOR OLDER MEN

(A) Participatory Research Process

A participatory research process was employed as part of the investigation of the relationship among isolation, loneliness and older men. Public meetings were held to explore how older Manitobans perceive the issues surrounding social isolation and social loneliness in the older population. The participatory research process is particularly valuable in exploring local knowledge and locally defined priorities and perspectives. By engaging community members as participants in the research, a wider understanding is gained of both the issues, as well as potential policy or program directions. The participatory process is particularly relevant for the present investigation of older men's experiences of isolation and loneliness as the literature review established that knowledge in this area is limited. As a result, the public meetings were important as they focused on obtaining information about the experiences of older men. The qualitative information collected at these meetings has contributed important knowledge about the life experiences of individuals, providing context and insight to the quantitative analysis that is also part of this report.

The participatory research component of the investigation consisted of eleven public meetings that were held between October 23, 2001 and February 18, 2002.[8] The communities involved were selected in consultation with Veterans Affairs Canada (VAC) to provide representation from both urban and rural Manitoba. In Winnipeg, the primary metropolitan center of Manitoba, three meetings were held. Two of these meetings were open to the public, while one was restricted to veterans, their families and caregivers to ensure that any concerns particular to veterans would be discussed. In rural areas, those communities with active veterans associations were chosen. Meetings were held in the following rural communities: Brandon, Killarney, Carman, Dauphin, Swan River, Russell, Beausejour, and Stonewall.

As part of the participatory research process, the organization of the meetings was facilitated by VAC, as well as local organizations within the communities. For each community, VAC identified individuals, usually executive members of veteran's organizations, who could act as local contacts and assist with planning the meetings. In some communities assistance was also received from Support Services to Seniors staff, and/or the local senior centres. Wherever possible, meetings were held in central, barrier free locations. Meeting dates, locations, and local contacts are found in Appendix D.

[8] In addition to the eleven public forums, the issue of isolation and loneliness for older Manitobans in general was discussed with service providers at a presentation given at the Annual Meeting of the Association of Seniors Support Coordinators on September 26, 2002. The insights provided through this discussion are incorporated in this report.

In order to attract participants, the meetings were advertised through a variety of media forums including news releases, public service announcements on radio, community newspapers, community programming on cable television, posters, and letters of invitation to regional health authority employees, ministerial associations, veterans, and seniors organizations. Examples of this publicity are found in Appendix E. Attendance at the meetings was also encouraged by both personal letters of invitation, as well as the provision of a light lunch which is a strategy often used by senior centres to promote participation.

The outlets used to promote the meetings also generated attention from the media. Media interest in the research led to several newspaper articles and a radio interview. CBC Radio One aired an interview with one of the researchers, on the local afternoon program, following the first public meeting in Winnipeg. Articles describing the study appeared in the Brandon Sun (October 22/01), the Carman Valley Leader (October 29/01) and The Winnipeg Free Press (February 13/02) before the meetings in those communities. In addition, reporters were in attendance at the meetings in Winnipeg, Swan River, and Dauphin.

The duration of each meeting was approximately two hours. Attendance at the meetings ranged between 2 and 25 individuals. In total, approximately 110 people participated in the eleven public forums. Older men represented over one third of the participants. While a greater number of male participants would have been desirable, it is difficult to recruit men for public forums like these because, as indicated in the literature review, men have not been socialized to express their feelings and perspectives. In addition, older men may not identify themselves as being part of a group consisting of lonely men. Rubinstein (1986) has observed, for example, that men who live alone do not have a consciousness of themselves as a naturally occurring group whose members share an identity. Nevertheless, the older men who did attend the meetings provided important insights concerning the experience of isolation and loneliness. It is also important to note that the remaining participants included some older women, as well as many professional service providers and volunteers, who contributed important observations that are included in the discussion of the results that follows.

Participants were informed that the discussion would be recorded by audiotape, detailed handwritten notes, and flipchart notes. Although individuals were not asked to identify themselves, some did so through the course of discussion. All were assured that individual responses would remain confidential in reporting the results. In addition, the discussion questions were provided in a handout with a stamped, self-addressed envelope, and individuals were invited to respond in writing if they could not attend the entire meeting or wished to add to their comments.

The structure of the meetings consisted of an introduction of the researchers and VAC representatives, followed by opening comments that defined the study topic. The issue of isolation and loneliness in older men was then discussed based on information obtained in the literature review. In addition, the Aging in Manitoba data

were presented using graphic representation to describe the results of preliminary analyses. Conclusions from the preliminary analyses were also highlighted. These results are found in Appendix C.

(B) Outline Of The Research Questions

After the introduction and preliminary discussion of the issue, participants were invited to address the following four questions:

1. Are you aware of social isolation and loneliness among older people in your community? If so, where do you see it?

2. Why are social isolation and loneliness problems for older people… especially for older men?

3. Do you think poor health results in fewer contacts with other people… or, do fewer contacts with other people place older people at greater risk of poorer health?

4. What suggestions can you make to reduce social isolation and loneliness for older people now and in the future?
   (a) What could individuals do? (friends, family, neighbors)
   (b) What could the community do?
   (c) What organizations / groups are already reaching out to those who are isolated and lonely? And what might other organizations and groups do?
   (d) What could those who plan seniors' (or veterans') programs and services do?

These questions provided the context for participants to discuss the issues surrounding isolation and loneliness in the older population. A substantial amount of information was garnered in these discussions and the following sections provide a summary of the responses to the questions.

Question 1: Are you aware of social isolation and loneliness among older people in your community? If so where do you see it?

In the meetings, there was acknowledgement by all of the participants that social isolation and loneliness were issues facing many older people. It was also indicated that older adults find it difficult to admit that they feel lonely. Of particular note, on two occasions the groups stated that older men often do not recognize their loneliness and, consequently, do not take steps to address their isolation.

While the discussion surrounding Question 1 varied at each meeting, the participants identified several circumstances in which older persons experience social isolation and loneliness. The situations that were identified as resulting in loneliness are reflective of the research findings and include: a change in the social support network; chronic health problems; housing and transportation issues; economic hardship; and a change in role identity. These situations are highlighted below and described more fully in the following sections.

In all of the meetings, the discussion concerning social isolation and loneliness for older persons focused on the effect of a reduced social network.

- Participants recognized social isolation and loneliness among people who had lost important and meaningful social relationships.
- They also indicated that isolation and loneliness were problematic for those who live alone.
- In all but two of the meetings, widowhood was identified as a cause of loneliness and social isolation. It was discussed that many older individuals are not prepared for the social changes that occur with widowhood. One widower, for example, indicated that it was difficult to accept his wife's death as he was "not supposed to be alone". Another widower reported that he "didn't expect such a drastic change in life" when widowed.
- Older widowers spoke about the difficulties they encountered in trying to maintain contacts with their social networks as this had previously been the role of their wives. One man reported that "no one comes to visit an old man" and while his wife had always had friends for tea, he did not do the same.
- Losing the companionship of close friends was also reported as a cause of loneliness and social isolation. One man, having outlived his wife and friends, felt he had "lived too long".
- The participants also identified that persons without families, or with little contact with their family, experienced social isolation and loneliness.

In several of the meetings, participants also identified that loneliness and social isolation occur when an older person experiences poor physical or mental health.

- They spoke about how deterioration in health leads to declines in an individual's independence and ability to access services and attend social gatherings.
- The effect of communication problems was also discussed. Interaction with others is made much more difficult for those whose cognition, hearing or

speech are impaired. An older woman whose husband was hearing impaired described his limited abilities to interact and indicated that she "can't always take him with me".

- Depression was identified as a cause of social isolation.
- Participants also identified the association between declining health and reduced mobility. They suggested that mobility problems result in isolation and loneliness as mobility limitations reduce an older person's ability to access services and attend social activities.

In addition to the impact of mobility problems on social isolation and loneliness, the compounding effect of inadequate transportation provision was discussed at a number of meetings.

- The participants spoke of several circumstances in which transportation was inadequate and how this could lead to isolation and loneliness.
- The cessation of driving due to health problems was reported to be a problem of particular significance. While older women are less likely to drive, older men must often face the loss of their license ultimately leading to reduced independence. One participant questioned what those who did not drive did all day as they were forced to stay at home.
- Other issues that create transportation problems were identified at the meetings including winter conditions and the expense of door-to-door transportation services.
- Repeatedly, the inadequacy or non-existence of transportation services in rural areas was brought up as a source of isolation and loneliness.
- The participants suggested that the inadequacy of transportation restricts an older person's access to services and social activities. They also spoke about the stigma of being dependent on others and how older persons will not ask for assistance in accessing appropriate transportation.

The issue of housing was also identified at several meetings to be an area of concern when addressing isolation and loneliness in the older population.

- Many participants described the living conditions of older persons who lived alone and who were isolated from the community. They reported that loneliness and social isolation were experienced by older persons residing in all types of housing including the family home, as well as seniors housing and personal care homes.
- Participants considered many older persons who remained in their own homes to be "trapped" as a result of health problems, mobility and/or transportation problems, care-giving responsibilities, financial constraints, or personality characteristics that lead individuals to become loners.
- Many older persons move into senior housing and the inadequacy of this type of housing, particularly in rural areas, was discussed at the meetings. Those who move to senior housing are often faced with establishing new friendships in buildings that have no accommodations for social activities.
- A move to a long-term care facility was also identified to be a factor in isolation and loneliness. Overall, living in a personal care home was thought

to be isolating and was reported to discourage family and friends from visiting. The decrease in an individual's social support network was further diminished by declines in health that impaired communication such as dementia, and hearing and vision loss.

The low income of older persons was also identified to be a cause of social isolation and loneliness at some of the meetings.

- Many older persons may become isolated and lonely because the cost of socializing – transportation, meals, memberships and events – can be prohibitive for some.
- Participants also spoke about how it was difficult for some older persons to spend money on social activities. These individuals put greater importance on saving money because of their experiences in the Depression.

One situation that was considered to be particularly problematic for men was the loss of role identity associated with their life work.

- Although not discussed extensively at the meetings, participants did point out that for the most part men focus throughout their lives on their work and do not establish extensive social networks. With retirement they often experience difficulty in replacing this role with other activities including establishing social contacts.
- It was suggested that the loss of role identity was particularly problematic for persons who had worked in isolation, such as farmers and trappers, as they found it difficult to establish a new lifestyle with alternative activities.

At the meetings, the discussion surrounding Question 1 provided insights into what participants perceived to be the circumstances that lead to social isolation and loneliness in the older population. In the following section, the circumstances outlined above are examined in more depth to explain why older adults experience isolation and loneliness. In particular, the circumstances that create isolation and loneliness for older men are considered.

Question 2: Why are social isolation and loneliness problems for older people, and especially for older men?

Throughout the meetings, the one area focused on in the discussion of social isolation and loneliness was the effect of a changed social network. In offering explanations about why loneliness and social isolation were problems for older people, participants described ways in which established social networks were eroded or lost. They identified the primary loss for older persons to be the death of one's spouse. They also discussed other important events affecting social networks that include the loss of friends, decreased involvement with family, and moving to a new residence. Participants at the meetings recognized the importance of making new friends, but described many barriers for older persons in maintaining an active social life. These barriers include unsuitable housing, transportation difficulties, few

social opportunities, financial limitations, coping with changes in health, lack of services, and one's attitude towards being a 'senior'. It was recognized at the meetings that these barriers and circumstances contribute to making socializing and establishing new friendships difficult. The issues discussed at the meetings are highlighted in this section in order to provide a greater understanding of the experience of social isolation and loneliness for the older population, and in particular, for older men.

Widowhood was identified to be the primary source of isolation and loneliness for older persons. The loss of one's spouse often means the loss of a long time companion and confidante. One widower, for example, felt that although he was not socially isolated, the loss of his wife brought with it the loss of companionship and, ultimately, feelings of loneliness. Some participants shared how emotionally difficult and lonely their bereavement was. Many described their own or others withdrawal during grieving. They reported that while grieving the death of a spouse, older persons often withdraw from others, refuse invitations and isolate themselves. Almost all participants respected the widowed person's desire to withdraw and did not persist with invitations. The participants also pointed out that some people lose a sense of purpose in life after losing their spouse that may ultimately lead to their own death through natural causes or suicide. They also suggested that those who are widowed are often not prepared for the consequences of living alone and may seek companionship through remarriage.

In addition, participants related that the loss of their spouse brought with it the unexpected loss of friends. They interacted less with their friends and could no longer relate in the same way to their married friends. Some older men reported that couple friends did not include them in activities and they felt like a "fifth wheel". There was also discussion concerning the reduction of social networks that occurs when friends die, move away, or suffer health problems. One man felt outliving all his friends contributed more to his loneliness than being widowed. Participants at one meeting discussed how widowhood brought with it the need for adjustment in order to make new friends. However, it was also noted that, in the case of men, there are relatively small numbers of older men with whom to form new friendships. Through these discussions, it was concluded that the loss of companionship of both spouse and close friends brought with it social isolation and loneliness.

Participants also discussed that the loss of support from a spouse is not always replaced by additional support from adult children. Participants reported that social contact with family members was sometimes difficult. Often adult children live far away and have busy lives centered on work and children. In addition, it was mentioned that relationships between family members may be strained and an older person may not be able to rely on these members for support. An interesting observation was that family members are more likely to help with instrumental support, but may frequently not provide social support. As well, adult children may not understand a parent's social needs; participants reported they knew people who

had not shared accommodation or remarried because of objections from adult children.

An older person's housing situation was also reported to be a cause of social isolation and loneliness. There are many older persons who prefer to remain in their home in the community. Participants suggested that this preference is the result of a natural tendency to resist change, as well as the social expectation to maintain one's independence. Older persons may also perceive that their present conditions are better than the real or perceived conditions they would encounter following the move. In addition, participants reported that some older persons are forced to remain in their own homes because, as a result of the lack of affordable housing, they face few options and long waiting lists.

For those who remain in their own home, the possibility of isolation becomes greater as their long-time neighbors move away and they are confronted with a changing neighborhood. Many in their own homes are also faced with the stresses of caring for an infirm spouse and being left alone when the spouse passes away or is placed in long-term care. Participants discussed the consequences for those whose spouses moved into a long-term care facility. These individuals who remained in the community experienced isolation and loneliness because they no longer fit in with their couple friends. In addition, older persons who remain in their own home are at risk of isolation and loneliness as their own health deteriorates and they experience greater difficulties getting out and about. As their social networks are reduced, they are forced to rely on services such as homecare and grocery delivery that only meet an individual's physical needs. An interesting observation by service providers was that the programs designed to keep older persons in their own homes may, in fact, create circumstances of isolation.

