The Quiet Room.

A Narrative Analysis of Elderly Widowed People’s Perspectives of Loneliness

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ABSTRACT

INTRODUCTION

By 2050 approximately two billion people will be aged 60 plus (World Health Organisation, 2013). The increased risk of physical and mental health issues associated with ageing, along with the estimated costs, are a worldwide social concern (Harris, Cook, Victor, De Wilde, & Beighton, 2006; Ng, Lee, & Chi, 2004; Stek, Vinkers, Gussekloo, Beekman, Van der Mast, & Westendorp, 2005). The World Health Organization has classified depression as one of the most frequently diagnosed mental illnesses in old age and highlighted the need for greater understanding of causes of depression one of which is deemed to be loneliness (World Health Organization, 2004).

Loneliness is an experience that can occur throughout a life span. Advanced age has been heralded as a protective factor against loneliness and as a risk factor for increased loneliness (Ip, Lui, & Chui, 2007). Life experiences, not ageing per se, may impact upon the prevalence of loneliness (Rius-Ottenheim, Kromhout, Van der Mast, Zitman, Geleijnse, & Giltay, 2012; Smith, 2012). Widowhood is purported to be a common catalyst for feelings of loneliness in old age (Band-Winterstein, 2012; Greenfield & Russell, 2011; Heikkinen & Kauppinen, 2011; Moyle, Kellett, Ballantyne, & Gracia, 2011). Successful interventions to remedy or reduce loneliness in old age are, somewhat, elusive and the subjective views of older people are given nominal consideration. The aim of this study is to retell the story of the experience of loneliness from the perspectives of older widowed people in New Zealand.
METHOD

A qualitative narrative research design was used. Forty widowed participants, aged between 70 years and 97 years, were recruited. Face to face interviews were conducted with each of the participants, in their own homes. The interviews were recorded and transcribed. The narratives within each transcript were identified, coded and analysed.

FINDINGS

A collective story emerged that described the meaning, impact, and reality of widowhood and its relationship to loneliness. The context of meaning ascribed to the event by the individual influenced the intensity of the emotional response, specifically loneliness. The apperception of loneliness represented the first part of the collective story. The plot continued with participants’ accounts of the process of renegotiating self-identity following bereavement. Loneliness was influenced by the ageing process and the impact of societal expectations. The final stage of the collective story described a continuum of integration and adjustment to loneliness and is an amalgamation of participants’ coping responses. Cultural influences shaped personal coping strategies and the perception of formal support.

CONCLUSIONS

The collective story revealed that each individual experience of loneliness has a story that underpins it. The stories from the older widows and widowers, that took part in this study, have contributed new knowledge to the field of gerontology. If we aim to identify and address loneliness, we need to learn how to access these stories, the way we communicate plays a central role. The findings from this study may be used to develop meaningful interventions and initiatives that help facilitate greater understanding of loneliness in old age.
ACKNOWLEDGEMENTS

First and foremost this thesis is dedicated to the older men and women and their family and whanau, who I have had the privilege to work with throughout my nursing career. The wealth of knowledge and experience that I have encountered and the stories of resilience that I have heard have been both joyful and poignant. They serve as a keen reminder to me that my role is not only that of a health professional, but also a collector and caretaker of treasured tales.

Second I want to thank my family particularly my husband Stephen, my daughters Lucy and Niamh, and my parents who have lovingly listened to my theories and findings for the last five years. You have given me the time, space and support that I have required to write this thesis. Without your understanding I am fully aware that I would not have come this far. My close friend Sally also deserves a medal for tolerance. I shared the confined space of an office with you, you were a captive audience, and you guided me through the Masters and have been a reliable navigator during this journey.

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Fourth my thanks go to my supervisors Dr Marie Crowe and Dr Lisa Whitehead. This has been such an incredible journey. I am so very grateful for your patience and your wisdom. I have watched my professional life develop in many positive ways, as a result of your guidance.
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CHAPTER ONE INTRODUCTION

AGEING, WIDOWHOOD AND LONELINESS

The estimated costs of an ageing population are widely reported as a social concern (Ng et al., 2004). With age comes physical health issues, however, mental illness is an equally increasing concern to most societies as it can impact upon independence and lead to increased care needs (Harris et al., 2006; Stek et al., 2005). Globally countries are keen to respond to the health and social needs of older people, in a bid to sustain quality of life, and manage the financial demands associated with the treatment of mental and physical illness in this age group whose numbers are increasing (World Health Organization, 2011). The World Health Organization has classified depression as one of the most frequently diagnosed mental illnesses in older people. There is a call for greater understanding of causes of depression, one of which is deemed to be loneliness (World Health Organization, 2004).

This study narrates the story of loneliness from the perspective of older widowed men and women, living in rural and urban community settings in Christchurch and its environs. The subjective nature of loneliness was explored through the relationship between a life event, the meaning ascribed to the event, and the impact on loneliness.

Loneliness is an experience that can occur throughout a life span. As to whether loneliness is experienced more frequently in old age remains a matter for debate. Advanced age has been heralded as a protective factor against loneliness, and as a risk factor for increased loneliness (Ip et al, 2007). Life experiences, not ageing per se, may impact upon the prevalence of loneliness (Rius-Ottenheim et al., 2012; Smith, 2012). Widowhood is purported to be a common catalyst for feelings of
loneliness in old age, although bereavement in general is a significant source of loneliness (Band-Winterstein, 2012; Greenfield & Russell, 2011; Heikkinen & Kauppinen, 2011; Moyle et al., 2011).

A universally accepted definition of loneliness remains elusive, and researchers do not appear any closer to reaching a consensus (Beal, 2006; Bekhet, Zauszniewski, & Nakhla, 2008; Grenade & Boldy, 2008; Moyle et al, 2011; Palkeinen, 2005; Perlman, 2004; Savikko, 2008). The debate about loneliness being a one-dimensional phenomenon versus a multi-dimensional phenomenon persists (Steed, Boldy, Grenade & Iredell, 2007; Yang & Victor, 2008). Researchers argue the merit of measuring a single item such as an individual’s opinion of loneliness versus measuring multiple items such as opinions and contextual characteristics (De Jong Gierveld, Van Tilburg, & Dykstra, 2006).

Loneliness has been defined as “a subjective and negative state that occurs when the number or quality of personal relationships falls short of the level desired or expected” (De Jong Gierveld & Dykstra, 2008, p.272). Loneliness may be viewed as a negative experience that leads to dismay, or as a positive experience that promotes change, depending upon the manner in which it is interpreted (De Jong Gierveld et al, 2006; Hawkley & Cacioppo, 2010; Tiikkainen, Leskinen, & Heikkinen, 2008). As highlighted, the process of establishing the meaning and the measurement of loneliness is fraught with disagreement (Grenade & Boldy, 2008; Victor, Grenade, & Boldy, 2005). Some researchers advocate for subjectivity, and a research process focused upon individuals and meaning. Alternatively some researchers opt for large scale studies with substantial sample numbers in the name of objectivity (Yang & Victor, 2008).

For the purpose of this study the investigation of individual meaning was particularly important. To ensure that the subjective nature of loneliness was given credence yet did not predetermine the experience of loneliness as negative a
definition of loneliness was selected, to guide the research process, which approached loneliness without judgement. “Loneliness is a complex set of feelings encompassing reactions to the absence of intimate & social needs” (Ernst & Cacioppo, 1999, p.1). Ernst and Cacioppo (1999) appear to reserve judgement without minimising the complexity of loneliness.

There is an existing body of research that examines the prevalence of loneliness in old age (Alpass & Neville, 2003; Bekhet et al., 2008; Savikko, 2008; Tiikkainen, Heikkinen, & Leskinen, 2004). The research findings are significant, however, there is still much to learn about culture, gender, age, and functional ability in relation to loneliness. The experience of widowhood and bereavement is a traumatic but inevitable part of ageing that requires further consideration, particularly in relation to loneliness (Dykstra, Van Tilburg, & De Jong Gierveld, 2005; Reid-Keene & Prokos, 2008). Researchers acknowledge the protective elements of a long-standing relationship such as marriage (Rasulo, Christensen, & Tomassini, 2005). A conflicting viewpoint argues, however, that such relationships can contribute to loneliness particularly if one partner is ill and the other partner has to assume the caring role (Scheel-Gavan, 2003).

The way in which individuals ascribe meaning to events and changes in their lifestyle, may impact upon loneliness. In preparation for this study the researcher acknowledged the gaps identified by previous research studies. The current study explored the relationship between loneliness and the life event of widowhood. The way in which an individual views ageing may be shaped by the society in which they live, and could be a potential risk factor for loneliness. The personal experience of physiological change and the impact of societal expectations, in relation to loneliness, are considered. Finally, coping responses to loneliness are reviewed. Coping mechanisms are highly subjective, influenced by age, gender, culture and functional ability, and perhaps help to demonstrate why a one size fits
all mentality towards effective intervention to combat loneliness can be inappropriate.

RESEARCH DESIGN

The primary aim of this research was to understand widowed individuals’ subjective experience of loneliness. It was inspired by Randall, Prior, and Skarborn (2006), who undertook life story interviews with people aged 80 plus as part of a well-being study. The research question consisted of three parts. Each part related to older people’s accounts of loneliness and what it meant to them.

1. How do older widows/widowers describe experiences of loneliness?
2. How does the experience of loneliness change over time with age and lifestyle for older widows/widowers?
3. What strategies are used by older widows/widowers to manage the negative features of loneliness? What role do health services play?

A considerable amount of thought was given to which research methodology would be most appropriate, to answer the parts to the question of loneliness in old age. The conclusions drawn from a literature review on loneliness and old age are both positive and negative. It is widely accepted that the needs of older populations need addressing; yet, misunderstanding and stereotype still surround this age group (Chalise, Saito, Takahashi, & Kai, 2007). The diversity of themes relating to loneliness confirm the complexity and prevalence of this phenomenon in old age. A collective definition of loneliness is not the only issue for debate in research circles; a unified approach to the measurement of loneliness also remains under discussion. Researchers continue to debate the merit of utilizing a quantitative research method versus that of a qualitative research technique. Some methods of data collection can obscure self-report bias which can lead to possible
under reporting of loneliness (Kaplan, Huguet, Orpana, Feeny, McFarland, & Ross, 2008).

The fact that there are more quantitative research studies relating to loneliness in old age compared to qualitative research studies, emphasizes a potential gap in subjective experiential data from the perspective of older people. Studies that address the meaning of loneliness and interventions to manage it are limited. This could suggest that a purely quantitative approach may not be the ideal research paradigm for this phenomenon. The opinions and narratives of older people need to be given greater attention, if successful interventions are to be developed (Heylen, 2010). Greater understanding is required of male and female experiences of loneliness. An ageing population brings with it an increase in men and women, yet a majority of research focuses upon the needs of older women (Ruxton, 2006). The idea that women are more vulnerable to loneliness than men is a notion that requires further investigation as it is unclear whether longevity and increased exposure to life events, combined with an ability to self-disclose, may be distorting results (Golden, Conroy, Bruce, Denihan, Greene, Kirby, & Lawlor, 2009; Luanaigh & Lawlor, 2008).

Further research is required into loneliness and the gender specific social and emotional needs of older men and women, particularly in relation to health and social service development (Arve, Lavonius, Savikko, Lehtonen, & Isoaho, 2009; Ferguson, 2011; Krause-Parello, 2008). Homogeneity is often assumed in older people, failure to respect individual differences could lead to misunderstanding, misdiagnosis, and misuse of health and social resources (Howse, Ebrahim, & Gooberman-Hill, 2004; Savikko, Routasalo, Tilvis, Strandberg, & Pitkälä, 2005; Valadez, Lumadue, Gutierrez, & De Vries-Kell, 2006). For a service to meet the demand efficiently, policy makers need to consider the wider implication of unmet needs and loneliness in the older population. While there is a plethora of literature concerning loneliness in old age, there is still much to be learnt.
A qualitative research strategy, such as narrative interviews, may facilitate greater understanding of the personal meaning of loneliness. Personal narratives are used as a means of “coping and surviving” (Bennett & Vidal-Hall, 2000). The opportunity to reminisce and recount past life events provides an insight into lived experiences (Riessman, 2008). Narratives embody individuality and also represent history, society, culture and geography (Bruner, 1991; Day-Sclater, 2003). A narrative research approach to loneliness may address aspects of the knowledge gaps identified by previous researchers, such as gender specific social and emotional needs and individuality (Arve et al., 2009; Ferguson, 2011; Krause-Parello, 2008; Savikko et al., 2005; Valadez et al., 2006). Despite the fundamental presence of narrative as part of daily human activity, there is no globally accepted definition (Elliott, 2005; Mishler, 1995; Riessman & Quinney, 2005; Squire, Andrews, & Tamboukou, 2008). With regard to the topic of loneliness Riessman’s definition is favoured. Riessman (1993, p. 3) maintains that people ‘narrativize particular experiences in their lives often where there has been a breach between the ideal and real self and society’. This definition complements the definitions of loneliness, which describe a perceived discrepancy between desire and availability of relationships (De Jong Gierveld, 1998; Dykstra et al., 2005).