Participants also identified loneliness and social isolation to be a concern for those who moved from their family home. Moving was identified as a stressful event, in particular, if the older person was not convinced that it was necessary. Service providers discussed how many individuals must move from their smaller towns in order to access services provided in larger communities. A consequence of this type of move is that the older persons must leave behind social networks of family and friends. Furthermore, as there are few affordable housing options for seniors in Manitoba, moving was often reported to entail drastic changes that require relinquishing both lifestyle and possessions. For example, an older individual living in a rural area who requires more supportive housing may be forced to move from a large farmhouse to a bachelor suite in a seniors' apartment block. Participants reported that this type of change was strongly resisted by older persons who therefore delay moving until they are quite old and frail.

After the move to senior housing, older persons are often faced with establishing new social networks that were disrupted by their move. Participants at the meetings reported that some people experience isolation and loneliness because they find it difficult to establish friendships in this new setting. They also suggested that the

characteristics of seniors housing, especially in rural areas, may contribute to these feelings of isolation and loneliness. Many of the senior housing projects were not designed to accommodate social activities. They consist of multi-story apartment blocks offering only bachelor suites. These bachelor suites do not provide space for a resident to have visitors. In addition, in many housing projects, there is no common space to have social activities.

Service providers indicated that social programming and the provision of social directors were non-existent in senior housing, particularly in rural areas. A further problem is the lack of barrier-free adaptation in senior housing that can hinder social interaction. For example, participants reported that many of the buildings do not have elevators. In addition, some housing projects have rules that limit visiting times, or discourage or prohibit group activities. It was also reported that older buildings were run down and without air conditioning while, at the same time, having rules against leaving doors open for ventilation. Some buildings are far from shopping and services such as doctors and pharmacies. An additional problem in senior housing is the lack of facilities for activities such as carpentry. The participants discussed the difficulty for men in particular who had retired from farms and were no longer able to participate in activities that had been part of their life-long identity. It is important to note that it was suggested in the meetings that buildings which did not meet social needs were most likely to house many isolated and lonely people, while those with good social programs and facilities had waiting lists. Therefore, overall living in seniors' housing was not seen by the participants to lead to an improvement in social interaction.

There was also discussion at the meetings about the implications of moving to a long-term care facility. The participants perceived that such a move resulted in a loss of connection to the community. A service provider noted that social support is often reduced when an individual moves into an institution ultimately leading to isolation and loneliness. An interesting observation was that an inability to communicate in English by either residents or support workers created greater feelings of isolation in some facilities as the residents found it difficult to communicate with the staff.

In addition to the effect of inadequate housing on an older person's experience of isolation and loneliness, participants also discussed the implications of mobility problems. It was noted that difficulties getting out and about cause barriers to remaining socially active. With the onset of declining health, older persons may experience mobility problems that reduce their ability to access services and attend social activities. Difficulty walking or climbing stairs can make it hard to get out of one's house or into other buildings, or can make what was once a trouble-free trip into a tiring event. In addition, participants noted that many buildings, especially in rural areas, were not accessible. Many Royal Canadian Legions, for example, are inaccessible because older persons are faced with a steep flight of stairs immediately upon entering the building. At one meeting, frustration was expressed because the newest building in town was designed with a large flight of stairs at its

entrance, with no apparent ramp. Participants also suggested that physical mobility and access problems are particularly problematic in winter as ice and snow diminish the mobility of older persons. It was concluded that the declining mobility of older individuals resulting from health declines and accessibility issues ultimately creates greater risks of isolation and loneliness.

The effect of mobility problems is further exacerbated by the lack of adequate transportation that can affect the independence of older persons. Some people are faced with the loss or restriction of their drivers' license as a result of poor health. It was recognized at the meetings that this is particularly an issue for older men as many women from this older generation never learned to drive. Participants reported that without access to personal transportation, many older persons are left without a reliable or affordable means of transportation. Friends and family may not be available to provide rides. In addition, service providers suggested that many older persons may not accept the offer of rides because they do not want to feel dependent. A further problem is the cost of door-to-door transport services such as taxis and handi-vans that can be prohibitive for an older person on a restricted budget. Participants also reported that older persons may be reluctant to use para-transit services because of the stigma of disability. It was noted at the meetings that transportation problems are particularly pronounced in rural areas, as many communities have no access to transportation services. It was concluded in the meetings that without access to appropriate transportation, an older person's social interaction becomes very limited leading to loneliness and isolation.

The effect of health problems on isolation and loneliness was also discussed at several of the meetings. In addition to health declines that restrict mobility, participants also identified health problems that were thought to increase the likelihood of becoming socially isolated and lonely. They reported that conditions such as incontinence create feelings of embarrassment that may lead some individuals to withdraw. Loss of vision was also noted to impose many restrictions and lead to a loss of independence. Similarly, the participants discussed conditions such as hearing, speech or cognitive impairments that create communication problems for older individuals and make it difficult for them to interact with others. It was also suggested that the communication problems of older persons may affect how they are treated by others. As a consequence of these health problems, older individuals may be excluded or withdraw which ultimately leads to greater isolation and loneliness.

A further issue noted by participants to influence whether an older person becomes socially isolated and lonely is the issue of money. It was reported that many older persons are on very restricted incomes limiting their ability to participate in social activities. Some older persons find the cost of socializing to be prohibitive. It should also be noted, however, that the participants reported that many of those who had lived through the Depression considered it more important to "save for a rainy day" than spend money on social activities. This is particularly problematic for older men

who, the participants reported, will not spend money on themselves and regard saving money to be more important than socializing.

Another contributing factor to social isolation and loneliness in older persons was reported to be the inadequacy of services that could potentially increase an older person's social contacts. One component of this is the lack of services related to geographic isolation. The participants noted that the availability of services varies from area to area. Within one health district, for example, it was observed that in an area with relatively prosperous communities and good resources, there was much less social isolation and loneliness than in a nearby area that contained fewer resources and a sparse, more dispersed population. Older persons also regard some service provision to be inappropriate. Many participants reported an unwillingness to use services specifically designed for older adults because of the perception of a stigma about being 'senior', 'old', or 'handicapped'. Many people said they do not think of themselves in those terms and would prefer not to use services with those labels. The lack of and inappropriateness of services for older adults may, therefore, also contribute to an older individual's experience of isolation and loneliness.

Participants also used the public meetings to discuss issues specific to veterans' services. In particular, discontinuing services for veterans' spouses a year after their husband (or wife) had died was often mentioned. Regardless of whether the spouse is male or female, the termination of services and income received for many years was seen to be particularly difficult, placing many of the widows and widowers at risk of residential relocation at a time when they may be least prepared to deal with these decisions. Changes such as these may contribute to an older individual's risk of isolation and loneliness. Another issue that was raised concerned equitable treatment of veterans. Availability of information to all was deemed to be essential to ensure that all veterans, urban and rural, have equal access to the programs and services for which they are eligible and which can assist in maintaining mobility and fostering socialization.

The above discussion demonstrates that the meetings provided a useful forum to evaluate the issues related to isolation and loneliness in the older population. At these meetings, there was also informative discussion regarding the relationship between loneliness and older men. Participants had many ideas about issues that were specific to men. The discussions provided insight to explain the factors that lead to feelings of isolation and loneliness for older men. It is noteworthy that these insights are reflective of the research findings that assist in explaining why older men may be particularly at risk for loneliness. The two primary factors discussed in the meetings were, firstly, the loss of role identity for older men, and, secondly, the difficulties older men encounter in attempting to adjust to changing social networks.

As discussed in the literature review, older men may be particularly at risk for social isolation and loneliness after retirement because their role identity is derived from their working lives. Participants at the meetings also recognized that work

established men's status. It was thought that men found work to be personally rewarding and that, after retirement, many men are not prepared for the effects of their non-working status. Participants suggested that with the onset of retirement men no longer felt like the "boss" and, in addition, they felt that no one was interested in what they had to say. These perceptions could affect their ability to develop social relationships. In addition, because of their focus on work, men are less likely to develop interests and hobbies during their lifetime. As a result, at the time of retirement, they may not have activities to replace their work. The change in working status may also occur at a time when men are experiencing health declines which creates further difficulties in adopting new activities.

It was pointed out on numerous occasions at the meetings that farmers had a particularly difficult time adjusting after retirement. As their lives had been dedicated to farming, they had not had the time or the interest to develop other activities and hobbies. They may have continued to farm as long as possible, by which time it was very difficult or impossible to establish a new lifestyle with alternate activities. A similar situation was reported for men, such as trappers, who live in geographically isolated areas. It was also noted that these rural men had few social contacts and were accustomed to solitary lives. As a result, the participants suggested that they may not recognize their feelings of isolation and loneliness as they get older.

As men are accustomed to working, it was indicated at the meetings that it was more difficult for men than women to cultivate hobbies or social activities in older age. Some participants reported that older men may be reluctant, or find it difficult, to establish new hobbies and activities because they are hesitant to try new things. Participants described men to be task oriented and in need of activities to feel useful such as fixing things, gardening or workshop projects. An important observation was that a change in housing may eliminate the activities that keep men busy if facilities are not provided for these types of activities. Participants also indicated that it was difficult to encourage men to participate in social activities. It was reported, for example, to be very difficult to convince men to attend seniors centers, and extremely difficult to get them to join any group. They also suggested that the programs offered were geared towards women and "joiners", but once involved, the men tended to be happy.

In addition to changes in role identity, the literature review also discussed the greater ease with which women socialize and express emotions. At the meetings, there was also recognition of these gender differences. It was observed that because of different gender roles, women are traditionally more sociable and talkative. It was suggested several times that men are lonelier by nature than women and have fewer friends. It was observed, for example, that in senior housing, men were less likely to socialize and seek out the companionship of others. It was felt that men are not as talkative as women, are less likely to share their problems and emotions, and may feel they lose pride by showing their feelings. Men were thought to be proud and stubborn, and therefore not as likely to seek out others or join groups. The participants suggested that these male attributes have important implications for the

experience of isolation and loneliness for older men. Service providers, for example, noted that men who do not talk about their feelings may isolate themselves, pushing people away with unhealthy coping strategies such as alcohol use and distasteful behavior.

The literature review also discussed the reliance of men on their wives to establish and maintain social networks. At the meetings, many participants commented that as men spend more time than women working during their lifetime, they have less opportunity to develop a network of friends. It was observed that wives are often responsible for the couple's social life. In addition, participants suggested that a man's role as breadwinner may have limited the development of his relationships even within the family. Consequently, an older man may not be close to his children and grandchildren and may not be able to rely on them for social and instrumental support. It was suggested at one meeting that because women have developed activities and relationships with friends and family, they are better prepared for changes in later life. In particular, the participants identified the greater problems men experience when widowed.

The discussion in the literature review focused on the implications of widowhood for an older man's experience of isolation and loneliness. Similarly, at the meetings, the participants discussed the difficulties men encounter in their adjustment to widowhood. One service provider pointed out that men are disadvantaged when widowed because it was their wives who maintained their social networks. In one account, a widower could not face life without his wife and committed suicide, while another remarried soon after his wife's death because he could not cope with being alone. Men also reported that their widowhood precipitated an unexpected loss of friends. These widowers felt that they saw less of their friends and were excluded from the activities planned by couples. Participants suggested that widowers were particularly vulnerable to isolation and loneliness because they did not have the social skills to develop new friendships to replace the companionship of their spouse. For example, service providers reported that men do not visit at the homes of friends, but, rather, will only visit if they can go out for coffee. These service providers also noted that it was extremely difficult to find men to volunteer to be friendly visitors. It is significant that some of the men at the meetings indicated that while friends are important, they found it difficult to make new friends because there are few older men to seek out.

It was also suggested at the meetings that men are less prepared for widowhood because they lack the skills performed by their wives thus making it difficult for them to live alone. Participants reported that some widowers are unable to take care of themselves and maintain their household but, at the same time, resist learning how to cook, shop, and pay the bills. It was noted that an older man's inability to adapt to widowhood and manage homemaking activities could affect his self care and lead to poor health. However, service providers at the meetings felt that some men would rather live at risk than make necessary changes. It was suggested that older men who have difficulty with self-maintenance may be at greater risk for isolation and

loneliness. This can be compounded by the reluctance of many older men to spend money particularly on socializing.
The above discussion demonstrates that there are various circumstances that can lead to the isolation and loneliness of older men. An awareness of these circumstances is essential in order to provide appropriate services to address the needs of older men. Also important to service planning is the observation made by some women at the meetings that older men may not be conscious of their loneliness. It was also suggested that the families of older men may have a greater awareness of their isolation and loneliness than the men themselves. For example, it was reported that it was not unusual for male veterans to indicate to VAC counselors that everything was fine, while their wives were able to identify the issues and problems that were affecting their husbands. It is also significant that participants reported that men generally do not want others to know that they are lonely and will not ask for help. Both men and women noted that there is a stigma attached to being socially isolated and lonely.

Question 3: Do you think poor health results in fewer contacts with other people… or, do fewer contacts with other people place older people at greater risk of poorer health?

The discussions at the meetings regarding the association between health and social contacts demonstrated that these factors are inter-related and that the relationship works in both directions. In particular, participants spoke of the "vicious cycle" that can develop making it difficult to determine the direction of the relationship between health and social interaction. For example, a decline in health, such as a stroke, can lead to less social contact and increased loneliness, which in turn can lead to further declines in health. Equally, a reduction in social interaction, such as may occur in widowhood, can lead to declines in health, which further exacerbates the social isolation and loneliness experienced by the individual. In this section, the insights provided by the participants concerning the relationship between health and social interaction are examined. The impact of poor health on the degree of social interaction is discussed first, followed by a consideration of the effect of decreased social contacts on the health status of an older person.

In describing how poor health leads to fewer contacts with others, two types of explanations were offered: first, poor health creates difficulties in maintaining social contacts thus leading to withdrawal from social networks; and, secondly, friends and family that make up the social network of an individual withdraw when that individual is in poor health.

Participants offered a variety of reasons why it is difficult for older persons in poor health to maintain contact with their social networks. The lack of energy and chronic pain associated with many health conditions create difficulties for an older individual to participate in social activities outside the home. It was often stated that people only go out when they are feeling well and that they lose interest in activities when in

poor health. Consequently, when older persons are experiencing ill health they may be unable to attend voluntary or senior centre activities that provide them with social interaction. An individual with poor health may not be able to participate in social activities, and, as a consequence, may become more isolated and experience greater loneliness.

Many of the health conditions that occur at older ages create specific difficulties for older persons to participate in their social networks. Communication problems resulting from health conditions were reported to cause many social difficulties. It is challenging, for example, for older individuals experiencing hearing loss to participate in conversations. As well, someone with hearing loss may appear socially inept or cognitively impaired. Service providers pointed out that hearing aids are not effective in large group situations. They suggested that persons with hearing problems often withdraw from social contact as they find it difficult to communicate. In addition, cognitive impairment and speech impairment, perhaps caused by a stroke, can make it difficult or impossible to participate in previously enjoyed social activities such as playing cards. Participants also reported that functional problems, including those caused by vision impairment, may result in a loss of independence that creates difficulties in getting out of the house. Other conditions such as incontinence or Parkinson's create feelings of embarrassment that may cause older people to withdraw. As older individuals withdraw from their social networks as a result of health problems, they ultimately experience greater social isolation and loneliness.

Older persons who are in poor health may become homebound. They must rely on friends and family to visit them in order to maintain social interaction. However, the participants noted that often times social interaction becomes limited to home care service workers who are provided in order to allow the individual to remain in their home. The participants suggested that while home care services may be an important aspect of service provision for the older population, these services may also contribute to their isolation. Nursing and housekeeping services meet the medical and physical needs of older persons, however, home care workers do not address the social needs of these individuals. It is noteworthy that most communities were reported to have no formal services to meet the social needs of homebound people. As a result, those with limited social networks must rely on contact with service providers suggesting that isolation is inevitable.

It was also reported that the declining health of an older individual contributes to the isolation of that individual’s spouse. If a person is homebound, the care-giving responsibilities of their spouse will severely limit their ability to participate in social activities. A spouse who takes on extensive care-giving duties may be able to leave their home for only short periods of time. It may also be difficult for the caregiver to find respite care that would allow them to participate in social activities. If they are unable to maintain social interactions, they, like their spouse, will become homebound and socially isolated.

In addition to declining physical health, poor mental health was also reported to create difficulties for older persons to maintain social interaction thus leading to withdrawal from their social networks. Participants identified a connection between poor mental health and a lack of exercise that leads to isolation and loneliness. Depression was noted to be fairly common among older individuals and was identified on several occasions to cause withdrawal. The participants regarded poor mental health and depression to be important components of the cycle that can develop between poor health and decreasing social interaction. They suggested that depression could be caused by social isolation, and that prolonged depression would inevitably lead to further health declines.

Participants also reported that some older persons impose their own isolation because they are unwilling to request assistance and make required changes that are precipitated by declines in health. Some people would rather become socially isolated and live at risk than make necessary lifestyle changes. It was suggested that older persons are reluctant to accept help because they fear losing their independence and becoming a burden to others. Their pride may also stop them from using required aids, as well as moving to more supportive housing. The inability or reluctance of older persons to make required adjustments when faced with declining health may, therefore, result in increased isolation and loneliness.

In addition to the difficulties older persons with declining health face in maintaining social contacts, participants reported that decreased social interaction is also caused by the tendency of people to withdraw from someone in poor health. In describing how people react to ill health, one participant said, "When sickness comes in the window, friends go out the door". Many people were said to be uncomfortable with illness and disabilities. It was noted that the comfort level of family and friends changes as health continues to decline. This issue is particularly apparent in personal care homes and hospitals. It was observed that as poor health becomes protracted, family members and friends tend to withdraw, reduce the length of visits and visit less often. It was also noted that visitors may become discouraged if it is difficult to keep up a conversation or if visits seem ineffective because the person is not responsive. The institutional environment may make visitors feel uncomfortable or unwelcome. It was suggested that families sometimes "drop 'em off and forget about 'em". One resident of a long-term care facility reported that his family forgot about him when he got sick; he felt that they did not care whether he lived or died. As a result, residents may feel isolated from both the community and their families. An interesting observation was that those who have more visitors in long-term care facilities tend to have less psychosomatic complaints. This suggests that if social networks are maintained, an older person may experience fewer declines in health.

Participants at the meetings recognized that, in addition to the effect of poor health on social interaction, fewer social contacts could also lead to declines in health among older persons. There was a sense that “it isn't healthy to live without contact with other people”. Many participants felt social isolation and loneliness caused mental health problems, in particular, depression. They suggested that isolation,

loneliness and depression were quite common among older people. One participant felt depression resulted because those who are alone have no sense of belonging or connection to others. A service provider illustrated the relationship between loneliness and mental health. She reported that men who seem fine while at a mental health centre would quickly decline if they had to go back to a lonely life.

While it was clear that participants believed social isolation and loneliness lead to depression, and depression to other health problems, there also seemed to be a general reluctance to openly acknowledge social isolation and poor mental health as problems. The discussion about these subjects was hesitant and not forthcoming as had been the lively discussion that developed around housing. Several people noted that there is a stigma associated with being socially isolated and lonely, that is, those people who are lonely or isolated don't want others to know. The stigma associated with mental health problems was never stated, it was implicitly understood.

There was also discussion surrounding the effect of widowhood on an older person's health. Participants noted that sometimes the withdrawal of a bereaved person leads to their premature death from illness, or loss of purpose in life, and occasionally, from suicide. More typically it was felt that individuals may not look after themselves very well after being widowed. As was discussed in the previous section, men, in particular, are at risk of poor health following widowhood because they lack the skills to take care of themselves. Their health can be compromised because they do not know how to cook and consequently do not eat well. A service provider described how widowed men were resistant to accepting Meals-on-Wheels services because it still meant that they ate alone. It was also suggested that older widowed men do not maintain self-care practices such as taking medications. In addition, men's coping strategies are often times unhealthy as it was observed that loneliness and depression can lead men to alcoholism and gambling.

Although not clearly expressed in the meetings, there was recognition that social isolation and loneliness caused other health problems, in addition to depression. It was reported that being alone left one with more time to reflect inward and dwell on problems. It was suggested that, as a result, the individual felt greater pain. Without others to monitor a person's health, it was thought that gradual changes might not be noticed, or that the individual might not think to seek medical attention. Also, being alone might make one more resistant to change, as there is no one to make suggestions or share ideas, and no opportunity to observe what steps others are taking relative to health.

It was noted that the reverse relationship also occurs; that is, increased social contact improves the health of older people. Examples of improved health and well-being after individuals moved to housing with excellent facilities and social programming were reported. Service providers indicated that senior housing has a positive effect because older individuals are among other people. Participants in one small community reported great improvements to the mental and physical health

of residents at a personal care home when greater emphasis was placed on social interaction. As well as a very active visiting program at the facility, some residents were assigned social responsibilities such as acting as greeters and exit monitors (to keep Alzheimer patients from leaving). In another instance, after a homebound woman was given the responsibility of making telephone calls regarding community events, there was a noticeable improvement in her well-being. These examples illustrate that given the relationship between isolation and poor health, measures can be taken to improve social interaction and, thereby, improve the health of older persons.

Question 4: What suggestions can you make to reduce social isolation and loneliness for older people now and in the future?

(4a) What could individuals do? (family, friends, neighbours)

Participants proposed various ways for individuals to assist in improving the social interaction of older people. Most suggestions to reduce isolation and loneliness among older persons related to: 1) maintaining relationships with friends and family; 2) assisting older persons to remain connected to the community; and 3) providing social interaction for persons in long-term care facilities.

The discussion at the meetings focused on how individuals could maintain relationships with older persons who were at risk of isolation and loneliness. The suggestions made by the participants included:

- Recognize the identity of the individual, respect and listen to them.
- Phone and visits friends, family and neighbours frequently.
- Be proactive, stay in regular contact to ensure awareness of arising issues thereby avoiding the development of crises.
- Include the older person in family and community events, in particular, at traditional family times such as birthdays, holidays and special events.
- Include older persons in activities as men in particular have difficulty with simply visiting.
- Persist with invitations to join in activities if a person makes excuses and is withdrawing. One man recounted how his neighbour had withdrawn and died after being widowed. When another neighbour became widowed, he insisted that the widower accompany him to new activities.
- Recognize that friendships can be more important than family contact, particularly if family relations are not good and if older persons find it difficult to ask children for assistance.

The second type of recommendations to reduce isolation and loneliness referred to ways for individuals to assist older persons to remain connected to the community. It was advocated that individuals should become a member of a caring community and provide the following support for older adults:

- Supply information regarding social activities in the community and provide transportation so that the older person can attend social and family events.
- Volunteer to assist with organized group activities for seniors.
- Recognize that some older persons have difficulties in joining groups. Accompany socially isolated people to activities to provide them with reassurance in trying new things and making new friends. One service provider thought that while her father would enjoy his local senior centre, he would be unlikely to become involved if she did not take the initiative and accompany him the first few times.
- Seek out those older persons who are isolated. Look for those who have no social contacts and become a friendly visitor. Communication is the key to addressing the withdrawal of isolated persons.
- Spend one-on-one time learning about the older person, finding common interests, and sharing stimulating activities. One man felt that looking after others, and making others smile, was good for your health.
- Encourage service providers such as home care workers, delivery persons, and Meals-on-Wheels volunteers, to spend extra time visiting with the person. It was reported that some homebound individuals are desperate for company; one man turned back his clock to try to get the home care worker to stay longer.

There were also suggestions concerning the role of individuals in maintaining the social interaction of older persons living in long-term care facilities who are at particular risk of isolation and loneliness.

- Visit older persons who live in long-term care facilities regularly. Build relationships and provide spiritual support.
- Find activities and topics of conversation that are enjoyable for the individual.
- Continue to visit even if the person is non-communicative as the presence of another person is considered to be important.
- Assist residents to maintain a connection with the community by accompanying them on outings to shop, have coffee, and see the doctor.
- Encourage support staff to develop social relationships with residents that they see regularly. Interaction is especially important on weekends when activities are not programmed.

(4b) What could the community do?

Participants had many suggestions about what communities could do to help reduce loneliness and social isolation among older people. Among these was the recognition and promotion of the idea that social needs are as important as health needs. In addition, three areas were identified to be particularly important for the community to focus on in order to assist those older persons who are isolated and lonely. First, participants in both urban and rural communities felt steps should be taken to provide better access to existing services and programs. Secondly, it was

recommended that more services and programs be established to address the isolation of older persons. In particular, increased services in rural areas and programming to reach lonely individuals living independently were identified. Finally, recommendations were made to enhance service provision by establishing community networks.

Several recommendations were made for ways to improve access to existing community programs and services.

- Programs and services must be available to older persons at low-cost. For example, it was noted that the cost of congregate meals was a barrier for some to use this service.
- Ensure that transportation services are: affordable, available for both medical and social reasons, provided during the daytime, as well as in the evenings and on weekends, and operated by friendly and polite personnel.
- Implement a barrier-free policy to ensure that business and service buildings, as well as seniors housing, are accessible to older persons. Barrier-free components must include ramps into buildings, handicapped parking and snow and ice clearing in the winter.
- Address the stigma of “senior” and “handicapped” by restructuring services to be inclusive of the whole community. For example, several communities were designating new facilities as “active living” centres rather than “senior” centres.
- Increase awareness among seniors and their families about the availability of existing resources through regular publicity of programs and services in community directories and newspapers.

In addition to improving access to existing programs, participants felt more programs and services were required particularly in rural areas, which were often identified as lacking resources.

- As the rural population is made up of a large proportion of older people, it was recommended that local governments adopt a positive attitude toward seniors, recognizing the benefits of their contributions.
- Undertake measures to allow older people to remain living independently. It was recommended that rural governments could be more involved in providing housing options such as multigenerational housing and housing with on-site services including social activities.
- Provide adequate transportation services that are crucial for the well-being of older persons who can be isolated in rural areas.
- Establish senior centers to provide many useful services such as transportation, social and recreation programs, that seldom exist in smaller communities.
- Ensure the adequate provision of a range of other programs and services including congregate meal programs, housing with adequate services, recreation facilities, and social activities.
- Provide funding for paid staff to organize and maintain activities, programs and facilities in order for these program and service resources to be effective.

- Encourage business development that caters to the needs of the older population such as the sale of mobility equipment, as well as housekeeping and personal assistance services. Business practices should also be adapted to allow employees time to socialize with older clients.

It was also recognized at the meetings that programming was necessary for older persons living in the community who are at risk of isolation.

- Create awareness in the community concerning the problems of isolation and loneliness faced by those older persons who prefer to remain alone in their own homes, especially for those in declining health.
- Identify solutions that can address the difficult problem of isolation for persons living independently. For example, a pilot project of paid one-on-one companions was reported to have been very successful, but funding was not continued.
- Identify older persons who are difficult to reach, in particular, loners and those who are resistant to joining groups and participating in established programs such as friendly visiting.
- Take activities to peoples' homes that are meaningful and encourage social contact.

As well as increasing access and establishing improved programming for seniors, the participants also recommended that the creation of community networks could enhance service provision to older adults.

- Develop community networks of service providers and organizations to foster better communication between services, as well as promote greater awareness and understanding of locally available resources. This is considered to be a way for service providers, particularly in rural areas, to stay connected and share ideas and information. It was noted, for example, how helpful it had been to meet and hear from others at the public forums.
- Facilitate information exchange by establishing inter-service referrals. For example, home care workers can provide information about isolated older individuals to senior resources centers and recreation programs.
- Coordinate health and housing services.
- Recognize the importance of physicians in promoting the use of services such as life-lines and recreation programs. Doctors can also endorse the credibility of other service providers to increase the trust of older persons.
- Foster recognition and support for the role of churches in maintaining older persons' connection to the community. Such backing is required to sustain the work of churches in providing social opportunities for older persons such as home visits and Sunday services.

(4c-i) What organizations are already reaching out to those who are isolated and lonely?

A variety of organisations were identified to provide services that assist in reaching out to those who are isolated and lonely in Manitoba. In Winnipeg there are several large seniors organisations, and in both urban and rural areas a variety of service groups, associations, and churches were reported to be active.

It was also noted that isolated seniors are reluctant to ask for assistance, and consequently organisations and programs must find methods to identify older persons at risk that would benefit from their services.

In Winnipeg, the following organisations were identified to be involved in addressing isolation and loneliness in the older population:

- Age and Opportunity Centres, Inc.
- Creative Retirement Manitoba
- Manitoba Society of Seniors
- Meals on Wheels
- Seniors Resource Councils (Support Services to Seniors)
- Seniors Centres offering programs and/or activities for seniors
- Churches providing pastoral care, as well as friendly visiting programs and support groups for widows and widowers.
- Adult day programs
- Congregate meal programs

In addition, the work of veterans' organisations was noted:

- Branches of the Royal Canadian Legion and Army Navy and Air Force Veterans arrange outings and visit their members who reside in personal care homes.
- Within individual branches, some Legions have "over 60" clubs that provide measures to look out for the well being of their members.
- Ladies auxiliaries purchase items such as televisions and equipment to enhance the long-term care environment.
- Veterans Affairs Canada provides a bus for weekly outings of Deer Lodge Centre residents.
- Intergenerational programs have been implemented between local schools and the Deer Lodge Centre.