Event centred narratives concentrate on actual past events that have been encountered by an individual (Squire et al., 2008). Experience centred narratives allow the researcher to analyse narrators accounts of situations that have happened to other people, which could prove useful for the research topic of loneliness, due to the associated stigma. Experience centred narratives acknowledge subjectivity, and the changeable nature of narrative. An individual can provide completely different accounts of the same experience on separate occasions (Frid, Öhlén, & Bergbom, 2000; Squire et al., 2008). Narrative analysis also allows for the consideration of big story versus small story analysis. According to Phoenix (2008) big story analysis looks at life story and identity as a whole, and takes cognitive
and developmental aspects of life into consideration. Alternatively small story analysis examines selected narratives of “everyday encounters….ongoing events, future or hypothetical events, shared events but also allusions to tellings, deferrals of tellings and refusals to tell” (Georgakopolou, 2006, p.123). For the purpose of the research topic of loneliness it was felt that a small story approach may be more appropriate as it allows for a review of everyday life narrative fragments, including conjectural experiences (Williams, 2004).

Age, gender, and location were highlighted as potential research areas, as they represent the knowledge gap within Gerontological research in New Zealand. The Ministry of Health’s ‘Health of Older People Strategy’ called for future research in the areas of environment and gender (Ministry of Health, 2002). Although this strategy is now over ten years old the availability of qualitative New Zealand research concerning loneliness, environment, and gender remains limited as is demonstrated by the literature search. Research into the subjective experiences of the 85 plus population is also limited (Foster & Neville, 2010; Stek et al., 2005). The term subjective refers to the personal understanding of shared experiences.

The decision to concentrate upon older widowed individuals, and the impact of widowhood on lifestyle and loneliness, stems from Davidson (2001) and Victor et al., (2005). The experience of widowhood encompasses both physical and psychological changes (Demichele, 2009). Participants did not have to be lonely to take part in the study. The stigma associated with loneliness may prevent individuals from coming forward. Alternatively, some individuals may talk openly about someone they have known who has been lonely, rather than admitting that they have been, or are lonely (Victor et al., 2005). As a result of the impact of potential stigma, the researcher wanted to open the research up to narratives that included broader experiences of loneliness, not just first-hand experiences.
The research project is situated in Canterbury on the South Island of New Zealand. Canterbury is a beautiful location composed of the rural plains and surrounding mountains and is also home to a large city, Christchurch. As a mark of respect the researcher would like to make reference to the devastating Canterbury earthquakes which took place in 2010 and 2011. The last of the 40 interviews were completed one week before the first of the earthquakes. Fortuitously the first of the earthquakes in September 2010, though the largest, resulted in no loss of life but caused considerable damage to buildings and land. Tragically the February earthquake in 2011 claimed the lives of 185 people and has changed Canterbury forever. Anyone living in Canterbury at the time of these events will have their own story. The researcher is mindful of how precious the stories contained in this thesis are and is extremely grateful to those people who so generously offered their time and shared their stories. Kia Kaha Christchurch for with each new day comes the opportunity to write a new story.

THESIS OUTLINE

The remainder of chapter one will be given over to the motivation behind this thesis. This includes the professional and personal background of the researcher, and how this has influenced the choice of research topic and research methods. Chapter two presents a review of national and international literature on loneliness and ageing. The aim of this chapter is to present a comprehensive, though by no means exhaustive, overview of loneliness and ageing detailing the strengths and weaknesses of existing research studies and highlighting areas for further research. The review will act as a platform, from which to present the case for exploring older widows and widowers’ narratives on loneliness, and acknowledge the potential contributions that this form of research could make to the field of gerontology. Chapter three describes the developmental process, leading up to the design of an appropriate research methodology to meet the demands of the research topic of loneliness. A detailed case will be made for the choice of narrative
analysis. The decision trail is detailed and explicit to ensure rigour and trustworthiness.

Chapters four, five and six cover the findings of the thesis. Although separate, each of the chapters form part of a collective story of loneliness as told by the participants. Chapter four includes a brief summary of the participants’ demographic characteristics in particular age, gender, ethnicity, time bereaved, locality and driving license. The purpose of this is to provide some background information about the widows and widowers whose narratives contributed to the collective story. This is followed by an explanation of the apperception of loneliness through context based life events, which for the purpose of structure represents the onset of loneliness and the beginning of the story. Chapter five explains loneliness and the renegotiation of self-identity (through individual ageing, widowhood and societal expectations). This is a progression of the collective story of loneliness, and relays how individuals made sense of the experience in relation to their own circumstances and the society in which they live. Finally chapter six describes the spectrum of adaptive/maladaptive coping strategies individuals employed, to address loneliness or keep it at bay. Chapter six could be considered the climax of the story, however, the experience of loneliness is a continuum of integration and adjustment. Chapter seven is the discussion section of the thesis. This chapter explores the collective story of loneliness from the perspective of older widows and widowers. The central argument of the thesis is presented along with the limitations identified within this study. Chapter eight is the conclusion of the thesis. This chapter will, briefly, discuss how well the study design met the study’s aims. The key findings and the limitations of the study will be summarized and the implications of the findings addressed. Finally, areas of interest for future research and recommendations developed from the study will be covered.
PERSONAL AND PROFESSIONAL BACKGROUND

It is quite easy to become engrossed in the research topic of loneliness and dismiss as insignificant the personal and professional motivations that lead to its inception. In retrospect it becomes apparent that each step of the process of completing a PhD thesis is not only a quest for new information about the research topic of choice, it is also a journey of self-discovery from the perspective of an emerging researcher. From its beginnings as a persistent thought about loneliness and old age to the typing of the last full stop of the thesis, the changes to my own research skill set have been quite profound.

I embarked upon this journey as an experienced nurse but a relatively novice researcher. I had 13 years of clinical practice under my belt, my specialty being mental health care of older people. During the final year of my nurse training, I made the conscious decision that on graduating I would specialize in older person’s health, specifically psychiatry. Sadly this was to the alarm of some of my nurse tutors who advised me, albeit diplomatically, that I could be throwing away my career opportunities by settling on such an area of care. Needless to say I pressed on with my intention and spent the next 13 years of my career working in a variety of mental health settings with people aged 65 and over and their families. I am to this day filled with respect for the tutors who taught me, and understand their reasoning for attempting to guide me away from Gerontological nursing. Historically this area of care has been given negative exposure, with an emphasis placed on dependency and ageism (Townsend, 2006). I am pleased to say that I have never once regretted my choice to work with older people and have encountered many incredible characters throughout my nursing years.

On consideration, my enthusiasm for gerontology can hardly be called altruistic as I find my interest in this area of nursing is piqued by the stories that older people tell about their lives and their experiences. These stories bring life and
animation to the storytellers. Eyes and minds that may have long since lost the ability to focus on the present can, more often than not, recall with clarity stories from bygone days. Fear, grief, happiness, excitement, mischief, the full spectrum of human emotion is expressed within the stories. A key skill of mental health nursing is to encourage patients and their families to openly and comfortably relay information about the particular health concern. As the health concern in question is mental health there can be a degree of embarrassment or stigma surrounding any discussion, both on the part of the person and their families who seek to protect their loved one from embarrassment. The ability of the nurse to connect with a patient on a person to person level will influence the development of trust and rapport and determine how much information is ultimately disclosed (Byrne & Neville, 2010).

During my nursing career I have worked in a variety of settings including acute assessment wards, respite wards, day hospitals and community teams. Although each setting is different and each patient is unique, a key skill I developed during my time in each of these areas was the ability to encourage patients to tell me stories from their lives. There was no academic paper or intensive course that I had to complete to acquire this skill, although this does not mean the skill was easy to learn. During my years of practice I found that a genuine curiosity about other people’s lives, fostered a person centred connection and helped to develop trust and rapport. Casual comments, stemming from the photographs that people had in their homes or brought into hospital with them, were sometimes enough to initiate a story.

My interest in loneliness and old age developed from a different source entirely. In 2003 I moved from England with my family to live and practice nursing in New Zealand. At the time of the move I had not long commenced my Dissertation for a Master of Arts in gerontology. My initial plan was to complete a systematic literature review of spousal carers of people with a diagnosis of
dementia, having spent the last few years of my nursing career working with this patient group and their relatives. Following my move to the North Island of New Zealand I started work, as a psychiatric district nurse, in a small multi-disciplinary community team that specialized in mental health for older people. The geographical area was a popular retirement destination. My nursing role included acute assessment of mental illness and providing maintenance nursing care via community visits.

Whilst working in this role, four patients in particular caught my attention. Although I was not directly involved in their care, they had been referred to the service with severe generalized anxiety symptoms but were not responding to conventional treatments. Each clinical case open to the team was brought to a daily clinical meeting, by the respective health professional, for discussion with the rest of the multi-disciplinary team. From the clinical presentations it was apparent that the patients had certain characteristics that were similar: they were successful high achievers who had remained in employment well after the age of 65, the standard age of retirement. They were married and had been for a considerable time. They had grown up children and grandchildren and to any unknowing observer their lifestyles appeared enviable. Following full time retirement they appear to have applied the same business mind to organizing their lifestyle in preparation for what they perceived as old age. Interestingly, this preparation appeared to involve curtailing activities they saw as unnecessary demands of time, for example, downsizing houses in case of ill health so that maintenance is minimal, purchasing new homes that were near to public transport routes should neither spouse be able to drive in the future. Having completed their preparation for old age severe anxiety appeared to set in, which proved difficult to treat despite being referred to a specialist mental health service.

In each of the cases that presented the patients were quite incapacitated and unable to perform even basic tasks without severe anxiety. Each of the patients
required high resource input from the mental health team and presented as treatment resistant. The cause of the patients’ severe anxiety and subsequent depression to this day remain a source of mystery. During and following the clinical discussions that took place I started to develop an interest in the concept of loneliness and how this may impact upon mental health. I explored Weiss’s (1975) theory of social and emotional loneliness and how an individual could be socially connected but still feel emotionally lonely. I started to question the existence of intellectual loneliness, which could potentially surface with the loss of a significant role or status and the perceived inability to find new roles that challenge the individual. On further discussion with my university supervisors I requested a change of topic for the systematic review, from the original topic of spousal carers of people with dementia to loneliness and old age. My first venture into research was the systematic review titled; Perceived Loneliness in Older People: Causes, Effects and Interventions.

A rigorous and systematic review of the research literature pertaining to loneliness and old age revealed a diversity of themes. The themes revealed the complexity surrounding loneliness and the potential repercussions of loneliness in old age. Whilst it was heartening to see the growing interest in loneliness and old age, supported by the increase in worldwide research publications, it was also disheartening to learn that misunderstanding and stereotype still surround this age group (Scheel Gavan, 2003; Sousa & Figueiredo, 2002). The loneliness studies reviewed, published between the years of 2000 and 2005, called for further research in several key areas namely qualitative research, gender, and cultural sensitivity (Havens, Hall, Sylvestre, & Jivan, 2004; Howse et al., 2004; Ministry of Health, 2002; Savikko et al., 2005; Valadez et al., 2006). The systematic review was completed in 2006.

Following the successful completion of the M.A. in gerontology, I relocated from the North Island to Christchurch on the South Island. I was fortunate enough
to be offered employment with a specialist older person’s mental health team, as a community psychiatric nurse. I found the team to be dynamic and forward thinking. The Consultant Psychiatrists working with the team were particularly supportive of evidence based practice and research. For several years I was quite content to continue with my clinical nursing practice. I enjoyed the interactive nature of the assessment role, particularly the stories I was told by people referred to the service. It was almost two years after I had completed my previous study that I found myself in conversation, with one of the team’s Consultant Psychiatrists who was also a part time lecturer for a University. The conversation started on the topic of depression in old age and gradually moved onto people who were labelled as treatment resistant. I told the story of the four patients I had encountered in the North Island, and my subsequent literature review. I explained that the review had left me with more questions than answers. In retrospect I now consider this conversation my own personal Eureka moment. My colleague asked me if I had ever considered undertaking further research, or contemplated PhD study.

The conversation that took place between my colleague and I in 2008 was the beginning of a journey that has taken me six years to complete. Throughout that journey I have seen preliminary thoughts develop into a rigorous research proposal. I have searched for, located, read and cogitated on the work of other researchers. There have been many detailed debates with my supervisors in the quest to achieve the most appropriate research design to accommodate the topic and to elicit true meaning from the perspective of older widow and widowers. I have entered into discussions with, and received approval from, the Upper South A Regional Ethics Committee so that the values and beliefs of prospective participants are respected and that no harm is caused. I have liaised with Māori representatives, both in the academic setting and on a Marae, to ensure that the voices of New Zealand’s indigenous people are heard and afforded the deference they deserve which has long been overdue. I have contacted GP practice surgeries
and spoken with staff alerting them to my research and the need for it. Finally I have spent many hours talking with the 40 participants who kindly agreed to share their stories with me.