The work of service organisations in rural areas was also reported:

- Lion's and Eastern Star provide support to their members. Lion's, for example, hosts a free seniors' dinner once a year in some communities.
- Veterans' associations assist their members but generally do not have programs or services for community seniors. However, in one small town that is actively trying to attract retirees, the local Legion had recently changed its rules to encourage more community participation in its activities.

- Seniors centres and Support Services to Seniors programs are available in many, but not all, communities.
- In some seniors' housing units, tenant resource co-ordinators keep in regular contact with isolated individuals.
- Pastoral care provided by churches was reported to be increasingly difficult, as small community churches cannot staff ministries.
- Adult day programs
- Computer courses, though not widely available, were noted to be a useful resource to connect isolated older persons to the community.

(4c-ii) What might other organisations and groups do?

There were numerous suggestions for what organisations and groups could do to enhance services to address the isolation and loneliness of older persons. Some of these recommendations identified the need to provide services in an all-inclusive manner, while other suggestions were specific to the programming needs of isolated seniors. In addition, some suggestions referred to the need to support those organizations and groups that provide programming to older persons

First, there were various suggestions to provide programming that is inclusive of all older persons.

- Offer programming not only to service group members, but also to older persons throughout the community.
- Sponsor regular events, rather than concentrating programming only during specific times of the year such as at Christmas.
- Include seniors of all ages and health levels in recreation programming, instead of targeting only healthy persons, such as at senior centres, or frail elderly, who have limited options such as at day hospital programs.
- Adopt inclusive policies to ensure that older persons are included in activities geared toward the entire community.
- Develop intergenerational programs to encourage interaction between older persons and younger generations. Although difficulties in this type of programming were discussed, examples were provided of successful activities such as home visiting by high school students and a pioneer curriculum in schools.

There was also discussion surrounding the issue of isolated seniors in the community who "fall through the cracks" of regular programming. Suggestions were provided to address isolated older persons who are difficult to reach.

- Address the lack of resources for home-based activity programs.
- Develop new programming that will allow service providers to reach non-joiners or individuals restricted to their homes. Examples of previous programs that were successful included the homebound learning program formerly offered by Creative Retirement and paid companions.

- Encourage delivery and service persons to spend extra time with isolated individuals.
- Teach computer skills in order to connect isolated older persons with the larger community.

Finally, recommendations were also provided concerning the limited capacity of organisations and groups who provide programming for older persons and the need to provide them with greater support.

- Recognize the need for both paid staff and volunteers in maintaining existing programs.
- Provide funding for paid staff who are essential to initiate and organize social activities and programs, and to coordinate volunteers.
- Provide additional financial assistance for advertising programs and services, for upgrading or securing appropriate space for programs and activities, for consultation services, and for networking support.

(4d-i) What could those who plan seniors' (or veterans') programs and services do?

It was emphasized at the meetings that the method by which programs and services are planned and funded has an impact on the ability of seniors to remain socially integrated. For that reason, program planning is an integral component of addressing social isolation and loneliness in the older population. Participants stated that "social needs are important in community living" and, as a result, social needs should be an important consideration in planning programs and services. They also stressed the importance of including older persons in all stages of the planning process. These considerations were particularly evident in recommendations made with respect to housing, accessibility, and social activities.

Participants focused predominantly on the issue of housing for older persons and provided several recommendations to create residential environments that are more conducive to social interaction.

- Develop affordable housing for older persons, the seniors housing currently being built is not an option for persons on fixed incomes.
- Consider multigenerational housing options that would include older persons.
- Ensure that senior housing is accessible, designed to allow the use of mobility equipment and include features such as elevators, ground level entrances, and grab bars.
- Keep senior housing in good repair for both safety and aesthetic reasons.
- Develop housing that facilitates social activities and wellness. It was suggested that housing should include indoor common spaces for recreation (including workshops, exercise and activity programs), informal socialising, congregate meals (kitchen facilities), meetings, presentations, and bulletin boards. In addition, outdoor socialising and recreation space such as gardens should also be included.

- Establish housing opportunities that provide alternatives to bachelor suites. It was suggested, for example, that individual apartments should include space for socializing separate from the sleeping area.
- Employ social facilitators in senior housing to initiate and organize social activities, invite newcomers to become involved, and help people feel comfortable with new friends and activities.
- Provide block home care services or 24-hour on-site care when there are many seniors requiring these services.
- Locate senior housing near community services such as shopping, doctors, pharmacies, and community or senior centres.
- Organize special events such as flu shot day or health and safety presentations. It was suggested that these events were an effective means of facilitating social interaction, in particular for persons who would not normally participate in group activities.

Participants also made several suggestions to policy makers to address the issue of accessibility for older persons.

- Ensure the availability of low cost transportation for social activities and provide this service days, evenings and weekends. Church going, for example, was reported to be an important activity for which transportation could be a problem if there was no handivan service on weekends, or because the nearest church was now in another community.
- Investigate alternatives to formal transportation services, such as subsidising regular transportation provided by friends or neighbours.
- Inform businesses about accessibility issues for older persons. Encourage them to accommodate different levels of mobility with handicapped parking, ramps or ground level access, adequate snow clearing, and barrier-free or universal design.
- Make service providers aware of the availability of subsidies for mobility aids, as well as their clients' eligibility.
- Ensure required aids are received in a timely fashion. For example, a delay in receiving a walker can leave someone homebound throughout the winter.

Many recommendations were made for ways in which social activities for older persons could be supported.

- Secure funding for paid co-ordinators to ensure social and volunteer activities are initiated, organized and maintained.
- Provide facilities for programs and activities.
- Provide affordable and timely transportation.
- Supply funding for ongoing advertising in order to promote awareness of programs and services to people new to the community, or those with changed circumstances.
- Recognize and support the work of community agencies and their volunteers.
- Establish and maintain community networks so that independent organisations do not work in isolation.

- Make expert advice available to groups in the planning stages, to make certain services and programs are designed to meet the needs of older persons.
- Design community programs and services to be inclusive to ensure that the needs of all ages are accommodated, rather than targeting seniors specifically.
- Avoid using labels such as “senior” and “handi” to eliminate the stigma of old age. One man in his early eighties, for example, stated he would not go to a 'senior centre' because he did not consider himself to be a senior.
- Plan comprehensive programs and services. This would consist of programs that include all ages of seniors and levels of wellness, and is available throughout the week and on holidays. The programming would also attempt to integrate joiners and non-joiners, ensure affordable costs for participants, and provide barrier-free facilities.
- Address the needs of homebound persons and “non-joiners” who do not benefit from group activities. It was suggested that one-on-one outreach, through paid companions and volunteers be included in programming.
- Ensure that information regarding programs and services for older persons be provided in a format that is accessible to all seniors. For example, it was reported that some encounter difficulties navigating menu choices on the telephone.
- Provide retirement information that, in addition to the financial aspects of retirement, emphasizes the social and health aspects of aging. It was suggested that men could be helped to recognise that in older age their well-being may increasingly depend on their social relationships and that developing a social network when younger is important.

(4d-ii) Specific Recommendations for Veterans Affairs Canada

The recommendations outlined above provide effective strategies for individuals and community organizations and groups to address the issue of isolation and loneliness for older persons. Participants at the meetings also considered measures that would be relevant for Veterans Affairs Canada to adopt in order to assist aging veterans to remain active members of the community.

Recommendations were made to maintain the social networks of veterans.

- Provide outreach to the community. It was suggested that organizations such as RCL should identify veterans who are living in isolation and include them in activities by providing transportation.
- Establish visiting programs for veterans who can no longer attend veterans’ events.
- Build new support linkages by identifying veterans in the community and encouraging them to interact with other veterans. It was stressed that contact among veterans is particularly important because of their common interests related to war experiences.

- Provide transportation services for veterans to attend social events, in addition to medical appointments.
- Establish support groups for veterans who are widowed and are experiencing difficulty adjusting to being alone.
- Provide support to caregivers and spouses of veterans in long-term care facilities. Services such as transportation and respite care assist an individual to maintain social networks.

In addition, the recommendations made regarding improvements in senior housing to increase social interaction, are also applicable to housing for veterans.

- Provide barrier-free access in all housing accommodations.
- Ensure that veterans' housing includes adequate space for recreation programs.
- Employ social coordinators to organize programming and address the potential isolation of residents.
- Review housing policies to address procedures that may limit the social interaction of residents.

Recommendations were also made to enhance the social interaction of residents of long-term care facilities for veterans.

- Create a home-like environment where veterans will feel more comfortable to socialise.
- Recognize the individuality of each resident and that desire or ability to participate in activities varies.
- Encourage residents to interact by finding topics and life experiences that they have in common. For example, connect those who were in the same military/veterans regiments. Also, provide an awareness of news events so residents have common topics to talk about.
- Provide larger spaces for recreation programs.
- Establish greater diversity in programming to include activities other than bingo.
- Inform residents of available aids that can assist them to participate in activities, such as special playing cards.
- Encourage interaction with the community by: maintaining the resident's connection to community organisations such as RCL and ANAF; pairing residents with volunteers; and finding ways for the residents to contribute to the community.

There were also suggestions related to improving service delivery to veterans.

- Create greater links between veterans' organizations and services provided in the community for older persons. These links will enhance awareness of social activities that are offered in the community.
- Increase visits by VAC counselors to veterans in the community. By improving contact with veterans, issues of isolation will be more effectively addressed.

- Provide greater awareness to both individuals and service providers regarding services available to veterans.
- Ensure that services available to veterans promote social interaction. One service provider, for example, related that while she was able to obtain support for Meals-on-Wheels for a veteran, that same support was not available for a congregate meal program which would promote social contact.
- Changes that result from the termination of benefits for veterans' widows (or widowers) may place many at increased risk of isolation and loneliness. The assistance of VAC in helping surviving spouses find appropriate and acceptable ways to manage major changes that may result from the termination of benefits is essential.

VI. CONCLUSION

Our study found that loneliness among older men is influenced by widowhood, poor life satisfaction, chronic illnesses and feelings that seniors are not treated with respect. In addition, it was found that limited social contacts for older men are influenced by the lack of participation in leisure activities and vision problems. The results of the analyses also identified specific characteristics of older men that were associated with greater incidence of social isolation and loneliness. Older men who were isolated and lonely were more likely to be older, widowed and living alone. They were also less satisfied with life and had fewer visits from friends and family while participating in fewer social activities. Our exploration of the interrelationships among isolation, loneliness and health revealed that poor health increases levels of loneliness, and loneliness negatively affects health both in the short term and over a longer period as evidenced by the use of home care services one year later. Social isolation was also found to increase the risk of functional restriction.

Input from the public discussions helped to reveal important insights regarding the factors associated with isolation and loneliness for older people. These factors include a change in the social support network, chronic health problems, housing and transportation issues, economic hardship, and a change in role identity. Through the discussions, it was determined that older men are particularly vulnerable to isolation and loneliness when they experience difficulties adjusting to changes in role identity associated with retirement, as well as to the changes in social networks especially resulting from widowhood. In addition, the meetings provided important information regarding the relationship among poor health and social isolation and loneliness. Of particular note were the examples provided to illustrate that improvements in social interaction can have an important impact on the well-being of an older person.

A greater understanding of the socially isolating experiences that accompany later life is particularly important in developing intervention programs that are appropriate to seniors, and to older men in particular. These programs might aim at enabling older people to maintain and strengthen established relationships with family and friends, adapt to the shifts and changes that occur within relationships especially as a result of retirement and widowhood, and enhance their ability to develop new, satisfying relationships.

Understanding adaptation processes that are successful in the face of the loss of an intimate partner is important for developing programs with men that target factors associated with the negative impact this loss may have. Knowledge of the gender specific differences in these experiences is also essential for developing programs that target the issues, concerns, and experiences common to older men who are socially isolated or lonely.

This study has increased our understanding of the complexity of social isolation and loneliness among older people. Knowledge of the factors associated with these

experiences among older people enhances the ability of policy makers, program planners, and those interested in the well-being of seniors to identify and support those at greater risk for social isolation and loneliness. This knowledge is important for the development of programs that will have effective and long-term results.

APPENDIX A

Review of Current Research on Isolation and Loneliness

The Effect of Social Isolation and Loneliness on the Health of Older Men: Review of Current Literature

This literature review provides an overview of the factors that are known to be related to social isolation and loneliness, as well as how these factors affect an older person's experience of isolation and loneliness in relation to their quality of life. The review will look specifically at the issue of gender. One area in particular that has not been addressed in gerontological research is how older men and women differentially experience social isolation and loneliness. Most studies that have considered gender, have looked specifically at the circumstances of women because it is believed that their longer life span and poorer health status puts them at greater risk to feel isolated and lonely. As a result, knowledge of the factors related to social isolation and loneliness among older men is limited. The effects of the aging process are distinct for both men and women. Therefore, it is possible that factors related to social isolation and loneliness differentially affects how older men and women experience loneliness and isolation. It is envisioned that a greater understanding of gender differences will contribute to the development of more responsive policies and programs to address issues of isolation and loneliness for the aging population.

A Definition of Social Isolation and Loneliness

Social isolation is an objective measure of social contacts, and specifically refers to a lack of personal contacts with others. S*ocial loneliness,* on the other hand, is the subjective expression of dissatisfaction with a low number of social contacts (Holmen et al., 1992; de Jong-Gierveld and van Tilburg, 1995; Hall & Havens, 1999; Havens &Hall 2001.) In other words, social loneliness can be described as negatively perceived social isolation (de Jong-Gierveld et al., 1987).

Social isolation is sometimes referred to as aloneness or solitude. Delisle (1988) defines social isolation as the experience of being separated from one's environment to the point of having few satisfying and rewarding relationships. It can occur as a result of various life changes that accompany aging such as retirement and the loss of daily contacts related to work, the death of family members or friends, or through changes in residence often necessitated by declining health and the absence of regular caregivers. Those who are often alone, however, are not necessarily lonely, as solitude can be a personal choice (Berg et al., 1981; Woodward & Queen, 1988).

In contrast, social loneliness, which is associated with the absence of an intimate and engaging social network, occurs irrespective of choice. Loneliness has been defined as the unpleasant feelings experienced when an individual's network of social contacts is deficient in terms of either the quantity or quality of relationships. It occurs when an individual's subjective evaluation of the level of social interaction is deemed to be inadequate in terms of what is personally expected, needed and desired (Perlman & Peplau, 1981; Peplau & Perlman, 1982).

Weiss (1973) defined two types of loneliness: the first results from social isolation, and the second from emotional isolation. Emotional loneliness is defined by the lack of a reliable attachment figure such as results from the death of a spouse, whereas social loneliness is associated with the absence of an engaging social network and can occur following relocation, the death of friends or retirement. In these situations, an individual may no longer feel included in a supportive network.

Prevalence of Social Isolation and Loneliness Among Older People

Although isolation and loneliness have been identified as important issues for an aging population, it is less clear as to the proportion of older adults who experience these phenomena. On one hand, some studies have found no association between age and loneliness (de Jong-Gierveld et al., 1987; Tijhuis et al., 1999), while others have found that loneliness actually decreases with advancing age (Rokach, 2000; Mullins et al., 1996; Walker and Beauchene, 1991). Some studies suggest that the overall levels of loneliness among older people may not be extreme (Mullins, Sheppard & Andersson, 1991; Wenger et al., 1996). Woodward and Queen (1988), for example, found that older people were less lonely than other age groups, and concluded that older people have more realistic expectations and are better able to adapt to life changes than younger age groups.

Opposing research has found that the prevalence of loneliness increases with age. In the 1974 National Council on Aging survey in the United States, it was found that while 10 percent of those 65-69 years old reported feeling lonely, 17 percent of those 80-89 years old reported loneliness (Mullins & McNicholas, 1986). Tijhuis and colleagues (1999) found that loneliness increased with advancing age. Similarly, studies conducted in 11 different countries found that loneliness was strongest in the oldest age groups (de Jong-Gierveld and van Tilburg, 1995; Forbes, 1996; Holmen et al., 1992; Ryan, 1996).

Many other studies have found loneliness to be a significant factor for aging individuals. These studies report varying levels of isolation and loneliness among older populations. Early studies, such as the 1974 National Council on Aging survey in the United States found that between 12 and 40 percent of those aged 65 years of age and over suffered from problems of loneliness (Harris et al., 1975). In a study of the discriminators of loneliness among rural elderly in the US, Kivett (1979) found that 15.5 percent of the sample reported being lonely quite often, while 41.6 percent perceived themselves to be lonely only sometimes. In a more recent study Dugan and Kivett (1994) found that 66 percent of the sample reported some level of loneliness.

In a review of Canadian studies, Delisle (1988) found that rates of loneliness among older people ranged from 20 percent to almost 60 percent. The Aging in Manitoba Study found that 83 percent of the 1996 participants expressed some degree of loneliness, and 45% expressed the highest levels of loneliness (Hall & Havens, 1999). The study also found that the majority of the sample had a low number of

regular social contacts as measured by the Life Space Index (Cumming & Henry, 1961), with 81% percent of the men in the sample and 89 percent of women who could be described as isolated.

Other American and European studies have reported that approximately two-thirds of older adults are never or rarely lonely, one-fifth of aging populations experience loneliness sometimes, and about one-tenth are often lonely (Forbes, 1996). The variations found in the level of loneliness reported by older adults may be attributed to several factors including divergence in the measures or definitions employed, as well as cultural differences among the countries included in the studies.

Theories Related to Social Isolation and Loneliness

Several theories of aging may help in understanding the relationship between aging and social isolation and loneliness. The disengagement theory (Cumming & Henry, 1961), for example, is based on measurements of role counts, interaction, and social space. Its premise is that an individual's social network decreases over time, and the authors contend that this is a natural part of the aging process. In contrast, the continuity theory proposed by Rosow and Breslau (1966) states that as people age they draw on habits, interests, and patterns of coping developed over their lifetime. Successful adaptation to the aging process depends on the ability to maintain consistency with previous patterns of behavior. Therefore, individuals who have been socially active over their lifetime will feel a need to maintain interactions in older age.

Another perspective, a social environmental theory, suggests that the structural environment in which older people live becomes important for enhancing or inhibiting independence, or for enabling or restricting social interaction (Hendricks & Hendricks, 1981). The proponents argue that those who are widowed and live alone, for instance, and those who are restricted due to mobility limitations have fewer opportunities for interaction. Ryff (1986) has integrated several theoretical perspectives to develop a model of successful aging. She defines important criteria that pertain to social isolation and loneliness, including self acceptance (feeling good about one's self and a positive attitude towards life), positive relations with others (interpersonal relationships throughout the life span), autonomy (independence and ability to function), environmental mastery (ability to manipulate the environment to fit one's needs), purpose in life (feelings of meaningfulness and directness), and personal growth (life as a continuous process of realization and growth).

An additional theory that is relevant to explaining social isolation is that of mental incongruity. Dykstra (1995) links feelings of loneliness to a lack of harmony between relationship standards, such as the value of being married rather than single, and personal circumstances such as widowhood, coupled with perceptions of few opportunities to change one's personal situation. From this perspective, then, widows and widowers would be more vulnerable to experiences of loneliness if they placed a high value on being married but perceived few opportunities to change their status. This theory focuses on the manner in which individuals perceive and

evaluate their situation, and how these perceptions and evaluations influence behavior.

Regardless of the theoretical perspective used, however, researchers agree that social isolation in older age tends to occur as a result of situational factors and that these factors may also contribute to loneliness (Butler, 1975; de Jong-Gierveld & Raadschelders, 1982; Andersson, 1984; Delisle, 1988; Hall & Havens; 1999).

Characteristics Associated with Social Isolation and Loneliness for Older Persons

Loneliness and social isolation are associated with a range of characteristics of an individual's network of relationships (de Jong-Gierveld, in review). One relationship of particular importance is the partner relationship that provides a protective effect for the well-being of older adults. An association exists between loneliness and marital status as research has demonstrated that older individuals who are married have lower mean loneliness scores when compared to single persons (de Jong-Gierveld, 1986). Similarly, older adults who have recently been widowed are more likely to report loneliness (Kivett, 1979; Holmen et al., 1992; Forbes, 1996; Ryan, 1996). Studies have found that those who expressed the lowest level of loneliness lived with a partner, while those individuals who had recently experienced a death of a spouse reported the highest levels of loneliness (Holmen et al., 1992; Lopata, 1996; Mullins et al., 1996). In addition, Korpeckyj-Cox (1998) also found that divorced individuals living alone were more likely to be lonely than those who were married and lived with a spouse. Woodward and Queen (1988) found that there was a relationship between increased loneliness and the length of marriage among older widows, with those married 50 years or more being the most lonely following the death of their spouse. The length of widowhood is also a factor in the degree of loneliness. Dykstra (1995) found that loneliness was greater for those who had recently lost their partner compared to those widowed for longer periods of time.

The living arrangements of older adults have also been found to be an important factor in the prediction of social isolation and loneliness (de Jong-Gierveld, in review). While living alone is not directly associated with loneliness, loneliness is more common among those living alone (Wenger et al., 1996). Older people who live with a spouse are generally less lonely than those who live alone (Holmen et al., 1992; de Jong-Gierveld & van Tilburg, 1995). De Jong-Gierveld (in review) suggests that the absence of a partner in the household has important implications because persons living alone have smaller networks.

Although it has been assumed that loneliness among those who have lost their spouse can be ameliorated by visits with children, there is conflicting evidence as to whether contact with children reduces loneliness (Mullins & Elston, 1996). Children are often regarded as crucial sources of support for older adults, in particular, for those who have been widowed and are currently living alone (de Jong-Gierveld, in review). Some studies have found that older individuals who are living with or near

their children experience lower levels of loneliness. Berg and his colleagues (1981) found that feelings of loneliness were associated with lack of contacts with children.

Mullins and Elston (1996) also propose that an association exists between social isolation and childlessness because those without children are more likely to live alone thus limiting opportunities for social contacts. On the other hand, other studies have found no relationship between interaction with children and the experience of loneliness (Mullins et al., 1996; Wenger et al., 1996). Koropeckyj-Cox (1998) found, for example, that widowhood was significantly linked to greater loneliness regardless of whether the older individual had adult children. Also of note is Holmen and colleagues' (1992) finding that older adults who lived with children experienced the highest levels of loneliness.

Friendships appear to be particularly important for older people in promoting high morale and decreasing feelings of loneliness. For example, Berg and colleagues (1981) found that loneliness was associated with a lack of friends. Several studies have also found that friends and neighbors are more important than children for reducing loneliness in widowhood (Mullins et al., 1996; Riggs, 1997). Friendships are thought to reflect the quality of interpersonal relationships that promote well being among older people because they are voluntary relationships freely entered into, rather than obligatory. An older person who maintains contact with friends and experiences satisfaction with these relationships is generally less lonely (Mullins & Elston, 1996).

Research has also illustrated that the prevalence of loneliness is dependent upon the quality of an older person's social networks, more so than the total number of friends or even the frequency of contacts (de Jong-Gierveld, 1998). Plouffe and Jomphe-Hill (1996) found the quantity of interaction and satisfaction with the quantity of interaction, along with the qualitative dimension of the presence of a confidante, to be important predictors of loneliness. In-person and telephone contact with family and friends were important for social satisfaction, and as other researchers have shown, have a positive impact on feelings of well-being and on reducing feelings of loneliness (Fees, Martin & Poon, 1999).

The ability of an older individual to establish and maintain a satisfying network of social relationships may be affected by declining health. Research has found a strong association between poor health and isolation and loneliness (Mullins & Elston, 1996; Wenger et al., 1996; de Jong-Gierveld, 1998). Hall and Havens (1999) have pointed out that multiple chronic health conditions and restricted mobility inhibit an older person's ability to access their social network. This situation can be further exacerbated by the inadequacy of resources in the physical environment. Inadequate transportation has, for example, been linked with loneliness and isolation in the later years (Kivett, 1979; Woodward & Queen, 1988). If an older person has limited mobility and cannot access appropriate transportation, contact with others can be significantly reduced, thereby creating a greater risk of isolation and loneliness.

Other aspects of the physical environment have also been identified as influencing the experience of isolation and loneliness for older persons. The ability to access one's social network may be affected, for example, by the location where an older person lives. Whether older persons live in a rural or urban environment may have profound effects on the degree of social isolation and loneliness that they experience. However, there is a lack of research examining geographic location and loneliness, and the urban-rural comparisons that have been made have so far been inconclusive as to which setting provides greater social advantages (Mullins & Elston, 1996; Wallace & Wallace, 1998).

Various housing situations may also affect a person's feelings of loneliness. The findings of Tijhuis and colleagues (1999) indicate that an association exists between relocation to a personal care home and loneliness. Hicks (2000) also found that nursing home residents who lacked intimate relationships had increased dependency, and that those who had experienced the loss of friends, home, previous lifestyle and self-identity showed an increase in levels of loneliness. The author concluded that such isolation may lead to further declines in health and feelings of loneliness.

There are several social and individual characteristics that have been linked to social isolation and loneliness. It has been suggested, for example, that cultural values and norms influence the level to which an older adult experiences social isolation and loneliness. Rokach and colleagues (2001) found that older persons in Canada reported higher rates of loneliness compared to similar age groups in Croatia. The researchers suggest that the varying levels of social integration expected by individuals in diverse cultures may account for these differences. Differences in loneliness were also examined among older persons in the Netherlands, Italy and Manitoba, Canada (van Tilburg, Havens & de Jong-Gierveld, in review). The researchers found higher levels of loneliness among the Dutch and Manitobans, and concluded that a greater emphasis on individualism in these cultures, compared to cultures such as in Italy where people have a greater orientation to the family, could lead to greater feelings of loneliness in the later years.

Finally, there has been some preliminary evaluation of the influence of gender on an older person's experiences with loneliness. As with research on age and loneliness, however, the investigation of gender differences relevant to social isolation and loneliness has produced conflicting results (de Jong-Gierveld, 1987; Mullins & Elston, 1996). Some research has found no link between gender and loneliness (Mullins et al., 1988) while other studies have found that women are more likely than men to express loneliness (Berg et al., 1981; de Jong-Gierveld et al., 1987; Holmen et al., 1992; Ryan, 1996). A meta-analysis of gender differences in the psychological well-being of older persons conducted by Pinquart and Sorensen (2001) revealed that overall older women reported more loneliness than older men. Similarly, Hall and Havens (1999) found that while equal proportions of older men and women expressed loneliness, more women than men experienced higher levels

of loneliness. It is important to note that the higher incidence of loneliness found in older females in many of these studies may be attributed to the much higher percentage of widowed women (Pinquart & Sorensen, 2001).

In contrast to the majority of studies that have found greater loneliness among women, other studies found that males indicated greater loneliness (Mullins and Mushel, 1992; Andersson and Stevens, 1993; Mullins et al., 1996. These findings were unexpected as previous research had indicated that men, as a rule, were either less lonely than women, or there was no difference. The inconsistencies in the findings discussed above suggest that it is important to explore further the relationship between gender and loneliness. Most research exploring factors associated with social isolation and loneliness among older people has focused almost exclusively on women. As a result, knowledge about the experiences of loneliness among older men is limited.

Gender Differences

It has been suggested that older women are particularly vulnerable to social isolation and loneliness because of their greater advantage over men in terms of longevity, with the result that women are more likely to outlive husbands, other relatives and friends, to live alone, and to experience a greater number of chronic health problems which limit social interaction. Hall and Havens (1999) found, for example, that women who were older, lived alone, reported their health as poor, and reported a high number of chronic illnesses, scored significantly higher than older men on measures of social isolation and loneliness. In addition to women's greater disadvantages, Pinquart and Sorensen (2001) have suggested that men who survive into older ages represent hardy survivors who may have higher psychological resources when compared to older women.

Several researchers have suggested that gender differences in loneliness may be the result of women's greater willingness to disclose negative feelings (Mullins & Mushel, 1992), and that it is culturally more acceptable for women to be subjective and emotionally sensitive (Borys & Perlman, 1985; Rokach, 2000). Men, in contrast, have been socialized to suppress their emotions and to resist pain (Rubinstein, 1986). According to de Jong-Gierveld (1986), as it is culturally more acceptable for women to express their emotions, it is possible that the true prevalence of the experience of loneliness among men may be underestimated. This is illustrated by the observation of Pinquart and Sorensen (2001) that the degree of gender differences found in studies on the well-being of older adults is dependent upon the type of measurement used to determine the level in loneliness of the older person. In studies that utilized a single-item indicator of loneliness, it was found that gender differences were significantly greater than in studies using higher quality loneliness scales. Pinquart and Sorensen (2001) suggest that when direct questions are used, women are more willing to admit feelings of loneliness. They specify that it is possible to obtain a more accurate assessment of loneliness in men by using multi-item scales that have a higher sensitivity to specific aspects of the social network.

These observations reflect the complexity of gender differences in the loneliness of older persons. It may not be simply that women are at greater risk of loneliness because of their greater disadvantages in old age; rather, it is important to consider how the aging process differentially affects women and men and their experience of loneliness. In this section, the circumstances that contribute to the social isolation and loneliness of older men are considered.