From each corner I have turned on this journey I have learned and I value the knowledge that has been gifted to me. My research journey has been one of revelation both academically and personally. Along with my research skills, I have learned the arts of persistence and adaptability. The Canterbury earthquakes were and still are a daily presence in my life and the lives of people who live here. This thesis has evolved during a time of destruction and recovery. It was formulated in cricket clubs and hospital accommodation, when the campus buildings were uninhabitable and the University strived to support students. It has moved house with me and my family whilst our home was repaired. The key thing that I have taken from this process is that an enthusiasm for knowledge can maintain you throughout the darkest days.

CONCLUSION

The aims of this research were to investigate the research question which consisted of three parts.

1. How do older widows/widowers describe experiences of loneliness?
2. How does the experience of loneliness change over time with age and lifestyle for older widows/widowers?
3. What strategies are used by older widows/widowers to manage the negative features of loneliness? What role do health services play?

The research question explored i) individuals subjective experience of loneliness, ii) the impact of ageing and lifestyle upon loneliness and iii) what informal and formal coping mechanisms are used by individuals to manage loneliness. For the purpose of this study the term subjective referred to the personal understanding or interpretation of the shared experience of loneliness. A narrative
methodology allowed the participants who are widows/widowers to relay stories of loneliness and what it meant to them. The collective story of loneliness followed a trajectory that began with an event or a change in lifestyle which was ascribed meaning by the individual. The event/change precipitated an emotional response, specifically loneliness. For the purpose of this research study participants gave meaning to loneliness through the life event of widowhood. Participants explained through their stories the process of renegotiating their self-identity following bereavement. Loneliness was influenced further by the personal experience of physiological change, namely ageing, and the impact of societal expectations. The final stage of the collective story revealed a continuum of integration and adjustment to loneliness through adaptive and maladaptive coping responses, both informal and formal. Cultural influences shaped personal coping strategies and the perception of formal support.

The central argument of this research relates to the significance of the subjective nature of loneliness and the importance of interpersonal communication in identifying and addressing loneliness. A key conclusion from this work is that the contextual story behind loneliness, rather than the symptoms a person displayed, was pivotal to successful intervention. The management of loneliness was a continuum of adaptation and adjustment, which began with seeing the individual and listening to their story.
CHAPTER TWO LITERATURE REVIEW

INTRODUCTION

Prolonged life expectancy and decreased birth rates cause the average age of a country’s inhabitants to increase (Robotham, 2011). The phenomenon of ageing populations has generated a growing global response (Chalise et al., 2007; Moyle et al., 2011; Schnittker, 2007; World Health Organization, 2011). The response is diverse and is steered by many professions, including medical and social (Theeke, Turner Goins, Moore, & Campbell, 2012; Tomaka, Thompson, & Palacios 2006; Townsend, 2006). Matters such as quality of life and health are primary topics of investigation (Cattan, Kime, & Bagnall, 2011; Hellström, Persson, Hallberg, 2004). The responses to the costs associated with aged person’s health are sometimes reactionary and exacerbate panic, whilst perpetuating a stereotypical image of need and dependence (Bhatia, Swami, Thakur, & Bhatia, 2007; Drennan, Treacy, Butler, Byrne, Fealy, Frazer, & Irving, 2008; Hunter, 2012; Savikko, 2008; Yang & Victor, 2008). On the other hand, there are researchers who approach ageing with an air of activism and strategic planning as to how the needs of a particular age group can be best met (Chow, Au, & Chiu, 2008; Ip et al., 2007).

The issues associated with an ageing population call for greater understanding so that the health requirements and quality of life of this population group can be met. Loneliness in old age has gained increased attention in Gerontological research (Shiovitz-Ezra & Leitsch, 2010). Completing a comprehensive overview of the literature was a fundamental step in the research process as it allowed the researcher to appreciate loneliness as a research topic and identify areas in need of development. This helped refine the research aim and guide the choice of methodology.
SEARCH STRATEGY

The intention was to locate original research studies and articles pertaining to the research statement “Perceived loneliness in older people: causes, effects, intervention”. To adhere to rigor and keep the decision trail explicit certain inclusion/exclusion criteria were imposed. The search criteria also regulated the number of studies which allowed for a comprehensive yet succinct literature review. The author developed the criteria and a supervisor was consulted to validate reasoning behind the need for such criteria and the assumed impact upon the study. The search strategy was guided by several sources (Cattan, White, Bond, & Learmouth, 2005; Hatcher, Oakley-Browne, & Butler, 2005; Punch, 2000).

The search was two-fold and began with a general inspection of the literature, with the intention of becoming more specific as the search progressed. This method follows the recommendations of good practice described by Punch (2000) and ensured that the research aim was clarified as the search moved from general to specific. The primary search began with the following inclusion criteria:

- Articles had to be in English.
- Articles made reference to loneliness in text.
- Articles published/researched in last 10 years.
- Articles related to older people (mean age > 65 years).

The task of identifying relevant literature was made more achievable by defining the criterion of English only articles. It was also decided that English language articles would be useful to readers should the review be submitted for publication. It was unknown, prior to the search, how many articles would be located concerning the concept of loneliness.

A modification was made to the age criterion. Following consultation with a supervisor a decision was taken to change the definition of the term older. The age of 65 was chosen initially as a cutoff point, as it is a recognized age of retirement in
Western society and is associated with the potential loss of role and increased loneliness (Atchley, 2000). Retirement age also relates to disengagement theory, which predicts withdrawal by society and withdrawal from society by the ageing person (Cumming, 2000). The initial reading of articles revealed that numerous studies gave a mean age for participants as opposed to a specific age. Rather than disregard the valuable data for the 65 plus population it was agreed that the review would incorporate studies whose participants had a mean age of 60 plus.

The years of publication were selected to incorporate up to date research. As this is a PhD study a 10 year publication span was settled upon to demonstrate the trajectory of loneliness as a research topic in gerontology, although some seminal works were included.

The following search channels were used to identify and locate studies/articles.

- PsycINFO search Jan 2004 – Jan 2014, English language. Keywords: Loneliness, old age, isolation, depression, elderly.
- CINAHL search Jan 2004 – Jan 2014, English language. Keywords: Loneliness, old age, isolation, depression, elderly.
- Medline search Jan 2004 – Jan 2014, English language. Keywords: Loneliness, old age, isolation, depression, elderly.
- Cochrane search Jan 2004 – Jan 2014, English language. Keywords: Loneliness, old age, isolation, depression, elderly.
- British Nursing Index and Archive search Jan 2004 – Jan 2014, English language. Keywords: Loneliness, old age, isolation, depression, elderly.

Once potential material was identified the full texts were obtained and hand searches were undertaken of bibliographies and specific journals to elicit additional data. This concludes the first stage of the literature search.
**Stage Two**

A preliminary search of the literature using the specified criteria revealed over 200 books and research articles published across a wide range of journals. Further evaluation of relevance and quality resulted in some of the material being rejected. For the purpose of this study 193 articles, published between 2004 and 2014, were reviewed. Qualitative and quantitative research studies, mixed methodology studies, literature reviews and books were evaluated.

**Themes identified in the literature**

During the last decade loneliness and old age has emerged as a discrete but definite presence in the field of research. Over the last 50 years there has been a steady increase in Gerontological publications that feature loneliness in the title or abstract. This is a positive development as it publicizes the concerns associated with old age and loneliness (Savikko, 2008). The purpose of this section is to evaluate publications from the last decade and to organize them in a way that gives a comprehensive overview. The evaluation process generated six key themes. For the purpose of clarity and rigor the themes were discussed and verified at supervision. Data obtained from the following questions helped the developmental process.

- What is the title of the study?
- What is the main subject?
- What is the principal argument?
- What was the sample size?
- What methodology was used and what are the limitations?
- How relevant is it to the research topic?

The six major themes are listed below;

- Definitions, types of loneliness
- Theories of loneliness
Prevalence
Culture
Environment
Health

These themes are not mutually exclusive and were developed from the literature review data. It is not the intention of the author to present a biased view of loneliness in old age but to present an objective overview of the literature. An acknowledged limitation of the study is that some studies may have been omitted unintentionally. As a novice researcher, however, it is the belief of the author that a comprehensive search was undertaken.

DEFINITIONS - TYPES OF LONELINESS

Despite increased interest in loneliness and old age, researchers do not appear any closer to reaching a consensus about a universal definition (Beal, 2006; Bekhet et al., 2008; Grenade & Boldy 2008; Moyle et al., 2011; Palkeinen, 2005; Perlman, 2004; Savikko, 2008). The debate about loneliness being a one-dimensional phenomenon versus a multi-dimensional phenomenon persists (Steed et al., 2007; Yang & Victor, 2008). Researchers argue the merit of measuring a single item such as an individual’s opinion of loneliness versus measuring multiple items such as opinions and contextual characteristics (De Jong Gierveld et al., 2006). Agreement remains elusive on whether loneliness is a negative experience that causes harm, or a positive experience that promotes change and represents independence (De Jong Gierveld et al., 2006; Hawkley & Cacioppo, 2010; Tiikkainen et al., 2008). The process of establishing the meaning and the measurement of loneliness is fraught with disagreement (Grenade & Boldy, 2008; Victor et al., 2005). Some researchers advocate subjectivity and a research process that focuses upon individual meaning, whilst other researchers opt for objectivity and replication through large scale studies with substantial sample numbers (Yang & Victor, 2008).
Most of the reviewed literature refers to a core group of loneliness definitions (Beal, 2006; De Jong Gierveld et al., 2006; Drennan et al., 2008; Perlman & Peplau, 1981; Pettigrew & Roberts, 2008; Theeke et al., 2012; Tiikkainen et al., 2008; Weiss, 1975; Yang & Victor, 2008). The overarching message is one of negativity and leads to the question does the pessimism surrounding loneliness literature perpetuate stigma? De Jong Gierveld et al. (2006, p.485) define loneliness as “a discrepancy between the desired and the achieved network of relationships as a negative experience”. Perlman & Peplau (1981, p.31) define loneliness as “the unpleasant experience that occurs when a person’s network of social relations is deficient in some important way either quantitatively or qualitatively”. Both definitions describe loneliness as a disheartening occurrence that is based upon needs that are seemingly unfulfilled. Other definitions use terms such as inadequate, estrangement, painful, misunderstanding, abandonment, forlornness (Beal, 2006; Dong, Simon, Gorbien, Percak, & Golden, 2007; Tiikkainen et al., 2008; Wang, Zhang, Wang, Shen, Ge, & Hang, 2011). The terms described are mainly derived from quantitative research that utilized structured survey questionnaires. Researchers may inadvertently influence perception or understanding of loneliness through the applied terminology within a structured survey or questionnaire format (Barg et al; 2006). A questionnaire’s terminology may project the researcher’s values and endorse an exaggerated negative image (Karnick, 2005). For example the UCLA loneliness scale version 3 includes the questions ‘How often do you feel you lack companionship’ and ‘How often do you feel there is no one you can turn to’ (Russell, 1996, p.23) Such phrasing could be interpreted as an inadequacy on the part of the individual completing the survey. Furthermore, there is no reference to loneliness in the 20 item UCLA scale. It has been argued that some researchers have avoided mentioning the word loneliness concerned that the stigma attached to the term may prevent participants from admitting to the condition (De Jong Gierveld et al., 2006). Both extremes may impact upon the
way a participant reports or describes their subjective opinion of loneliness (Heinrich & Gullone, 2006).

Theories supporting the multidimensionality of loneliness have been in circulation since the sixties and seventies (Townsend, 2006; Weiss, 1975). Much of the research makes reference to the importance of recognizing types of loneliness (Ekwall, Sivberg, & Hallberg, 2005; Tiikkainen et al., 2008). A majority of research focuses upon the objective state of being alone or social isolation rather than the subjective experience of loneliness. Misunderstanding can arise when researchers use terminology interchangeably as although these concepts can at times intersect, they remain fundamentally different (Cattan et al., 2011; Routasalo, Tilvis, Kautiainen & Pitkala, 2009; Savikko et al., 2005; Savikko, 2008).