The aging process constitutes a series of continuities and discontinuities that are responded to differently by men and women (Barer, 1994). As women age, their on-going domestic and family responsibilities allow them to maintain their role identity. In contrast, men's identity has traditionally more often been derived from occupational status rather than marital status with a premium placed on competency and productivity (Barer, 1994; Davidson, 2001). Consequently, retirement represents a profound change of status for men (Rubinstein, 1986). In addition to role loss, retirement also results in smaller friendship networks for men. The workplace provides an important context for men to relate to others. After retirement, however, many friendships established at work are not maintained. Both Arber and Ginn (1991) and van Tilburg (1992) found that men's work-based friendships were weakened or terminated after retirement. While women experience a continuity of roles, older men are faced with overwhelming changes after retirement that necessitate adjustments to role loss, as well as reduced social circumstances. It is in this context, therefore, that older retired men may be at greater risk for social isolation and loneliness (Rubinstein, 1986).

Calasanti (1996), however, found that marital status was most important in explaining men's life satisfaction after retirement. Marriage provides a valuable support system for men that enables them to cope more effectively with feelings of unhappiness and pain than men living without partners (de Jong-Gierveld, 1986; Stevens, 1995). Whereas women often have more intimate relationships with friends, men tend to rely on their wives to fulfill this role (Arber & Ginn, 1991). The suggestions, then, is that the partner relationship may be of greater importance for the well-being of men than of women (Dykstra, 1995). De Jong-Gierveld (1986) also found that the experience of loneliness for women is associated with the evaluation of their network of relationships, while loneliness for men is more closely associated with the evaluation of their spousal or intimate relationship. She found, for example, both married women and men reported less loneliness than their unmarried counterparts with a striking difference in expressed loneliness between married and unmarried men. Pinquart and Sorensen (2001) also found that significant gender differences existed in favor of men for studies of loneliness utilizing all-married samples, and Katz, Kabeot & Langa (2000) found marriage to be a protective factor for men in terms of averting social isolation and loneliness.

Given the greater reliance of men on their partner relationship, it is also possible then that men are more negatively affected by the loss of a spouse (Arber & Ginn, 1991; Stevens, 1995). Widowhood is considered to be one of the most stressful life events requiring greater adjustment than any other life transition (Byrne & Rapahel,

1997; Utz et al., 2002). Although there has been very little systematic evaluation of the effect of widowhood on men, it appears that widowers experience greater difficulty than widows in adjusting to living alone (Arber & Ginn, 1991). Men may be less prepared for bereavement because their lower life expectancy reduces the risk of widowhood (Pinquart & Sorensen, 2001). As a result, the relationship among bereavement, isolation and loneliness is particularly pronounced for men when they experience the loss of their spouse (Byrne & Raphael, 1997; Lopata, 2002). Rubinstein (1986), for example, found that the cause of loneliness for men was predominantly the loss of a spouse. The advantages men experience when married are greatly diminished in widowhood, as some studies have found no difference in the rates of loneliness between widows and widowers (Stevens, 1995; Byrne & Raphael, 1997; Pinquart & Sorensen, 2001). Dykstra (1995) found that, in fact, formerly married men had the highest mean loneliness score. Other studies have also found a relationship between men's level of expressed loneliness and the loss of a partner (de Jong-Gierveld, 1986; Wister & Strain, 1986; Ryan & Patterson, 1987; Tijhuis et al., 1999). For example, Ryan and Patterson (1987) found that those older men who reported being very lonely were all widowers. In addition, other research has found that the incidence of loneliness, suicide, and alcoholism, which are indicators of general malaise, is highly dependent on the presence or absence of a partner for men (Gove & Hughes, 1980; de Jong-Gierveld and Dykstra, 1984).

The importance of family, particularly adult children, for older adults has been consistently documented in gerontological research because of the provision of social and instrumental support. Older adults with more family ties are considered to be more socially integrated and therefore protected against loneliness and depression (Koropeckyj-Cox, 1998). Overall, research has demonstrated that widowers are at greater risk of loneliness specifically because older widows experience greater contact with their family networks than do widowers. While Utz and colleagues (2002) found no differences in social support between widows and widowers, Fry (2001) found widowers to have significantly fewer social resources and contacts than widows. Similarly, while widows report increased social support from children, widowers have less regular contact with children, grandchildren, and extended family members (Weiss et al., 1973; Barer, 1994; Pinquart & Sorensen, 2001). As well, widowed men may be less likely than widowed women to receive instrumental support from their family networks (Chapman, 1989). Byrne and Raphael (1997) suggest the resulting loss of support after the death of a spouse may contribute to men's concerns regarding isolation and its effect on their capacity for continued independent living.

Gender differences in social integration and support are further demonstrated when the effect of childlessness on loneliness is considered. Because men are less socially integrated than women, the expectation is that childlessness will have a further negative influence on the well-being of older men, especially on loneliness and depression. This hypothesis was supported by Koropeckyj-Cox (1998) who found that while childlessness increased the level of loneliness and depression in

older men, it did not have the same effect on older women. Zhang and Hayward (2001) also found that childless men were at greater risk of social isolation, however, they found that the effect of childlessness was contingent upon marital status. There were no gender differences found for married childless persons. However, it is noteworthy that childless widowed and divorced men reported greater feelings of loneliness than childless unmarried women.

Friendship is also an important factor when considering the relationship between loneliness and widowed older men. The death of a spouse represents the loss of intimate companionship for men (Wister & Strain, 1986). While women often place a great deal of importance on friendships, men typically have less emotionally close relationships and rely on their spouse as their closest friend and confidante (Arber & Ginn, 1991; Barer, 1994). As a consequence widows have a much more extensive network of friends to confide in about emotional stress, while widowers turn mainly to their family. Stevens (1995) found that overall widowers rely only on the support of children as opposed to other family members or friends. This suggests that widowers may experience greater loneliness, as some research findings have demonstrated that friendship support is a more important determinant of loneliness than family support (Dykstra, 1995; Byrne & Raphael, 1997).

In addition, Barer (1994) suggests that widowers may experience greater social isolation because they are unaccustomed to the maintenance of social networks and may resist forming new relationships to substitute for their loss. Stevens (1995) found that widowers had fewer friendships than widows and that these relationships were not close. It has also been suggested that widowers experience greater difficulty establishing new friendships because when a man is widowed, most of his peers may still be married (Wister & Strain, 1986; Barer, 1994). Riggs (1997) found that, to the contrary, social networks were not diminished after the death of a spouse. He found that widowers were, in fact, able to maintain friendships, as well as develop new social networks that alleviated some of the feelings of loneliness. Similarly, Chapman (1989) found that time was an important component of widowhood as men who had been widowed for more than four years had more friends than married men. These findings suggest that further research is required to determine the effect of widowhood on older men's social networks and, concomitantly, on their experience of loneliness.

In addition to widowed older men, it is important to consider the circumstances of the never-married and their experiences of social isolation and loneliness. Rubinstein (1986) suggests that never-married older men construct different types of support networks to replace familial systems. Zhang and Hayward (2001), for example, found that childless men who had never married were less likely to report loneliness than childless divorced and widowed older men. This is indicative of the fact that never-married men obtain support from their relationships with other kin, friends and neighbours (Koropeckyj-Cox, (1998). Dykstra (1995) found that supportive friendships could compensate for the absence of a partner. However, some research suggests that during times of severe illness, older childless persons are at

greater risk of social isolation as non-family relationships are less likely to provide instrumental support (Connidis & McMullin, 1999).

While research on the relationship between gender and loneliness is limited, this discussion has demonstrated that factors related to the experience of social isolation and loneliness are distinct for older men and women. For instance, older men are particularly sensitive to the loss of a spouse, while isolation and loneliness for older women is more closely associated with longer periods of living alone in situations of declining health. As older men and women respond differently to the changes that accompany aging, further research is required to extend our knowledge of the relationship between gender and loneliness. A better understanding of how gender influences the experience of social isolation and loneliness will result in policy and program development that responds more effectively to the needs of older adults.

The Relationship Among Social Isolation, Loneliness, and Health

An enhanced knowledge of the factors that have an impact on loneliness in old age is particularly important as an absence of both isolation and loneliness is considered to be a crucial element for the well being of older adults (Sinclair et al., 1990). Social isolation and social loneliness have consistently been found to be associated with health (Bosworth and Schaie, 1997; de Jong-Gierveld et al., 1987; Kivett, 1979; Mullins et al., 1996; Ryan, 1996; Ryan, 1998). Specifically, it is believed that social isolation and loneliness negatively influence health, and that declining health status may also lead to increased social isolation and accompanying feelings of loneliness. For example, perceived loneliness has been found to be one of the strongest predictors of health status among institutionalized elderly persons (Proffitt and Byrne, 1993), and numerous studies have demonstrated that health is related to the emotional well-being of people in their later years (e.g., Larson, 1978; Mullins et al., 1996). In addition, a relationship has been found between an increase in the use of health care services, such as physician visits and prescription medications, and higher levels of loneliness (Bosworth and Schaie, 1997; Russell et al, 1997). It has also been found that older people suffering from disabilities or chronic conditions such as mobility restrictions, hearing or vision problems, are more likely to feel lonely, suggesting that these conditions may contribute to isolation because they tend to hamper adequate socialization (Forbes, 1996).

Research has demonstrated a link between diminishing health and loneliness in older women, and several studies have also found that older men experience increased loneliness when health status declines. These studies demonstrate that decreases in health create difficulties for older men in maintaining social contacts. Riggs (1997), for example, found that men who experienced ill health also experienced greater social isolation because they were unable to attend social activities, and Chen (1994) also found that hearing loss affected levels of loneliness for older men. In Mullins and colleagues' (1996) study of participants in a nutrition program, men expressed greater feelings of loneliness than women. Although the researchers had not expected this outcome, they suggest that the men's participation in the program indicated not only ill health, but also the loss of their

traditional role and, quite likely, the loss of their spouse as a caregiver. This implies that several factors, including ill health, role loss and decreasing social supports, are jointly related to an older man's level of loneliness.

Several studies have found that elevated feelings of loneliness are predictive of poor subjective health ratings (Kivett, 1978; Woodward & Queen, 1988; Mullins et al., 1996; Fees, Martin & Poon, 1999). In addition, loneliness has been found to be associated with various medical problems including diabetes, coronary heart disease, respiratory problems and chronic pain conditions (Adams et al., 1989; Berg et al., 1981). It has been suggested that there may be other factors mediating the relationship among isolation, loneliness, and health. For example, loneliness may predispose older people to the development or worsening of health problems either directly or indirectly through other mediating circumstances, such as depression; furthermore, loneliness is believed to have a negative effect on one's immune system, which can lead to a variety of health problems (Russell et al, 1997). Research has also found that individuals experiencing health problems coupled with high anxiety tend to express higher degrees of loneliness that are associated with both social isolation (number of regular contacts) and emotional isolation (lack of a confidant or intimate relationship) (Dykstra and de Jong-Gierveld, 1994; Van Baarsen et al., 2001).

The association between loneliness and health is also established when the effect of social support on mortality is considered. Forster and Stoller (1992) examined the impact of health and social support on the mortality of older people. They found that social support was important in predicting mortality for women but not men. Older women who were more socially integrated were more likely to have survived at seven years. In contrast, Benyamini and colleagues (2000) found that high levels of negative emotion effect self-rated health for both women and men, but the ratings were associated with a higher risk of mortality for men. They conclude, "the range of social as well as medical factors affecting women's negative emotions is wider than that affecting men's. This accounts for the stronger relationship of negative emotions to mortality among men" (Benyamini et al., 2000: 361). The researchers suggest that the positive association of negative emotions with mortality for men reflects the degree to which their negative emotions are associated with more serious disease. Life stresses increased negative emotions only in men who had serious diseases, thus indicating that serious illness limits the resources available for individuals to deal with life stresses. The researchers conclude that women and men draw on different evaluative sources when making global health judgments.

The effect of widowhood on older persons also represents a risk for poor health and mortality. A recent study by Quandt and colleagues (2000) examined the implications of widowhood on eating behaviors noting the health risks associated with poor nutrition. Older adults are considered to be at risk of malnutrition after the loss of a spouse because of shifts in eating practices. This study found poorer eating behaviors among the widowed, including the preparation of foods with low nutritional value or skipping meals. Other studies have also established a

relationship between living alone and poor diet. It is important that one national study found that the effect of living alone appears to be more pronounced for men than for women (Davis, Murphy & Neuhaus, 1988; Davis, Neuhaus & Lein, 1990). Riggs (1997) also found that many older widowers mentioned that eating alone increased their feelings of loneliness and that a means of alleviating this loneliness was to dine with friends.

The relationship among isolation, loneliness and health is further demonstrated when the use of health services is considered. For example, Mistry and his colleagues (2001) investigated the role of social networks and support in the re-hospitalization of older American veterans. They found that those patients who were socially isolated or at high or moderate risk for isolation, were 4-5 times more likely to reenter a hospital facility within a year. The authors stressed that it was essential to address the lack of social support in order to optimize the health care of older veterans. In another study, Auslander and Litwin (1991) examined the relationship between social networks, social support, and self-ratings of health among applicants and non-applicants for older persons' health services. Individuals who perceived their social networks as supportive were better able to meet their health needs, and had higher self-health ratings for both functional and psychological well-being. Subjective self-rated health measures were positively associated with objective health, but supportiveness was not associated with social network size. These results were supported by the work of Kouzis and Eaton (1998) who found that decreasing social networks among older people did not have a negative effect on health and well being if the fewer social ties that remained were supportive.

In addition to the use of health services, the relocation of older persons to more supportive settings reflects the association between loneliness and health. Many studies have found that older persons who are socially isolated, express feelings of loneliness, and experience declining health are more likely to move to nursing homes or seniors residences (Andersson, 1984). Barer (1994) notes that gender differences in response to relocation exist. He suggests that men tend to be less accepting of relocation to senior housing because, just as with widowhood, it is not anticipated in the lives of older men. As older men have difficulty in coping with new living situations and may have difficulty in adjusting to new social networks, it is possible that they will experience greater levels of loneliness. Tijhuis and colleagues (1999) found that exposure to the events of widowhood, declining health, and moves to institutional care were significant in explaining loneliness. Specifically, the men in the study who were living in or moving into nursing homes were lonelier than men living independently.

In addition, some participants in public discussions as part of the Aging in Manitoba study (Hall & Havens, 1999) suggested nursing homes were particularly isolating because residents are often immobile and have little opportunity to socialize with others in meaningful ways. They also felt that similar situations might occur for those in age-segregated housing. The participants supported alternative housing options such as group home settings or congregate housing that could provide privacy but still encourage stimulating social activities (Hall & Havens, 1999).