Weiss (1975) is the most frequently cited theorist with regard to types of loneliness (Adams, Sanders & Auth, 2004; Beal, 2006; De Jong Gierveld, Van Groenou, Hoogendoorn, & Smit, 2009; De Jong Gierveld et al., 2006; Drennan et al., 2008; Dykstra, 2009; ElSadr, Noureddine, & Kelley, 2009; Hauge & Kirkevold, 2012; Havens et al., 2004; Heinrich & Gullone, 2006; Heylen, 2010; Jylha, 2004; Karnick, 2005; Krause-Parello, 2008; Leung, De Jong Gierveld, & Lam, 2008; Luanaigh & Lawlor, 2008; Nilsson, Lindström, & Nåden, 2006; Palkeinen, 2005; Perlman, 2004; Pettigrew & Roberts, 2008; Prieto-Flores, Forjaz, Fernandez-Mayoralas, Rojo-Perez, & Martinez-Martin, 2011; Rius-Ottenheim et al., 2012; Rosedale, 2007; Savikko, 2008; Shiovitz-Ezra & Leitsch, 2010; Van Der Geest, 2004; Van Tilburg, Havens, & De Jong Gierveld, 2004; Wenger & Burholt, 2004; Victor & Yang, 2012; Yang & Victor, 2011). Weiss’s seminal work highlighted the distinction between social relationships and emotional relationships and the impact these relationships can have when there is a discrepancy between want and availability. According to Weiss (1975) emotional relationships involve a greater degree of intimacy and attachment such as an individual may have with a spouse, partner or confidante. Social relationships revolve around a broader network which may include adult
children, friends, acquaintances, and colleagues to name but a few. His groundbreaking work offered insight into loneliness and explained why, for example, widows who had a large and busy social network or married couples whose social network had diminished still felt lonely.

The findings from a hermeneutic study that explored the way 12 older Norwegians described loneliness depicts two types of loneliness: manageable and agonizing (Hauge & Kirkevold, 2012). Manageable loneliness refers to an intermittent state that is indistinct whilst agonizing loneliness is static and the associated feelings more damaging. Despite the study’s limitations, which include a small sample and a specific culture, the findings hold merit as the researchers allowed participants to describe loneliness in their own words. The debate about quantitative versus qualitative methods and which is the most appropriate for researching loneliness is ongoing as both approaches have their advantages and disadvantages (Palkeinen, 2005).

Over the last 10 years researchers have started to question what was once thought to be a symbiotic relationship between loneliness, aloneness and social isolation (Dykstra, 2009; Graneheim & Lundman, 2010; Wenger & Burholt, 2004; Yang & Victor, 2011). Loneliness has been called a feeling, a state of mind that is filtered through an individual’s perception (De Jong Gierveld et al., 2006). Social isolation is easier to quantify as, it is generally measured by the number of contacts an individual has (Dykstra, 2009). Isolation is now viewed as a lifestyle choice for some individuals, not a quintessential sign of loneliness as previously thought (McCarthy & Thomas, 2004). The subjective nature of loneliness and the objective states of being alone or being socially isolated are fundamentally different, although it is acknowledged that prolonged periods of uncontrolled isolation or aloneness can result in loneliness (Fokkema, De Jong Gierveld, & Dykstra, 2012; Havens et al., 2004; Heikkinen & Kauppinen, 2011). The relationship between loneliness, aloneness and social isolation is complex (Perlman, 2004).
Summary

A collective definition of loneliness and a unified approach to measurement remains elusive. Researchers continue to debate the merit of utilizing a quantitative research method versus that of a qualitative research technique. The failure to reach an agreement and the continued use of two significantly different methods limits the comparison between research outcomes.

THEORIES OF LONELINESS

There is a trend in the majority of loneliness research to refer to at least one theoretical framework to provide context and clarify findings. The most frequently cited theories include attachment, developmental and cognitive.

Weiss (1975) is cited by many researchers to explain the bi-dimensionality of loneliness (Beal, 2006; De Jong Gierveld et al., 2006; Drennan et al., 2008). The notion of social and emotional loneliness is a concept that fits within attachment theory and relational theory framework and highlights the impact that a particular type of attachment or relationship can have upon feelings of loneliness (Krause-Parello, 2008; Li, Liang, Toler, & Gu, 2005). Bowlby’s (1969) attachment theory proposes that all human beings require intimacy and security which is usually acquired through parental figures in early childhood and continues throughout adult life through other forms of social bonding. Disruption to this process can result in painful experiences such as loneliness (Heinrich & Gullone, 2006; Li et al., 2005; Rosedale, 2007).

Other psychological approaches include developmental theorists such as Erikson (1950), who suggests that individuals can progress through eight stages of development during a lifetime. Each stage needs to be negotiated successfully for the individual to establish and maintain meaningful relationships (Erikson, 1950). Researchers who adopt this type of theory view loneliness as a symptom of social conflict due to loss or limited availability (Hawkley & Cacioppo, 2010; Heinrich &
Resolution is required to alleviate feelings of loneliness.

Seminal cognitive theorists include Peplau and Perlman (1982) whose work has alerted researchers to the subjective nature of loneliness and the effect that thought processes can have upon the experience. From the perspective of understanding, the cognitive theory of loneliness allows researchers to grasp why two individuals of seemingly similar situations experience loneliness differently (Rosedale, 2007). Researchers who subscribe to the cognitive theory of loneliness invariably consider individual personality traits and cultural differences and how these relate to perception and the experience of loneliness (De Jong Gierveld et al., 2006; Heylen, 2010; Yang & Victor, 2008). An accepted conclusion amongst cognitive theorists is that loneliness is the result of a believed inconsistency between the need and availability of social or emotional ties (Shiovitz-Ezra & Leitsch, 2010). A derivative of cognitive theory is the cognitive discrepancy theory which accentuates the consequence of the perceived shortfall between aspiration and availability in terms of relationships (Rokach, 2012; Russell, Cutrona, McRae, & Gomez, 2012).

The socio-selectivity theory is one of the theories of ageing referred to in the loneliness literature. The theory suggests that greater emphasis is placed on close emotional bonds as people age, rather than social relationships (Carstensen, 1995). Researchers such as Heylen (2010) believe this theory offers an explanation as to why loneliness does not occur for all older people who may have experienced a decrease in social networks. Disengagement theory operates from the same premise and argues that as people age they develop an increased awareness of their own mortality (Cumming, Dean, Newell, & McCaffrey, 1960). This awareness results in a decreased desire for social contact thereby protecting against loneliness. Both theories place an emphasis on individual choices as a reason for reducing networks and social interactions. Adams et al. (2004) refutes this restricted view as
it does not take in to account enforced withdrawal by society, which can potentially result in a complacent attitude towards isolation and loneliness in old age.

**Summary**

Attachment, developmental, cognitive and ageing theories provide a contextual framework from which to interpret the phenomenon of loneliness. Context can give greater clarity to a research aim and facilitate understanding. However, in subscribing to a particular theoretical framework researchers should take care not to eclipse the heterogeneous nature of loneliness with homogeneous conclusions.

**PREVALENCE OF LONELINESS IN OLD AGE**

To date a universal definition of loneliness has not been agreed upon within Gerontological literature. The prevalence of loneliness in old age generates the same divergence of opinion (Heylen, 2010; Perlman, 2004). Conflicting research exists that argues that loneliness is widespread in middle age, an issue that is specific to early adulthood and old age, or a common problem of old age (Luanaigh and Lawlor, 2008; Victor & Yang 2012; Wang et al., 2011; Wilson & Moulton 2010). Savikko (2008) believes the disparity in reported loneliness levels is the result of the differing methods of data collection and the fluctuating nature of the subject. The reason for including prevalence of loneliness in old age as a theme is twofold. Firstly it allows for clarification of the term old age and secondly it highlights the ambiguity of loneliness as a research topic.

The fact that people are living longer can bring with it a host of social, cultural, economic and political repercussions (Robotham, 2011). Increased longevity renders the term ‘third age’ inadequate as a means of describing the post working generation (Gilleard & Higgs 2002; Laslett, 1996). Using a single term to describe an age group whose members can span a range of 40 years (plus) can increase the risk of endorsing homogeneity. Baltes and Smith (2003) maintain that the time at which the third age begins and ends depends upon an individual and whether they
live in a developed or developing country. They put forward an argument for a fourth age which a person from a developed nation can advance to at around the age of 85 (for undeveloped countries the chronological age may be younger). This transition period is calculated from the population of developing countries and focuses upon the age at which approximately half of a birth cohort has died (Baltes & Smith, 2003). These calculations do not include those within the cohort who died before the age of fifty.

The prevalence of loneliness amongst older Western Australians was researched by Steed et al. (2007). 355 participants completed a mailed questionnaire. The motivation behind this study was the limited information about loneliness levels in Australian elders. The findings suggested that prevalence of loneliness amongst older Western Australians was equivalent to some European countries, including Finland and Britain. The fact that 42% of participants were born overseas may have had some impact upon the findings. Interestingly the findings from this study suggest that loneliness levels are low amongst older people and therefore not problematical. Similarly, a Belgian study found that advanced age can be a protective factor as the emphasis is placed upon quality not quantity of relationships, which reduces the risk of social loneliness (Heylen, 2010). Conflictingly, some researchers argue that because it is often unspoken many older adults could be living with loneliness (Adams et al., 2004; Blažun, Saranto, & Rissanen, 2012). The point raised by these researchers highlights a potential flaw within the studies undertaken by Steed et al. (2007) and Heylen (2010). The method of data collection, namely questionnaires, can assume understanding and does not allow for the impact stigma can have upon the reported levels of loneliness. The truly vulnerable members of a society may be overlooked with only the confident completing a questionnaire.

Psychosocial group rehabilitation has been researched as an intervention for relieving loneliness in older people (Savikko, 2008). A mixed method approach was
used which incorporated intervention groups, feedback questionnaire and qualitative analysis of group leader diaries. The mean age of the 103 participants who completed the questionnaire was 80 and 74% of participants were female. The findings suggested that there is a positive relationship between the presence of loneliness and young old age. However in the old, old (those aged 85 plus) this relationship is less significant with those of advanced years less likely to acknowledge loneliness. This implies that it is not age alone that leads to loneliness but the experiences an individual encounters as they age, such as illness or bereavement (Savikko, 2008).

A major criticism of the group rehabilitation study was the participant sample. Vulnerable members of society, namely lonely people, may have been overlooked. Illness, infirmity or personality may have caused potential participants to refuse to take part in a group type project (Savikko, 2008). Theeke (2009) reported that one in five older Americans experience loneliness. Of the 8932 participants 3681 were men and the mean age was 74 years. Reasons for the high prevalence in this age group were given as marital status, living alone, functional level and health. As the study was positively skewed towards the young old it would be interesting to learn the results from an older participant sample. A cross sectional study looking at loneliness and increased hypertension found that a third of the 1880 participants with a mean age of 70 reported to feel marked loneliness (Momtaz, Hamid, Yusoff, Ibrahim, Chai, Yahaya, & Abdullah, 2012). The findings are consistent with Savikko’s study which found a relationship between loneliness and the young old (Savikko, 2008). There are limitations to the study; causality was not considered and results were based upon a single item self-report of loneliness (Momtaz et al., 2012).

Ayalon and Shiovitz-Ezra (2011) offer an alternative explanation for the reduced significance of loneliness in the old, old. They maintain that the prevalence of loneliness in this age group is actually high, but it is not considered significant, and
remains under reported, and has become an accepted part of ageing. Interestingly, a qualitative study of Iranian elders also came to the conclusion that some older people feel loneliness is an integral part of ageing (Heravi-karimooi, Rejeh, Foroughan, & Vaismoradi, 2012). Research suggests that feelings of loneliness increase when people reach old age, particularly when they exceed the age of 85 (Dykstra, 2009; Jylha, 2004). The results from these studies are persuasive as they use a large sample and are longitudinal. Heikkenen and Kauppinen (2011) undertook a longitudinal study which considered depression, anxiety and loneliness in elderly people living in Finland. Two hundred and twenty people were followed up over a 16 year period. Whilst overall, conclusions derived from this study indicate that the prevalence of loneliness is more likely to increase with age, the importance of subjective experience and perception was also highlighted.

Fokkema et al. (2012) considered the relationship between geographical location and the prevalence of loneliness. The study researched cross national differences and the impact on older adult loneliness. Data were taken from the SHARE surveys a project funded by the European commission to review health, ageing and retirement in Europe. According to the study findings, Mediterranean and Central European countries have the highest prevalence of loneliness amongst the older population (Fokkema et al., 2012). Reasons for this were not age per se, but rather the higher numbers of older people in the population, characteristics of the society, and the discrepancy between the individual and the characteristics of the society. Data about migrant/ethnic experiences was not considered in this research study although the authors highlighted it as an area of interest that may contribute to a higher prevalence of loneliness. Population movement around the world has increased over the last few decades coinciding with cheaper, quicker and more accessible modes of transport. It would be interesting to find out the impact of these moves as people age and families and network are geographically separated. A study of Americans aged 65 plus (Theeke, 2009) found a high
prevalence of loneliness (19.3%). A study undertaken by Victor, Burholt and Martin (2012) found that the average prevalence of loneliness amongst older British people has remained stable at 10% of the population group since the mid-1950s. For minority communities within Britain, however, the reports of loneliness can be between 24% and 50% of the minority population. Secondary analysis of data and accuracy of translation may have impacted upon the results of the study.

Summary

Prevalence of loneliness in old age is a matter for debate within Gerontological research. It has been argued that advanced age may serve as a protective factor against loneliness. Alternatively, it has also been reported that loneliness may increase as people grow older (Ip et al., 2007). Differences in data collection methods may account for divergence in opinion along with subjective participant experience, as it would appear that life experiences and not ageing per se impact upon the prevalence of loneliness (Rius-Ottenheim et al., 2012; Smith, 2012). The key issue to consider in relation to statistical information and prevalence of loneliness in old age is that, whilst statistics are useful for identifying that loneliness exists, they are ultimately numerical guidelines that do not reflect the subjective context of loneliness (Wenger & Burholt, 2004; Yang & Victor, 2011).

Loneliness and Culture

A person’s perception can be shaped by their culture. Culture has been defined as “Networks of knowledge consisting of learned routines of thinking, feeling and interacting with other people as well as a corpus of substantive assertions and ideas about aspects of the world” (Hong, 2009, p. 41).

The relationship between ethnicity, cultural perspective and loneliness is documented in the research literature but culture also encompasses migrant experience, gender, sexuality, spirituality, religion, age and socio economic status (Nursing Council New Zealand, 2011). According to an interactionist approach,
loneliness results from a combination of three factors: personal, cultural and situational, and the effect these factors have upon the formation or continuation of social relationships (Weiss, 1975).

Old age and the manner in which it is perceived is shaped by a person’s cultural perspective yet Gerontological literature is limited with regard to the wider interpretation of culture and loneliness. Transferability of research findings also requires greater consideration (Jylha, 2004; Lund & Engelsrud, 2008; Theeke, 2009; Valadez et al., 2006). Prevalence of loneliness in old age has been given greater consideration although a consensus has not been reached. The issue of cultural influence upon loneliness is problematical. The subjective nature of loneliness is made more complex by cultural variations within a single population, making it difficult to draw any definitive conclusions (Chalise et al., 2007; Fagerström, Gustafson, Johansson, Jakobson, & Vartiainen, 2011; Moyle et al., 2011). Older people’s attitudes to loneliness are not simply formed as a result of their age but can be affected by the group or society or place in which they were raised (Aebischer, 2008; Rokach, 2007). The relationship between religion, spirituality and loneliness is an area that requires further research as it has received limited attention, although a link has been reported. The degree to which it protects against loneliness is uncertain (Adams et al., 2004; De Jong Gierveld et al., 2009).

Gender may contribute to the experience of loneliness in old age as the way in which an older man understands and reacts to loneliness is very much dependent upon his cultural upbringing. In the UK report “Working with older men – a review of Age Concern Services”, Ruxton (2006) found that some older men are bound by a restricted view of masculinity that rejects the need for support or assistance and values independence over all matters. Such needs seemingly symbolize weakness. A criticism of the study was that the older men involved in the study were largely articulate, positive and confident which may not be reflective of the truly lonely. Barg, Huss-Ashmore, Wittink, Murray, Bogner, and
Gallo (2006) argued that a person’s cultural upbringing will determine how comfortable they are disclosing personal information, particularly details that could be perceived as stigmatized such as mental illness or loneliness.

Cultural awareness is salient to the development of health and social services. With regard to ethnicity most societies are multicultural; services can no longer afford to remain ignorant of cultural values and migrant experience and how these factors may influence loneliness levels (Howse et al., 2004, Nilsson et al., 2006). The role of the family, particularly adult children, should be researched as expectation and responsibility for parental well-being can fluctuate from culture to culture and vary in terms of impact upon loneliness levels (Minardi & Blanchard, 2004). In Chinese culture the notion of filial piety may cause a conflict between generations in terms of support; older generations may expect a higher level of support than younger generations are able to provide. In Chinese culture it is traditional for older people to live with their children yet recent research suggests intergenerational conflict and tension may be as detrimental to psychological well-being and loneliness as living alone (Dong et al., 2007; Ng et al., 2004).

Ip et al. (2007) believe there is a degree of complacency in some Western cultures with regard to the readiness and availability of certain migrant populations, particularly Chinese, to provide support to older family members. This may explain the paucity in research around ageing and loneliness in Chinese populations in Westernized countries such as Australia (Ip et al., 2007). Research suggests that loneliness in Chinese elders increased in the latter part of the 20th century as prior to that the role of the family was firmly cemented in Chinese culture (Yang & Victor, 2008). The one child policy along with industrialization and capitalism changed the functional role of family within Chinese society as it meant that some adult children were unable to meet expectations. Unmet filial obligation is considered a risk factor for loneliness, particularly amongst Chinese elders (Dong et al., 2007; Li et al., 2005; Wang et al., 2011; Yang & Victor, 2008).
The intergenerational tension caused by changing cultural views towards ageing and familial support was also highlighted in a qualitative study of 35 Ghanaian elders (Van Der Geest, 2004). Although the sample was small and a Dutch loneliness scale was used to ascertain loneliness within an African culture, the findings support the notion that disparity between generations can lead to increased loneliness. Bekhet and Zauszniewski (2012) maintain loneliness may result from a feeling of displaced affiliation particularly if an older individual’s cultural cohort is diminished through bereavement. Worldwide there are gradual cultural changes taking place amongst most societies. At any given time there may be individuals who fall outside of the mainstream cultural view and adhere to an historical or generational outlook, placing them at greater risk of loneliness. Due to chronology these are more likely to be the older element of a population (Rokach, 2012).

The cultural variation in the role of the family and geographical location feature quite prominently in Gerontological research. In Southern European countries traditional family ties are seen as strong and an integral form of support, whereas in Northern European countries the role is not as well defined (Tiikkainen et al., 2008). Interestingly there are greater levels of loneliness in Southern and central European countries (Fokkema et al., 2012). Loneliness becomes problematical for an individual when there is a discrepancy between their cultural view of a family and the supporting role it should play and actual availability (Barg et al., 2006; De Jong Gierveld et al., 2006; Savikko et al., 2005; Savikko, 2008).

Tomaka et al. (2006) carried out a phone survey with 755 participants (mean age 71 years). Twenty three percent of the sample identified their ethnicity as Hispanic. The findings confirmed the importance of the family and extended family as a protective factor against loneliness in old age for Hispanic participants. Interestingly, for the 72% of the participants who identified themselves as white or Anglo, a sense of belonging amongst friends was a more important source of
protection from loneliness than family. Two major flaws of this study relate to data collection. A phone survey by design omits those people with severe hearing deficits who may by nature of their physical condition be prone to isolation and loneliness. The translation from English to Spanish and cultural interpretation in terms of loneliness measurement were also raised as issues. American society is sometimes depicted as a society that promotes the role of the individual and the friendships formed outside of the family unit, as opposed to the collective relationships formed in an extended family unit (Perlman, 2004). This may explain the dissonance between mainstream American attitudes and subcultures that place value upon familial support, and the subsequent feelings of loneliness.

In New Zealand culture many older people utilize their families for practical and emotional support, which can help them maintain an independent lifestyle (Statistics New Zealand, 2004). Whilst families are a traditional means of support, policymakers need to consider whether this form of support is sustainable and the impact this may have upon loneliness in old age should tradition change. Families may have undertaken a responsibility to provide support, however, the demands of industrialized society mean that adults are not always available to support ageing relatives. Issues such as employment obligations highlight that older people may have to look to formal services for support that has previously been a familial responsibility. The generic services such as meals on wheels, day centers and home support require greater cultural sensitivity or the result may be poor user uptake and increased risk of isolation and loneliness (Lund & Engelsrud, 2008). The need for formal support is still viewed by some older people with a sense of stigma. A confession of loneliness may be perceived as a deficit in family obligation (Leung et al., 2008).

Health and social care professionals are in a position to provide education and support for elders and encourage user uptake. Individuals may identify with particular cultural beliefs and practices that are very different from Westernized
society; this may result in a culture clash (Valadez et al., 2006). A qualitative study in the UK interviewed 30 primary health care professionals, and asked about older people’s engagement with health care services (Murray, Banerjee, Byng, Tylee, Bhugra, & Macdonald, 2006). Participants included GP’s, nurses and counsellors. While the study took place in only one borough of London, the area is considered multicultural. Older women who were raised in Caribbean, South Asian and Asian cultures were more likely to present to primary health care professionals with physical health symptoms rather than psychological or psychosocial issues as there is still a cultural stigma attached to mental illness in some non-westernized cultures (Murray et al., 2006).

An individual’s ability to understand instruction could impact upon the efficacy of an intervention. Educational level is an expanding area within loneliness research that requires further investigation. Researchers remain undecided as to whether educational level is a direct or indirect cause of loneliness or whether it can act as a protective factor (Victor et al., 2005; Victor & Yang, 2012). Tiikkainen et al. (2008) and Victor and Yang (2012) found that higher education appears to increase an individual’s sense of worth and belonging and therefore acts as a protective buffer against loneliness whereas, Steed et al. (2007) found no significant relationship between higher education and loneliness.

Yang and Victor (2008) believe that people with lower education are less likely to report loneliness; this may be related to social skills. However, the research was undertaken in China where stigma of admitting to loneliness is still prominent. In an American study based in Western society, Barg et al. (2006) found that people with a lower educational background admitted to loneliness more, when surveyed, than those whose education went beyond high school. Barg et al’s findings were supported in later studies (Koc, 2012; Savikko, 2008; Shiovitz-Ezra & Leitsch, 2010). Ultimately higher education may place individuals in an upper socioeconomic bracket and expose them to other protective factors, such as increased security and
social integration, which may reduce feelings of loneliness (Gilmour, 2012; Hawkley, Hughes, Waite, Masi, Thisted, & Cacioppo, 2008; Savikko et al., 2005). Lower education may limit an individual’s confidence and ability to access or utilize strategies for addressing loneliness (Fagerstrom et al., 2011; Onrust, Cuijpers, Smit, & Bohlmeijer, 2007).

Summary

Whilst loneliness may be found in many cultures, it is not necessarily experienced by all people in all cultures or in the same way (Perlman, 2004; Van Tilburg et al., 2004; Victor et al., 2012). Ultimately individuals should be treated with respect and their cultural beliefs valued and accommodated (Theeke et al., 2012). As it has been suggested that the culture in which a person was raised, rather than their chronological age, has more impact upon loneliness being reported, it is essential that further research is undertaken. Many of the modern societies are made up of a diversity of cultures that include different ages and traditions within both the indigenous and migrant populations (Bekhet & Zauszniewski, 2012; Victor et al., 2012; Yang & Victor, 2011).

LONELINESS AND ENVIRONMENT

Environment can influence understanding and contribute to the issue of loneliness in old age through a diversity of issues. These include living alone, cohabiting, finances, retirement villages, rest home care, urban living, rural living and transport, to name but a few (Blazer, 2008). Loneliness is not necessarily about being alone or living alone (Kawamoto, Yoshida, Oka, & Kodama, 2005; Savikko et al., 2005; Townsend, 1973). According to a report from Statistics New Zealand (2004) older New Zealanders who live alone may receive, on average, more assistance than those who reside with spouses or children. This fact relates to a historical concern raised in the literature: that older people living with children can be lonelier than those living alone (Townsend, 1973). In an industrial age where a
majority of adult children work full or part time, it is not unusual for older people to spend a large part of the day alone.

The question as to whether living alone in old age is a predictor for loneliness delivers different answers. Research suggests that living alone reduces the opportunity for social contact, increasing the risk of isolation and loneliness (Dwyer & Hardill 2011; Havens et al., 2004; Koc, 2012; Savikko et al., 2005; Theeke, 2009). In a study of Indian elders, people who lived alone reported high levels of loneliness. The impact of filial obligation in Indian culture needs to be taken into account as this may have some bearing upon the results (Bhatia et al., 2007). Lo (2004) interviewed a random sample of 4859 elderly people living in Taiwan. Results revealed living alone did increase loneliness but in conjunction with feelings of abandonment related to social support. Other researchers argue that living alone brings with it mixed feelings: solitude and self-governance versus loneliness and isolation (Wiles, Allen, Palmer, Hayman, Keeling, & Kerse, 2009).

 Alternatively Cavallero, Morino-Abbele, and Bertocci (2007) found that living alone for some older Italian people particularly in an urban environment can generate self-development and optimism. However, the impact of participants’ personalities do not seem to have been considered. In some instances a connection to a home or land can promote feelings of freedom and independence as was the case for the rural elders who lived alone in Hinck’s study (Hinck, 2004). Although the study sample was small, the in depth interviews provided rich data that gave an insight into the meaning of old age and rural living. Ultimately both researchers and health professionals need to be cognizant that whilst isolation may be a predictor for loneliness, living alone does not necessarily lead to loneliness for all older people and other forms of living arrangements do not necessarily provide protection against loneliness (Bekhet & Zauszniewski, 2012; Greenfield & Russell, 2011).
An alternative living arrangement for older people that has gained in popularity in recent years is the retirement village. Retirement villages have been defined as “a collection of residences for older adults” (Graham & Tuffin, 2004, p. 184). Much of the attraction appears to be centered upon the instant companionship associated with such environments. It has been suggested that neighborhoods with a higher population of widows/widowers could have a positive effect on well-being in old age (Subramanian, 2008). In an American study of 200,000 people (aged 67 plus), it was found that neighborhood structure could be a potential modifier for the risks associated with widowhood, one of which is loneliness (Subramanian, 2008). Variables such as wealth, educational level and quality of marital relationship were not controlled; however, the importance of neighbors and friends in terms of social support was highlighted and considered worthy of further investigation. Likewise, De Jong Gierveld et al. (2006) noted shared concern and a sense of belonging within a community may help an individual to decrease their feelings of loneliness. The benefits associated with retirement village living may include an increased sense of security. However, an alternative outcome for older people who choose a retirement village lifestyle may be an increased sense of segregation from people and activities outside of the village setting, which may lead to a heightened risk of loneliness (Adams et al., 2004).