An individual's subjective evaluations of supportive social networks thus appear to be important for promoting positive effects on physical and psychological well being among older people. Although research has consistently demonstrated a strong association between social isolation, loneliness and health, the direction of this link remains unclear (Ryan, 1998). Specifically, do loneliness and social isolation precipitate health problems, or do health problems precipitate loneliness and isolation? Some researchers feel that loneliness may result from less contact with others due to ill health (Jerrome, 1991; Mullins et al., 1996; Ryan and Patterson, 1987), while others have suggested that loneliness and limited social contact precede ill health (Cattell, 1988; Koedoot and Hommel, 1993; Ryan and Patterson, 1987; Wenger, 1984). For instance, it is possible that an older individual with health problems may be unable or unwilling to engage in social activities with others, thus leading to social isolation and accompanying feeling of social loneliness. On the other hand, it is also possible that older individuals who are isolated may be less active, have poor nutrition and decreased mental stimulation, all situations which might contribute to the development of health problems (Hall and Havens, 1999). Others argue that there is an optimum level of social support and beyond that level, benefits diminish and can become negative, creating dependency, and diminishing rather than increasing feelings of control (Krause 1987; Havens & Hall, 1999).

The difficulty in determining the cause and effect of the relationship among isolation, loneliness and health is demonstrated by the model proposed by Russell and his colleagues (1997) to explain nursing home placement. Social isolation and loneliness, along with declining health, are considered to be primary causes of relocation for older persons. Therefore it is useful to consider this model as it may provide important insights into the development of programming that addresses the needs of at-risk older persons. The model proposed by Russell and his colleagues (1997) includes five possibilities for the association between social isolation and loneliness and declines in health that can result in institutionalization.

The first explanation proposed by Russell and his colleagues (1997) is that loneliness precedes a decline in mental health. For example, loneliness may result in symptoms of depression and deficits in functioning thus creating an increased burden for caregivers and, ultimately, an increase in nursing home placement. Cohen, Teresi & Holmes (1985) found that social networks had both a "buffering" and a "direct" effect on psychological well-being, and in turn, on individual physical health. They point to the clinical significance of social networks for adapting to one's environment and sustaining good health. Other researchers have also found that satisfaction with the amount of social interaction and the availability of a confidante protect against depression and physical illness (Chappell & Badger, 1989; Hays et al, 1998).

The second explanation proposed by Russell and colleagues (1997) is that loneliness precedes a decline in physical health. They found that loneliness predicted increased reports of poor health, chronic illness, declines in functioning,

and increased mortality. This is supported by other research that has also found that loneliness and limited social networks precede ill health (Wenger 1984; Ryan & Patterson, 1987; Cattell, 1988; Koedoot & Hommel, 1993).

The third possibility proposed by Russell and his colleagues (1997) is that loneliness may result from poor health. For instance, declines in mobility may make it more difficult for older people to interact socially. Both Mullins and colleagues (1996), and Ryan and Patterson (1987) have found that limited physical functioning is related to both loneliness and social isolation. Vision and hearing problems are isolating because they impede one's ability to communicate. Dugan and Kivett (1994) found that older people with hearing impairments are more likely to be lonely than older people without hearing impairments.

The fourth possibility proposed by Russell and his colleagues (1997) is that loneliness reflects the lack of a caregiver resulting in the need for institutionalization. Studies found that high levels of loneliness are linked to formal home care use and increased risk of institutionalization among older adults (Frederick, 1991; Russell et al., 1997). Andersson (1984) also found that older people who were less lonely, married, and had supportive social networks were at lower risk for institutionalization. Ghusn, Stevens and Attasi (1998) found clear differences in the qualities of interpersonal relationships and life satisfaction among inpatient and outpatient older American veterans. Veterans residing in nursing homes were less interpersonally involved and their expectations for later life had less often been met. Those residing in the community reported interpersonal involvement with family and friends, were more likely married and their expectations for later life had more often been met. The inpatients were more likely to perceive their health as poor, need help with activities of daily living (ADL) and were less likely to feel useful. The authors concluded that the presence of a social support system was an important component for optimal life satisfaction in later years, and, consequently they specified that comprehensive psycho-social services were required to address the needs of aging veterans.

The fifth possibility suggested by Russell and colleagues (1997) for the association between loneliness and health is that loneliness leads to social isolation. Wenger and colleagues (1996) stress that factors associated with loneliness, such as poor self-rating of health and low morale, may contribute to social isolation. As well, Koedoot and Hommel (1993), Wenger (1984) and Frederick (1991) found that loneliness related to situations of grief and that a sense of alienation contributes to loneliness and social isolation.

The research to date highlights the relationship among social isolation, loneliness, and the health and well being of older people. However, the impact of loneliness and social isolation on the health of older people is an area that still requires clarification. The predominant factors associated with social isolation and loneliness appear to be widowhood, living alone, other aspects of social networks and physical, mental and functional health. The focus of current research has shifted from

determining if there is a direct link between social isolation, loneliness and health, to attempting to unravel the multidimensional factors and causal interactions associated with these experiences that effect the health and well being of older people.

Summary and Conclusion

This review of the current research on social isolation and loneliness points out substantial gaps in describing the factors associated with experiences of social isolation and loneliness and their relationship to the health of older people. A number of correlates of social isolation and loneliness among older persons have been identified, specifically widowhood, gender, living arrangements, and health. However, the relative ability of these and other factors to distinguish between levels of loneliness and social isolation among older people remains unclear.

Retirement is accompanied by loss of social contacts through work, which is especially important to older men. Widowhood also brings with it shifts and changes in individual's social networks. Understanding which aspects of social networks promote well-being is an area requiring further study, particularly among older men. In addition, the long-range effect of loneliness interventions among older persons and the role of the family and others in the intervention process require investigation to enable effective program design.

The gaps in research impede the development of policy and program planning that may alleviate social isolation and loneliness for older men. The ability to develop and implement successful intervention programs rests on understanding the interaction between the situational factors associated with social and emotional isolation that result in feelings of loneliness for men.

APPENDIX B

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APPENDIX C

Aging in Manitoba Study Information Presented at Public Meetings

Social Isolation And Loneliness Among Older Men In Manitoba

Aging in Manitoba Study
University of Manitoba

Funding
Veterans Affairs Canada
Prairie Region, Winnipeg MB

1

The Aging in Manitoba Longitudinal Study 1971 - 2001

- The longest continuous study of aging in Canada
- One of the largest population-based studies of aging in existence
- The only longitudinal study of aging which merges personal interview data with complete health utilization data

2

Study Design

Year	*Number*	*Minimum Age*
Cross-Sectional Studies		
1971	**4,803**	**65**
1976	**1,302**	**60**
1983	**2,875**	**60**
Panel Studies		
1983 (1971 & 76)	**2,403**	**67**
1990 (1971,76,83)	**3,218**	**66**
1996 (1971,76,83)	**1,868**	**72**

TOTAL = 8,950 Manitobans

3

Aging in Manitoba – 1996

- **TOTAL NUMBER OF PARTICIPANTS.....1,868**
- **GENDER**
  - **Male..... 40%**
  - **Female..... 60%**
- **MINIMUM AGE..... 72**
- **RESIDENCE**
  - **Community..... 86%**
  - **Personal Care Homes..... 14%**
- **GEOGRAPHIC DISTRIBUTION**
  - **Winnipeg..... 39%**
  - **Other..... 61%**
- **INTERVIEWS COMPLETED BY PROXY.... 21%**

4

Definitions

- ***Social Isolation***
  A small number of regular contacts with other people

- ***Social Loneliness***
  Expressing *dissatisfaction* with a small number of regular social contacts

5

Components of the Loneliness Index

1. **Do you sometimes feel lonely?**

2. **Do you consider yourself to be ___**
   - **not lonely**
   - **moderately lonely**
   - **severely lonely**
   - **extremely lonely**

6

3. Do you agree or disagree:

There is always someone that I can talk to about day to day problems.

I miss having a really close friend.

I experience a general sense of emptiness.

There are plenty of people I can lean on in case of trouble.

I miss the pleasure of the company of others.

I feel my circle of friends and acquaintances is too limited.

There are many people that I can count on completely.

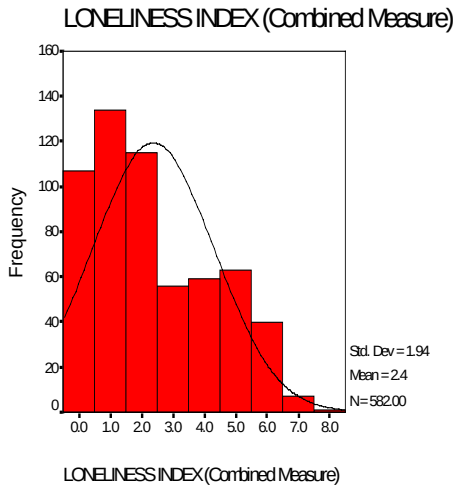
There are enough people that I feel close to.

I miss having people around.

Often, I feel rejected.

I can call on friends whenever I need them.

7



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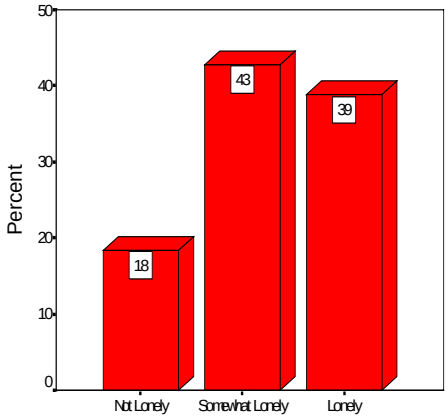
LONELINESS INDEX

Men - 1996



9

Components of Social Isolation

- Demographics
- Social Network
- Life Changes
- Life Satisfaction
- Health

10

COMPONENTS OF SOCIAL ISOLATION

	% Male	% Female
Demographics		
Widowed	22.8	65.6
Difficulty with finances now	11.4	13.1
Difficulty with finances in future	20.1	24.2
Social Network		
Live Alone	30.8	65.7
Nearest relatives more than 1 day away	1.9	3.8
Life Space Index = extremely isolated	12.1	19.1
Life Changes		
Lived in present house less than 3 years	14.5	19.9
Moved to present house from more than 1 day away	3.7	2.9
Lived in present community less than 5 yrs	9.2	10.9
Life Satisfaction		
Feel older people are seldom active in the Community	17.8	16.5
Feel community shows little respect to Older people	1.1	1.6
Low Life Satisfaction Scale score	3.6	3.3
Health		
4 or more health problems in last year	54.0	61.7
Spent more than 1 month in hospital In last year	13.7	17.4
Generally weak or unsteady state of mind	3.5	6.9

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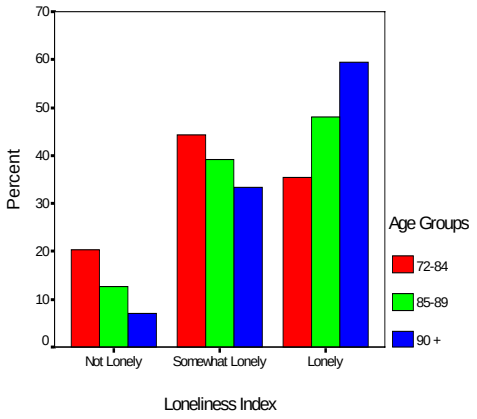
LONELINESS BY AGE OF RESPONDENTS



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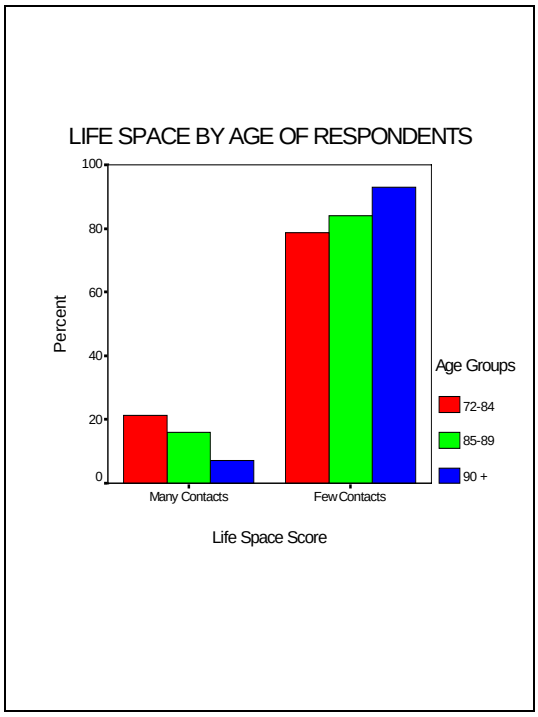
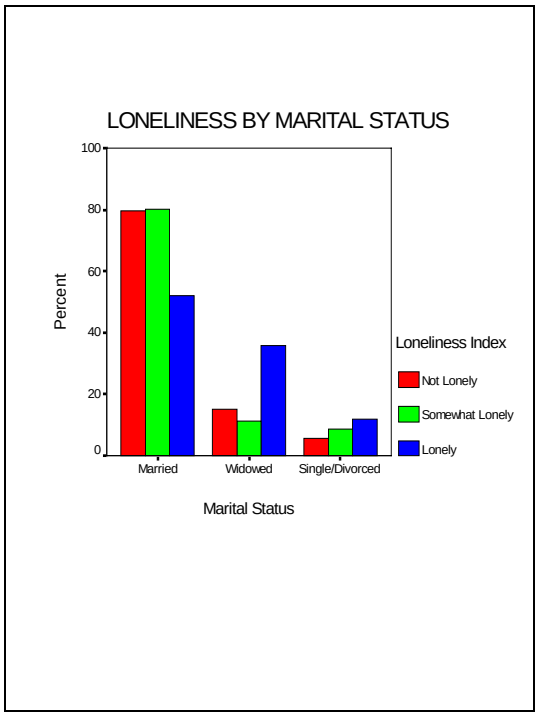
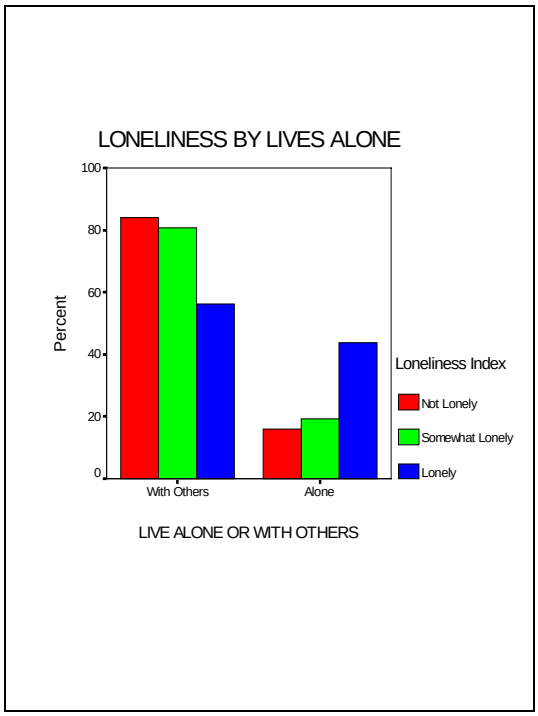