The numbers of people entering rest home care are increasing internationally and whilst rest home care offers 24 hour support it can also be a major source of loneliness (Jylha, 2004; Prieto-Flores et al., 2011; Savikko, 2008; Vikström, Bladh, Hammar, Marcusson, Wressle, & Sydsjö, 2011). The expectation and reality of such environments do not always correlate. Literature suggests that loneliness is not about the quantity of contacts an individual receives; although this can impact, it is about the perceived quality of relationships (Adams et al., 2004). While relationships within rest home care may provide regular contacts, the depth of the
relationship may remain superficial and be based upon a sense of need. Fear of dependency and institutionalization increases the sense of perceived loneliness for some older people (Ekwall et al., 2005).

A link between loneliness and lower income in general, or decreased income following the death of a spouse is widely reported (De Jong Gierveld et al., 2009; Dwyer & Hardill, 2011; Fokkema et al., 2012; Gilmour, 2012; Havens et al., 2004; Savikko, 2008; Savikko et al., 2005; Scharf & Bartlam, 2006; Shiovitz-Ezra & Leitsch, 2010; Steeves & Kahn, 2005; Stephens, Alpass, & Towers, 2010; Victor et al., 2005). A reduction in confidence, and perceived financial insecurity, secondary to widowhood, may compel older people to move in with family. As discussed this can be stressful and unsettling and not always an environment conducive to well-being or decreasing loneliness (Heravi-Karimooi et al., 2012; Reid-Keene & Prokos 2008; Wenger & Burholt, 2004). In a study of 355 Australian elders, living in a private residence, level of income was not related to loneliness. However, 65% of the sample were married or in a de facto relationship, and 70% of the sample were of middle or high socioeconomic status (Steed et al., 2007).

Inadequate transport, public or private, can limit access to health and social facilities and place people at greater risk of social isolation, which can increase the risk of loneliness (Davey, 2007; Ruxton, 2006). The impact of driving cessation has been highlighted as a major life event which can reduce networks so severely it can lead to depression, particularly in women (Mezuk & Rebok, 2008). According to Davey (2007) in New Zealand society driving cessation has a greater impact on men both emotionally and practically, as women are more likely to be passengers or to have a better understanding of public transport through having had children.

As the gender gap closes the impact of stopping driving may become a more significant problem for women. In a review of Age Concern services for older men it was found that transport was a major barrier for older men wanting to utilize the services (Ruxton, 2006). Similarly limited availability of transport was cited as a
risk factor for loneliness in old age in an Irish study by Drennan et al. (2008). The issue of older people accessing public transport is not clear cut, even when a service is available and people are functionally able to use it (Dickerson, Molnar, Eby, Adler, Bédard, Berg-Weger . . . Trujillo, 2007). Further research is required to encourage older people to consider public transport as an alternative to driving, which is seen as a mark of independence, particularly in New Zealand society (Davey, 2007). Limited access to transport can impact upon rural living and increase the risk of social isolation (Davey, 2007; Dwyer & Hardill, 2011; Ruxton, 2006).

The increased risk of loneliness for older people living in a rural area is documented internationally. Rural and urban areas are generally distinguished between on the basis of population. A criticism of this process is that it is does not accurately reflect the cultural diversity within these areas (New Zealand Statistics, 2004). Yang and Victor (2008) researched the prevalence and risk factors for loneliness amongst elderly Chinese people. Results indicated that females aged 85 plus in rural areas were much lonelier than those living in urban areas. This may be secondary to urbanization and a decrease in relatives’ ability to meet filial obligation (Shen, Li, & Tanui, 2012; Wang et al., 2011). Drennan et al., (2008) investigated the risk factors for social and emotional loneliness in older Irish people. Rural living was highlighted as one of several factors, although a major limitation of the study was the largely female sample. Comparably, Savikko (2008) found rural living for elderly people in Finland was more likely to result in loneliness than urban living. The isolating effect following the movement of young people to cities for employment was suggested as a possible cause.

Hinck (2004) argues that rural living is a way of life that people adapt to; alternative strategies such as telephone communication and correspondence are developed for managing loneliness rather than relying solely upon face to face social contact. However access to transport is still important. The notion of social
resilience being part of a rural lifestyle is supported by Scharf and Bartlam (2006) who investigated the lived experience of older people in rural communities. Although the sample was small the in depth interviews provided significant insight into country living and highlighted a structured way of life that provided a sense of support through routine. Loneliness presented as a threat via changing populations and the increased anonymity that sometimes arises as a result of a developing district. A striving to be resilient brought with it the risk that participants understated any associated difficulties (Scharf & Bartlam, 2006). This was also raised as a point of concern in a literature review of rural experiences in old age by Winterton and Warburton (2011).

It may be misleading to conclude that rural living equates to increased loneliness, as older people living in underprivileged urban communities also report acute levels of loneliness. Relocation from rural to urban areas and vice versa in late life can prove problematic in terms of social integration (Winterton & Warburton, 2011). Interestingly a perceived sense of community and belonging has more impact upon an older person’s well-being than an actual physical environment (Boneham & Sixsmith, 2006; Lund & Engelsrud, 2008; Murray et al., 2006; Wiles et al., 2009). Sabir, Wethington, Breckman, Meador, Reid, & Pillemer (2009) highlight a need to evaluate the term community especially in research, as community is not only geographically relevant, it can also refer to shared beliefs or experiences that bring people together. A sense of changing community, where belongingness is threatened, can increase feelings of loneliness for older people especially where loss of facilities or services are concerned (Scharf & Bartlam, 2006).

**Summary**

The issue of environment is far reaching and should be foremost in the minds of policymakers. Efficient, affordable public transport with an emphasis on encouraging older people to utilize the service is but one area in need of
development (Dickerson et al., 2007; McCarthy & Thomas, 2004; Mezuk & Rebok, 2008). The efficacy of a majority of interventions, to address loneliness in old age, is to some degree based upon access to transport (Davey, 2007; Scharf & Bartlam, 2006). Likewise, living arrangements and feeling financially secure are important considerations in terms of potential environmental interventions to address loneliness in old age (Havens et al., 2004; Wiles et al., 2009). Older people have the right to make informed choices and where possible should be encouraged to exercise that right, as an individual.

**LONELINESS AND HEALTH**

The theme of loneliness and health can be approached from two directions, namely the impact loneliness can have upon health, and the impact deteriorating health can have upon experiences of loneliness (Beal, 2006; De Jong Gierveld et al., 2006; Drennan et al., 2008; Krause-Parello, 2008; La Grow, Neville, Alpass, & Rodgers, 2012; Ní Mhaoláin, Gallagher, O Connell, Chin, Bruce, Hamilton. . . Lawlor, 2012; Rosedale, 2007; Tilvis, Kähönen-Vääre, Jolkkonen, Valvanne, Pitkala, & Strandberg, 2004; Tomaka et al., 2006; Wenger & Burholt, 2004).

Health issues are more prevalent as people age (Minardi & Blanchard, 2004). A high percentage of older people, however, tolerate ill health as a side effect of old age and will not necessarily approach a health professional with what they deem to be inappropriate symptoms (Howse et al., 2004; Jylha, 2004; Murray et al., 2006; Pettigrew & Roberts, 2008; Savikko, 2008; Victor & Yang, 2012). Loneliness has been linked to incidence of heart disease, hypertension and increased mortality rate in old age (Arve et al., 2009; Ekwall et al., 2005; Hawkley & Cacioppo, 2010; Luo, Hawkley, Waite, & Cacioppo, 2012; Momtaz et al., 2012; Savikko et al., 2005; Stek et al., 2005; Valadez et al., 2006). Decreased mobility may not appear serious but can have serious implications for both leisure and functional activities (Ruxton, 2006; Smith, 2012; Van Der Geest, 2004). Hearing or sight deficits can curtail a person’s ability to communicate and integrate with the outside world although this
does not always lead to loneliness (Alma, Van der Mei, Feitsma, Groothoff, Van Tilburg, & Suurmeijer, 2011; Arve et al., 2009; Fokkema et al., 2012; Savikko, 2008; Savikko et al., 2005; Tiikkainen et al., 2004; Townsend 1973; Verstraten, Brinkmann, Stevens, & Schouten, 2005).

The associated loss of independence as a result of multiple physical health changes or prolonged illness and the need for assistance can highlight a discrepancy between need and availability in a network and lead to loneliness and mental illness (Carling Elofsson & Ohlen, 2004; Kaneko, Motohashi, Sasaki, & Yamaji, 2007; Koc, 2012; Prieto-Flores et al., 2011; Ruxton, 2006; Theeke, 2009). People who have experienced good health previously but have suffered a recent decline demonstrate the greatest increase in loneliness (Dykstra et al., 2005; Savikko et al., 2005). The deteriorating health of a spouse can also lead to loneliness (De Jong Gierveld et al., 2009; Moyle et al., 2011). A positive perception of health and functioning may reduce feelings of loneliness (Gilmour, 2012; Tiikkainen et al., 2008). In the same way negative perceptions of health and functioning can lead to increased loneliness (Fokkema et al., 2012; Heylen, 2010). Such findings reinforce the importance of subjective well-being, healthy ageing and health promotion as protective factors against loneliness (Wilson, Harris, Hollis, & Mohankumar, 2011).

Loneliness is an undesirable state for an individual. With the added complication of depression it can escalate into a costly illness and is therefore an important clinical and public health concern (Harris et al., 2006). Unresolved loneliness in older people has been proven extensively to increase the risks of developing mental illness such as depression, anxiety and in some cases suicidal ideation (Adams et al., 2004; Ayalon & Shiovitz-Ezra 2011; Barg et al., 2006; Bekhet & Zauszniewski, 2012; Bergdahl, Allard, Alex, Lundman, & Gustafson, 2007; Dennis, 2005; Ekwall et al., 2005; Golden et al., 2009; Harris et al., 2006; Ip et al., 2007; Heikkinen & Kauppinen, 2011; Kaneko et al., 2007; Minardi & Blanchard, 2004; Van’t Veer-Tazelaar, Van Marwijk, Jansen, Rijmen, Kostense, Van Oppen. . .
Beekman, 2008; Prieto-Flores et al., 2011; Savikko, 2008; Leung et al., 2008; Theeke et al., 2012; Valadez et al., 2006). The World Health Organization (2004) has classified depression as one of the most common mental illnesses in older people. Treatment of depression and the premature admission to long term care impacts upon a nation’s health resources (Adams et al., 2004; Stek et al., 2005; Valadez et al., 2006). Researchers claim there is a heightened risk of developing Alzheimer’s disease in people who are lonely or socially restricted. As to whether this is a cause or a symptom remains undetermined (Hunter, 2012; Wilson et al., 2007).

A previously neglected area of research, loneliness and mental health in later life is now gaining interest due to the increasing ageing population (Minardi & Blanchard, 2004). The relationship between lifelong personality types and loneliness is thought to be significant (De Jong Gierveld et al., 2006; Ni Mhaolain et al., 2012). The actual number of older people experiencing loneliness remains unclear. The potential risks of loneliness are not always recognized, due to limited knowledge or embarrassment, which could lead to the acceptance of unpleasant feelings as a routine stage of old age (Howse et al., 2004). Increased alcohol is sometimes used as a means of coping with loneliness (Khan, Wilkinson, & Keeling, 2006). People who suffer from loneliness may not be clinically depressed and therefore will not necessarily respond to treatment aimed at depressive illness (Barg et al., 2006). Confusion remains as to how many older people are misdiagnosed with depression and then labelled treatment resistant when the loneliness remains due to inappropriate intervention (Adams et al., 2004; Minardi & Blanchard, 2004). By the same token, not all depressed people experience loneliness (Hawkley & Cacioppo, 2010; Heikkinen & Kauppinen, 2011). The costs and drain upon health resources due to this misdiagnosis require further investigation.

Historically both health and social assessments focus upon a restricted view of functioning and do not always include loneliness as part of their remit (Lester,
Mead, Graham, Gask, & Reilly, 2012). Support packages are limited predominantly to physical assistance and are generally reactive in nature, responding to need (McCarthy & Thomas, 2004). Attention to emotional and social support provides a protective factor against mental deterioration in older people (Hellstrom et al., 2004; Travis, Lyness, Shields, King, & Cox, 2004; Wenger & Burholt, 2004). Identifying tell-tale signs such as excessive talking despite listener disinterest may encourage people to admit to feelings of loneliness (Arbuckle, Pushkar, Bourgeois, & Bonneville, 2004). Older people are more likely to engage in emotional and social support services if referred by a formal agency such as a GP or nurse. Despite these research findings most formal care packages focus upon physical assistance and neglect psychosocial need (Manthorpe, Biggs, McCreadie, Tinker, Hills, O’Keefe, . . . Erens, 2007; Ruxton, 2006; Van Ravesteijn, Lucassen, & Akker, 2008). Input can quite often be focused on physical tasks and is time limited (Hellstrom et al., 2004).