LIFE SPACE BY AGE OF RESPONDENTS
Percent
100
80
60
40
20
0
Many Contacts
Few Contacts
Life Space Score
Age Groups
72-84
85-89
90 +

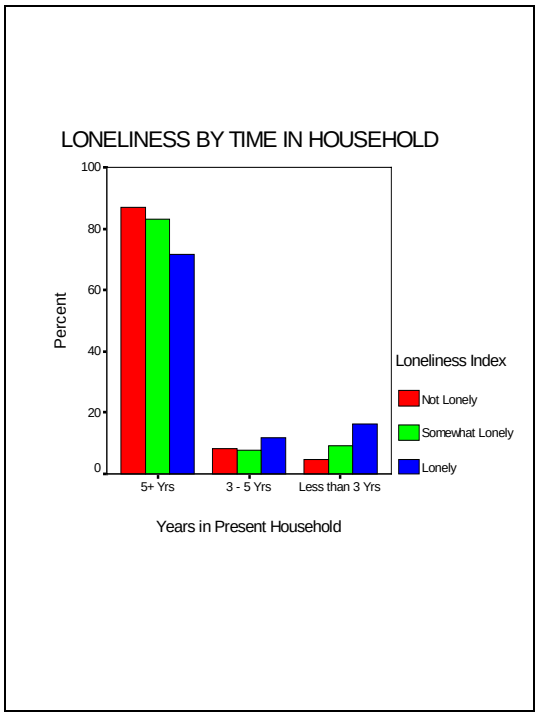
13


LONELINESS BY MARITAL STATUS
Percent
100
80
60
40
20
0
Married
Widowed
Single/Divorced
Marital Status
Loneliness Index
Not Lonely
Somewhat Lonely
Lonely

14


LONELINESS BY LIVES ALONE
Percent
100
80
60
40
20
0
With Others
Alone
LIVE ALONE OR WITH OTHERS
Loneliness Index
Not Lonely
Somewhat Lonely
Lonely

15


LONELINESS BY TIME IN HOUSEHOLD
Percent
100
80
60
40
20
0
5+ Yrs
3 - 5 Yrs
Less than 3 Yrs
Years in Present Household
Loneliness Index
Not Lonely
Somewhat Lonely
Lonely

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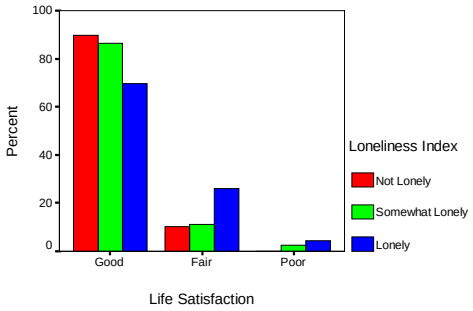
LONELINESS BY

SATISFACTION WITH LIFE



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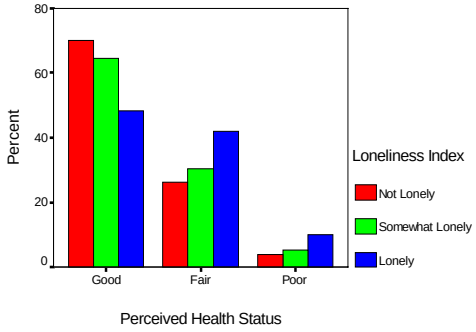
LONELINESS BY PERCEIVED

HEALTH STATUS



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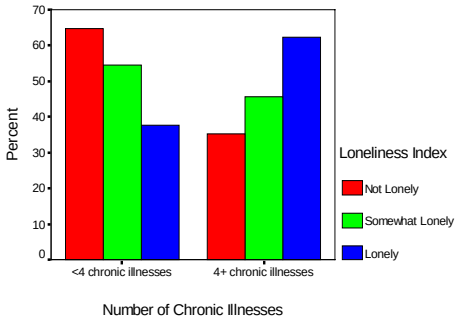
LONELINESS BY NUMBER

OF CHRONIC ILLNESSES



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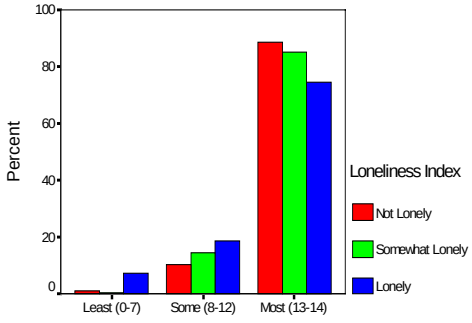
LONELINESS BY

ACTIVITIES OF DAILY LIVING



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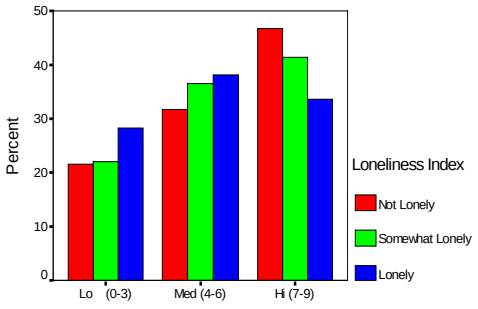
LONELINESS BY INSTRUMENTAL ACTIVITIES OF DAILY LIVING



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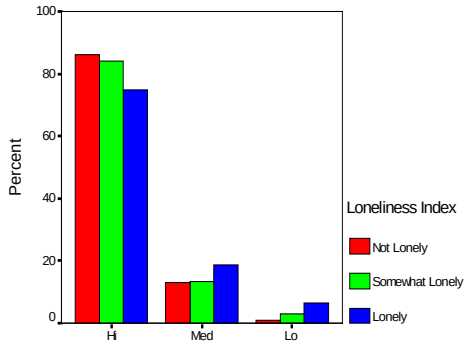
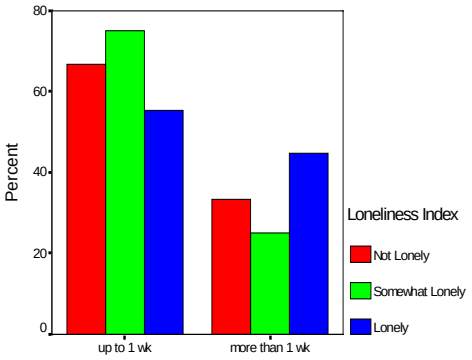
LONELINESS BY COGNITIVE STATUS



22

LONELINESS BY DAYS IN HOSPITAL



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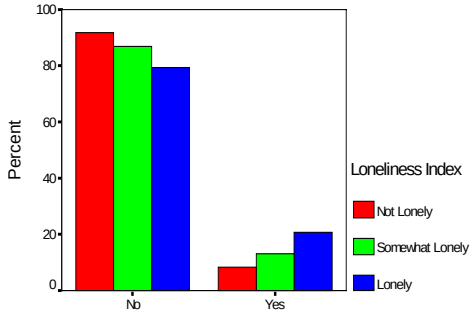
LONELINESS BY USE OF HOME CARE SERVICES



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CONCLUSIONS

Men who are lonely:

- ***Older***
- ***Widowed***
- ***Live alone***
- ***Recent moves***
- ***Less satisfied with life***
- ***Less healthy***
- ***Use more health services***

25

WHAT DO WE NEED TO KNOW?

26

Question 1

Are you aware of social isolation and loneliness among older people in your community?

If so, where do you see it?

27

Question 2

Why are social isolation and loneliness problems for older people…

especially for older men?

28

Question 3

Do you think poor health results in fewer contacts with other people…

or

Do fewer contacts with other people place older people at greater risk of poorer health?

29

Question 4

What suggestions can you make to reduce social isolation and loneliness for older people now and in the future?

30

Suggestions:

- What could individuals do? (friends, family, neighbors)

31

Suggestions:

- What could the community do?

32

Suggestions:

- What organizations/groups are already reaching out to those who are isolated and lonely?
- What might other organizations/groups do?

33

Suggestions:

- What could those who plan seniors' (or veterans') programs and services do?

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Acknowledgements

- **Authors**
  - **Madelyn Hall, Betty Havens, Gina Sylvestre (with the assistance of Susan Marshall, Y. Hosain, C. Nicholson)**
- **Technical Support**
  - **Henry Dyck, Computer Programmer**
- **Admin Support**
  - **Dept of Community Health Sciences, University of Manitoba**
- **Additional Financial Support**
  - **Canadian Institutes of Health Research**
  - **Social Sciences and Humanities Research Council**
  - **Manitoba Health**

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APPENDIX D

Meeting Dates and Locations

APPENDIX D: Meeting Locations

City/town	Date	Meeting location	Local contact	title	organization	local contact 2	title 2	organizaton 2
Winnipeg	23/10/01	St. James Legion	Jim Holland,	President	RCL #4			
Brandon	25/10/01	ANAF unit #10	Diane Mooney	President	ANAF #10			
Killarney	26/10/01	Killarney Legion	Earl Pawchuk	President	RCL # 25			
Carman	30/10/01	Carman Legion	Rod McFerson	President	RCL #18			
Dauphin	21/11/01	Dauphin Multi-Purpose Senior Centre	Lisa Clark	Older Persons Program Coordinator	Dauphin Multi-Purpose Senior Centre			
Swan River	22/11/01	Swan River Senior Centre	Ed Allen	President	Swan River Senior Centre	Jan Fawcett	Resource Coordinator	Swan River & District Community Resource Council
Russell	30/11/01	Russell Leisure Centre	Pearl Jeske	Seniors Resource Coordinator	Snr Services of Banner County			
Winnipeg (veterans)	06/12/01	Deer Lodge Centre	Kevin Scott	Director, Community Relations	Deer Lodge Centre			
Beausejour	28/01/02	Beausejour Legion	John Baker	President	RCL #132	Wayne Guitard	Services to Seniors Specialist	North Eastman Health Association
Stonewall	05/02/02	Stonewall Lion's Community Centre	Shelley Krause	Resource Coordinator	South Interlake Seniors Resource Council			
Winnipeg	18/02/02	Winnipeg Public Library						

APPENDIX E

Sample Letter, News Release, Poster

UNIVERSITY OF MANITOBA

Aging in Manitoba Study
Dept of Community Health Sciences
S-110, 750 Bannatyne Avenue
Winnipeg MB R3E 0W3
Ph: (204) 789-3831
Fax: (204 789-3905
E-mail: AIM_96@cc.umanitoba.ca

November 16, 2001

R.D. Tibbatts, President
RCL #74
Binscarth, MB

Researchers with the Aging in Manitoba Study from the University of Manitoba are conducting research into social isolation and loneliness among older men.

An important part of our project involves holding community discussion groups throughout the province. We would like to know if Manitobans think loneliness and social isolation among older men is a problem, why these conditions are problems, what difficulties are caused for older men and their families, and what could be done to lessen social isolation and loneliness.

A community meeting will be held in Russell on Friday, November 30, 10:00 a.m., at the Russell Leisure Centre Centre, 529 Main Street N. We would love to have some veterans, and anyone else who is interested, participate.

The meeting is for everyone concerned with the health and well-being of older people. A less academic title for the discussion might be *Is your health and well-being related to your social life?*

The research is funded by Veterans Affairs Canada. They are particularly interested in the opinions of veterans as the information will help improve services. We would appreciate any help you could give us advertising the meeting to veterans in the Binscarth area.

If you have any questions, or would like more information, please call me (975-7741) or Madelyn Hall (789-3831). The toll free number is 1-800-432-1960, ext. 7741 (Susan) or ext. 3831 (Madelyn).

Sincerely,

News release

Did you know 4 out of 5 Manitoba men over age 72 say they are lonely? Aging in Manitoba researchers are interested in speaking with Manitobans about loneliness among older men—why it occurs and what can be done about it.

Interested seniors, family members, caregivers, and community groups are invited to participate in a community discussion group on:

Tuesday, February 5, 10:00 am at the Stonewall Lion's Community Centre,
5 Keith Cosens Dr.

A light lunch will follow.
RSVP, by Jan 30, to Shelley or Sheryl 467-2719, South Interlake Seniors Resource Council.

Community discussion groups are being held throughout the province to determine if Manitobans think loneliness and social isolation among older men is a problem, why these conditions are problems, what difficulties are caused for older men and their families, and what could be done to lessen social isolation and loneliness. Results of the 1996 Aging in Manitoba data about older men will be presented.

Funded by Veterans Affairs Canada, researchers are exploring the issue of loneliness and social isolation among older men. Not much is known about the men most likely to be isolated and lonely, and why. Previous research found a relationship between social isolation, social loneliness and health of older women, however, the similarities or differences in the experiences of older men is unknown.

Aging in Manitoba is the longest continuous study of aging in Canada. Over the years, the study results have been used in developing policies, services, and activities for older Manitobans. Results from this study will be shared with veterans and seniors organizations, and anyone else concerned with the health and well-being of older people, especially older men.

For further information contact:

Madelyn Hall
Aging in Manitoba Study
Department of Community Health Science
University of Manitoba
Winnipeg, MB R3E 0W3
Phone 789-3831 fax: 789-3905 email: aim@umanitoba.ca

COMMUNITY MEETING

HEALTH
LONELINESS AND SOCIAL ISOLATION AMONG OLDER MEN

Researchers with the Aging in Manitoba Study University of Manitoba want to know: Are your health and well-being related to your social life?

FEB 18 1:30 pm ASSEMBLY ROOM
WINNIPEG CENTENNIAL LIBRARY
251 DONALD STREET

We want to hear from
Men, Women,
Family Members,
Caregivers, Community Groups
Volunteers, Everyone

Refreshments available

- **Research has shown that people who live alone and have poorer health are more likely to be socially isolated and lonely.**
- **In Manitoba, one third of men aged 72 and over live alone.**

For further information call: Aging in Manitoba Study
Department of Community Health Science, University of Manitoba
Toll-free: 1-800-432-1960 Madelyn Hall (ext. 3831) Susan Marshall (ext. 7741)

Funding for this study has been provided by Veterans Affairs Canada

Aging in Manitoba

1971 to 2001