Research has shown that older people receiving formal help actually report a lower quality of life, citing loneliness and depression as contributory factors (Hellstrom et al., 2004; Minardi & Blanchard, 2004). The number of contacts individuals received may not alter the degree of perceived loneliness (Weiss, 1975). The inconsistency and unreliability of support packages may also prove damaging to a person’s sense of autonomy by reinforcing a sense of dependency upon others. In contrast to most findings Vikstrom et al., (2011) found the Swedish participants with poor health in their study felt more contented and less lonely than those participants with better health. The study was cross sectional, so causality was undetermined. However, the researchers felt it was potentially the care and support the participants with ill health received that increased a sense of gratitude (Vikstrom et al., 2011).

**Summary**

Healthcare costs and a rising population have sparked an interest in the link between lifestyle and health status in old age. Promotion of self-responsibility for
life style and health in old age is gaining popularity. Whilst this change is welcome it also runs the risk of creating a sense of blame for ill health. Such a punitive approach will do little to combat the sense of loneliness in those older people who may encounter age related physical deterioration, which is beyond their control. Policy makers need to acknowledge the significance of loneliness in health care planning for older people; the relationship between health education and loneliness should not be dismissed (Beal, 2006; Hauge & Kirkevold, 2012; Hawkley & Cacioppo, 2010; Hellstrom et al., 2004; Heravi-Karimooi et al., 2012; Momtaz et al., 2012; Murray et al., 2006; Rosedale, 2007; Ruxton, 2006; Savikko, 2008; Wilson et al., 2011). Loneliness may not be a medical diagnosis; however, it has an almost parasitical nature whereby it is quite often present with other physical and mental illness (Hawkley & Cacioppo, 2010; Luanaigh & Lawlor, 2008; Nilsson et al., 2006). A proactive approach to loneliness may moderate the effects of deteriorating health (Havens et al., 2004). Further research is required to gain greater understanding of the relationship between subjective feelings of health and loneliness (Barg et al., 2006; Blazer, 2008; Luanaigh & Lawlor, 2008; Steed et al., 2007; Tiikkainen et al., 2008; Victor & Yang, 2012).

CONCLUSION

The review of the literature has been both encouraging and disheartening. It is widely accepted that the needs of older populations need addressing; yet, misunderstanding and stereotype still surround this age group. There are several limitations concerning this review. As only English language studies were considered due to time, and word constraints, the identified themes may omit themes identified in studies published in different languages. These themes are guidelines and will not be reflective of all ageing experiences or experiences of loneliness. Further research projects may benefit from a larger number of research assistants to validate themes and increase truth-value.
The diversity of themes relating to loneliness, confirm the complexity and prevalence of this phenomenon in old age. The limited amount of qualitative research studies emphasizes a significant gap in subjective experiential meaning from the perspective of old age. The opinions and narratives of older people need to be given greater attention if successful interventions are to be developed (Heylen, 2010). Greater understanding is required of male and female experiences of loneliness. An ageing population brings with it an increase in men and women, yet a majority of research focuses upon the needs of older women (Ruxton, 2006). The idea that women are more vulnerable to loneliness than men is a notion that requires further investigation, as it is unclear whether longevity and increased exposure to life events, combined with an ability to self-disclose, may be distorting results (Golden et al., 2009; Luanaigh & Lawlor 2008). Further research is required into loneliness and the gender specific social and emotional needs of older men and women, particularly in relation to health and social service development (Arve et al., 2009; Ferguson, 2011; Krause-Parello, 2008). Homogeneity is often assumed in older people (Howse et al., 2004). Failure to respect individual differences could lead to misunderstanding, misdiagnosis and misuse of health and social resources (Savikko et al., 2005; Valadez et al., 2006). For a service to meet the demand efficiently, policy makers need to consider the wider implication of unmet needs and loneliness in the older population. While there is a plethora of literature concerning loneliness in old age, there is still much to be learnt.
CHAPTER THREE METHODOLOGY

OVERVIEW

The primary aim of this chapter is to describe the process of selection for the methodology underpinning the research into the experience of loneliness amongst a sample of older widowed people from within the Canterbury area. For the purpose of this chapter and thesis, the term methodology refers to the “aims, concepts, strategies and methods used to gain knowledge” (Appleton & King, 1997, p.4). The term method will be applied essentially to processes of data collection, and data analysis. The decision trail that led to the choice of research topic, and subsequent methodology, will be made explicit so that readers can understand fully the reasons for adopting such processes.

RESEARCH TOPIC, QUESTION AND GOALS

The issue of loneliness as a topic related to old age, and wellbeing, is acknowledged (Adams et al., 2004). The emergence of the six themes within the literature review is significant, as they demonstrate the far reaching nature of loneliness and the relative ease by which an individual can experience it. The diversity of themes relating to loneliness highlights the complexity and impact of this phenomenon in old age.

The degree to which loneliness is understood, however, is questionable (Adams et al., 2004). Heinrich and Gullone (2006) emphasized the individuality of loneliness; a lonely person’s perception is very much their reality. Such a degree of individuality leads to difficulty, especially when trying to impose standardisation. What is an acceptable level of loneliness in old age and at what point does a person need formal intervention? The stigma surrounding loneliness adds a further problematical dimension, as some people are reluctant to admit to loneliness or fail
to recognise the potential risks associated with unresolved loneliness. Reasons for this stigma are largely the product of culture and society (Howse et al., 2004; Plummer, 2001).

Research into the effective management of loneliness is limited, and highlights a significant gap in the professional and academic knowledge bases. This in turn creates an opportunity for further research that explores possible prevention and management of loneliness in old age. Before the stages of prevention and management are developed, however, there is a need to consider the experience and meaning of loneliness. Individuality is a key component in loneliness research (Heinrich & Gullone, 2006). If the true meaning of loneliness cannot be identified how can the experience of loneliness ever be managed?

The main aim of this research was to understand individuals’ subjective experience of loneliness. It was inspired by Randall et al., (2006), who undertook life story interviews with people (aged 80 plus) as part of a well-being study. The research question consisted of three parts. Each part related to older widow/widowers’ accounts of loneliness and what it meant to them.

1. How do older widows/widowers describe experiences of loneliness?

2. How does the experience of loneliness change over time with age and lifestyle for older widows/widowers?

3. What strategies are used by older widows/widowers to manage the negative features of loneliness? What role could health services play?

A desired outcome is to disseminate any pertinent findings, to improve service planning and health and social support for older people.

Encouraging an individual to disclose sensitive information requires a specific approach. Consideration needs to be given to paradigm, sampling strategy, data collection, data analysis and ethics. As existing research pertaining to loneliness
and older people is predominantly quantitative, this chapter will consider the merits and deficits of both quantitative and qualitative research paradigms and their suitability for the proposed research topic. The chapter will also examine a synthesis of quantitative and qualitative research, as a means of approaching this topic. This chapter will be guided by Grassie (2008) who maintains that the phenomena should determine the choice of methodology “Good science then is altruistic fidelity to the phenomena. It does not impose itself on reality, but makes a space for many different realities of nature to tell their own authentic stories.” (Grassie, 2008, p.162)

Research Paradigm

The primary objective in selecting the research paradigm is to identify an approach, which embraces the research topic and interprets the phenomena in a way most genuine (Grassie, 2008). Guba and Lincoln (1994, p.105) define a paradigm as; “A basic belief, system or world view that guides the investigator not only in choices of method but in ontologically and epistemologically fundamental ways”.

Ontology refers to the structure of knowledge and what it is, whereas epistemology considers the relationship between those that claim to know and how they arrived at the conclusions (Bloomberg & Volpe, 2008). The methodological design of a research project provides the foundational base for the development of themes, theories, and concepts. If the foundations of a project are flawed, the subsequent conclusions will also be flawed and not an authentic representation.

Historically within the realms of research, there has been an on-going dispute for superiority between two central paradigms: quantitative and qualitative. This apparent dichotomy of paradigms has diminished with the increased popularity of qualitative research, and the progressive realisation that there can be no ‘one
size fits all’ mentality towards methodology (Denzin & Lincoln, 2011; Ercikan & Roth, 2006).

**QUANTITATIVE RESEARCH**

Supporters of quantitative research adopt a realist ontology (Hill-Bailey, 1997). Phenomena are classed as factual objective data that can be collected via surveys and tests and analysed to determine the causal relationships between variables, although it is acknowledged that many quantitative surveys are also cross sectional in design and therefore do not make claims about the causal relationships. Quantitative data can be translated into numerical or statistical information which in turn can be replicated by other researchers. Conclusions are viewed as clean and specific with minimal input from the researcher who is viewed as merely a research instrument in a value free framework therefore advocating an objective epistemology (Denzin & Lincoln, 2011; Ercikan & Roth, 2006; Gorman & Clayton, 2005; Krauss, 2005).

A quantitative approach to loneliness research may be useful as a measurement tool to determine prevalence, and to undertake large scale studies that identify social trends (Bryman, 2008). Scales such as the UCLA loneliness scale (Russell, 1996) and the De Jong Gierveld Loneliness scale are considered reliable and valid and have been used in many research projects (De Jong Gierveld & Van Tilburg, 2006). The fact that loneliness exists and is experienced by older people is supported by numerous quantitative studies, and is not doubted by this proposed research. The experience of loneliness and its meaning for older people does, however, remain ambiguous. The management of loneliness is not as prominent a topic in research studies, as is the identification of loneliness. A quantitative approach may be appropriate for the identification of loneliness, but may not be the ideal research paradigm for investigating the management of this phenomenon. Loneliness is a sensitive topic of conversation, and not a topic that
most people feel comfortable talking about or admitting to. There remains an
element of stigma attached to loneliness (Howse et al., 2004).

QUALITATIVE RESEARCH

The nature of loneliness as a research topic calls for sensibility, which may be
achieved through a qualitative paradigm. Qualitative researchers adopt a relativist
ontology that assumes reality is in a constant state of fluctuation. Reality is co-
constructed through meaning and understanding that is social and experiential
(Krauss, 2005). Supporters of this paradigm embrace a subjective epistemology,
and maintain that they cannot separate themselves from what they know or
research (Bruner, 1999). The main subject matter of qualitative research is the social
world. The spoken and written word, form the basis of the data. Data collection is
mainly via interview, and depends upon the stories or information participants are
willing to share. The relationship between the researcher and the participants is
closer than that of a quantitative researcher, as interviews are generally interactive
and take place on a 1:1 basis in a natural environment (Bryman, 2008). This
closeness has been and still is viewed by some positivists as soft science that is
lacking in reliability, validity, and value (Liamputtong, 2009).

Qualitative analysis can be viewed as more ambiguous, than that of
quantitative research, as researchers ultimately select data to develop theories
rather than stringently measure the quantity or intensity (Hill-Bailey, 1997). It
should not, however, be assumed that it is less reliable as the credibility criteria for
positivism cannot be imposed upon interpretivism. Qualitative research examines
meaning and interpretation, from the perspective of the participant being studied.
To understand an individual’s behaviour, one must first understand the
significance the individual ascribes to that behaviour (Liamputtong, 2009). Quality
is determined through validation, and transparency of process (Mishler, 1995;
Polkinghorne, 2007; Riessman, 1993). By lending greater credence to the opinions,
narratives, and meanings older people ascribe to loneliness, tailored interventions for preventing or managing loneliness could be developed.

RESEARCH METHODOLOGY

After considering both quantitative and qualitative methodological frameworks, the decision was made to undertake a research project that was qualitative and used narrative inquiry by way of interviews, as a method of data collection and analysis. Riessman (1993, p.5) writes that narratives are “well suited to studies of subjectivity and identity”. As loneliness is such a transient, personal phenomena, it can be easily misunderstood. Narrative research into loneliness, from the perspective of an older person, appears limited.

Demographic characteristics were collected from the participants, in particular age, gender, ethnicity, time bereaved, locality and driving license. The purpose of this was to augment the qualitative data, related to widowhood and loneliness, and provide background information about the participants.

NARRATIVE RESEARCH

The subsequent sections will discuss narrative research methodology in relation to the overall research aims. The sections include definition, history, and a selection of theorists. Methods of narrative analysis will also be discussed along with key elements of narrative research and the advantages and disadvantages of this methodology. These sections are a prelude to the actual method adopted in the current research, which will be examined in the method section.

The reason for such detailed deliberation is that narrative research has received criticism for its ambiguous process (Kelly & Howie, 2007; Plummer, 2001; Riessman, 1993). It is one of the aims of this thesis to present a comprehensive overview of narrative research methodology, before describing the specifics used within this study. In an attempt to establish rigour, particular attention was paid
to the decision trail within the project. The decision trail with regard to the choice of the topic, design and methodology, was kept transparent so that peer reviews could take place (Bryman, 2008; Gorman & Clayton, 2005).

**DEFINITION OF NARRATIVE**

Despite the fundamental presence of narrative as part of daily human activity, there is no globally accepted definition (Elliott, 2005; Mishler, 1995; Riessman & Quinney, 2005; Squire et al., 2008). An essential component of knowledge is said to be the story. People acquire the majority of their knowledge through both the telling of and listening to stories (Kenyon & Randall, 1999). Kenyon and Randall (1999) describe the basic foundation of a story as someone telling someone, about somebody doing something. The story usually incorporates a degree of meaning, or a message of some kind. The term story, however, is quite often confused with the term narrative (Plummer, 2001). Narrative is a broad spectrum term, of which story is a component (Lea Gaydos, 2005). Paley and Eva (2005) describe a continuum of narrativity ranging from the epic to the allegory, and incorporating such examples as biographies, diaries, news stories and fairy tales. Personal narratives are used as a means of “coping and surviving” (Bennett & Vidal-Hall, 2000). The opportunity to reminisce and recount past life events can provide an insight into lived experiences (Riessman, 2008). Narratives embody individuality and also represent history, society, culture and geography (Bruner, 1991; Day-Sclater, 2003).

Labov and Waletzky (1967, p.12) define narrative as “one method of recapitulating past experience”. This theory of narrative is considered to be responsible for the increased publicity of the narrative research movement, and the increased popularity of the method (Labov & Waletzky, 1967). This definition and overall approach does however have its limitations, as it fails to consider context and future orientated narratives focusing instead on past events (Patterson, 2008). Polkinghorne (1991, p.136) described narrative as “the cognitive process that gives
meaning to temporal events”, which is a more comprehensive definition. Polkinghorne, whose background is that of psychology and the cognitive and social sciences, focuses upon the perceptual and experiential components of narrative. The same can be said of Bruner (1991) whose psychological and educational background influence his thoughts on narrative, and produce a more inclusive definition than that of Labov and Waletzky (1967). Bruner (1991, p.4) refers to narrative as a method humans adopt to organize their everyday experiences “we organize our experience and our memory of human happenings mainly in the form of narrative.”

Although there is no universal definition, most researchers agree on some common features of narrative regardless of discipline (Hinchman & Hinchman, 1997; Riessman, 1993). McCance, McKenna, and Boore, (2001) cite sequence as the most common feature of narrative. Hinchman and Hinchman (1997, p. xv) define narrative as “forms as discourse that place events in a sequential order with a clear beginning, middle and end...The sequence must add up to something. The units so ordered must have an intrinsic meaningful connection.” Whilst this definition acknowledges sequence, it also highlights that sequence is more than chronology. With regard to the current research topic of loneliness Riessman’s definition is favoured. Riessman (1993, p.3) maintains that people “narrativize particular experiences in their lives often where there has been a breach between the ideal and real self and society”. This definition complements the definitions of loneliness, which describe a perceived discrepancy between desire and availability of relationships (De Jong Gierveld, 1998; Dykstra et al., 2005).

Paley and Eva (2005) suggest disorder arises in narrative research as a result of imprecision. Omission on behalf of the researcher, to make a clear distinction between the definitions of narrative and story leads to inconsistency. This inconsistency impairs the quality of research. In their research Paley and Eva (2005) make frequent reference to three separate definitions: narrative, story and
narrativity. They are specific in their argument, and maintain that all research using narrative analysis as a method needs to be clear about the use of these terms. According to Paley and Eva (2005) narrativity is the overarching term, under which sit the terms story and narrative. Paley and Eva describe a narrativity ladder which is made up of nine components. The presence of these components in a text, indicate the level of narrativity. A text that includes only one or two elements would be viewed as having low narrativity, whilst a text that contains eight or nine elements would be rated as having high narrativity. Elements include event narration, causality, explanation, character and plot reaction. In conjunction with the narrativity ladder Paley and Eva (2005, p.89) define a narrative as “a rehearsal of a sequence of events causally connected…generic”, whilst story is “specific…takes the causal sequence of events…organises it in such a way as to construct a plot with a central character, a problem, an explanation and an intended reaction”. To be classed as a narrative a text has to include elements one through to three on the narrativity ladder, whilst a story has to include elements four through to eight. Paley and Eva (2005) arrived at the conclusion that whilst all stories are narratives, not all narratives possess the necessary elements to be classed as a story. This distinction is vital if consistency is to be achieved, and research quality improved.

HISTORY OF NARRATIVE RESEARCH

The aforementioned definitions of narrative are evidence that even with such diverse interpretation, the narrative research movement has gained in popularity in academic research, particularly social research (Squire et al., 2008). Historically the origins of present day narrative research can be found in Western, post war, psychosocial humanist movements, Russo Franco structuralism, and post structuralism approaches that include postmodern, psychoanalytic, and deconstructionist elements (Squire et al., 2008). Although these movements are coextensive, there are differences in the underlying philosophical traditions.
Humanism developed as a reaction to the dominance of positivism and embraces a holistic, person centred method that focuses upon a singular unified subject. Post structuralism challenges empiricism further, by advancing the theory that there are multiple, changeable, and conflicting subjectivities in narrative which are influenced by society. A further divergence occurs in narrative theory. The divide arises between those researchers who undertake research with a narrative event in mind, and those who undertake research with a narrative experience in mind. This issue will be examined in greater detail later in the chapter, when the main narrative theorists are discussed. Both traditions reach agreement with regard to narrative research acting as a medium for the voices of the underdogs in society, and challenging existing powers or stereotypes (Hendry, 2007; Squire et al., 2008; Spector-Mersel, 2010). This aspect of narrative research lends itself to the topic of loneliness as historically, industrialized countries have painted a pessimistic and misleading picture of old age (Dykstra et al., 2005; Townsend, 1973). Stereotypes can be contested, by giving greater credence to the opinions and narratives of older people.

NARRATIVE ANALYSIS

Riessman (2008, p.151) defines narrative analysis as “a family of methods for interpreting texts that have in common a storied form”. Riessman elaborates on the definition by explaining that “narrative analysis can be accomplished in a number of ways depending on the objectives of the investigation”. There is no exclusive method within narrative analysis, rather a miscellany of methods that are discordant, and largely dependent upon the interpretation of the professional discipline undertaking the research (Phoenix, Smith, & Sparkes, 2010; Squire et al., 2008). Transparency of the process is essential during the analytical stage, to demonstrate how the researcher arrived at their conclusions. The examples discussed in this section are neither an exhaustive list nor superior in approach; they appealed to the researcher in terms of simplicity and usability so as not to
overshadow the research topic (Frost, 2009). Multiple researchers cited narrative identification and analysis as a contentious topic, as there are no set procedures (Kelly & Howie, 2007; Plummer, 2001; Riessman, 1993). Plummer (2001, p.190) suggests the following prerequisites as a format for identifying life narratives. “A sense of ordering (usually linear)... a sense of person behind the text ...a sense of voice and perspective belonging to a narrator and...a sense of causality” (Plummer 2001).

Labov and Waletzky (1967) place greater emphasis on the structural format of narrative. Their renowned model of analysis is the most frequently referenced in narrative research. Whilst Plummer (2001) describes a set of elements which help make up a life narrative, Labov and Waletzky (1967) present a more detailed description of six distinct sequential parts that they believe shape a narrative. These include the *abstract*, which encapsulates the main points and sequence of events of the narrative. The *orientation* communicates information about time, place, participant identity, and behaviour. The *complicating action* communicates causality, as in what happened next. *Evaluation* communicates consequences, and meaning as interpreted by the narrator. *Resolution* describes the ending of the narrative, whilst *Coda* returns the narrator back to the present moment. This format has been praised for its rigorous approach and standardised format, but also criticised for its inattention to context and its limited view of an event as having had to have taken place for a narrative to arise (Cortazzi, 2001; Frost, 2009). Riessman (1993) proposes the notion of entrance and exit talk as a means of recognizing narrative, which is comparable to the orientation and coda features of Labov and Waletzky’s model. Riessman also suggests isolating the tentative narratives from the main transcript, so that they can be re-examined.

Some contemporary methods of narrative analysis complement the research topic of loneliness as they utilise aspects of phenomenology and hermeneutics in their framework. Hermeneutics identifies interpretation as its main philosophy;
this may lead to greater understanding of subjective experience (Grassie, 2008). Lindseth and Norberg (2004) developed a method of narrative analysis that includes three procedural steps. The first step is a naïve reading of the transcript to gain an overall impression of the text. The second step, structural analysis, identifies sections of meaning that relate to themes and subthemes. The final step draws the whole process together, and allows for the researcher’s interpretation and a comparison with existing research. This approach to narrative analysis is succinct, has a simplistic framework, and pays attention to the collaborative relationship between researcher and participant in the production of meaning and new knowledge.

Murray (2000) describes four levels of narrative analysis. He suggests that the first level of analysis is the personal level, which incorporates individual life narratives and how they are presented. The second level is interpersonal, and studies the collaborative effects between narrator and listener. Positional level of analysis is the third level, and considers the social position of a narrator and listener. The fourth level is societal. This level of analysis examines the impact of the society or culture in which the narratives are shared. Murray (2000) believes that all four levels require attention to achieve holistic analysis of narrative. Frost (2009, p.24) lobbies for “within-method triangulation that encourages the viewing of data from several perspectives”. This approach reinforces Mishler’s viewpoint that no single approach to analysis can capture the multiple layers and meanings of narrative (Mishler, 1991b). By selecting a pluralistic approach to narrative analysis the researcher can combine the advantageous elements of singular methods, whilst offsetting the disadvantages (Frost, 2009).

**BIG STORY VERSUS SMALL STORY ANALYSIS**

The variety of analytic focus in narrative ranges from plot temporality, thematic, episodic and dramatic to the interactional, or ultimately a composite of all of the aforementioned (Phoenix, 2008). The issue of big story versus small story
analysis is also an ongoing debate in narrative analysis (Phoenix, 2008). According to Phoenix (2008) big story analysis looks at life story and identity as a whole, and takes cognitive and developmental aspects of life into consideration. Small story analysis, on the other hand, examines selected narratives of “everyday encounters...ongoing events, future or hypothetical events, shared events but also allusions to tellings, deferrals of tellings and refusals to tell” (Phoenix, 2008, p. 64). Small story analysis accommodates the everyday events of life, which makes it appropriate for the topic of loneliness.

As noted throughout this thesis, the goal of the research is to obtain a greater understanding of the experience of loneliness. With this in mind, secondary goals include avoiding the medicalisation of loneliness, and reducing any associated stigma. Ballard and Elston (2005) define medicalisation as “the extension of medicine’s jurisdiction over erstwhile ‘normal’ life events and experiences” (p.230). It is not the intention of this study to take the stories from participants and manipulate them into an unrecognizable account of how to cure loneliness. The view that loneliness requires a cure compromise’s the potential for viewing loneliness as an everyday life experience. Once an experience is viewed as requiring a cure it exposes the experience to stigma as it falls outside the realms of what is perceived to be normal. This may explain the stigma already surrounding loneliness. Link and Phelan (2001) argue that “Stigma exists when...people distinguish and label human difference...link labelled persons to undesirable characteristics [and create]...distinct categories so as to accomplish some degree of separation of ‘us’ from ‘them’” (p.367).

By focusing on the small story the researcher can accommodate both the normality of life, and cater for hypothetical situations, e.g. asking a participant what they would say to a friend who felt lonely. Removing the focus from the interviewee may be less confrontational, encourages more in depth comments on loneliness, and takes into account the context in which the narrative is being
constructed. The small story approach acknowledges the socio-cultural influences that may affect an individual’s willingness to comment on a given topic (Phoenix, 2008).

**CANONICAL AND PERSONAL NARRATIVE**

Bruner (1991) argues that the researcher needs to be aware of canonical narrative and personal narrative, during the process of narrative analysis. Canonical narratives refer to narratives that are constructed in line with the stipulations imposed by a culture or a society. In contrast, personal narratives represent an individual and candid view, which may clash with canonical narrative and lead to stigma and ostracism. It is for these very reasons that individuals may acquiesce and present a canonical narrative in a research environment. The skill of the researcher is vital at both the interview and the analysis stage, as clarification and interpretation are key elements that are dependent on the spoken and the unspoken. Incongruity between language and body language may help identify the difference between a personal narrative, and a canonical performance. The performative analysis of narrative provides an insight into how the narrative is delivered, and for what reasons (Phoenix et al., 2010; Riessman, 2008). Fraser (2004) presents another dimension to Bruner’s argument. Fraser maintains that narrators do not always perform the narratives that society or a specific culture expects from them, therefore a role of analysis would be to consider why. Furthermore the significance of genres should be recognized in narrative analysis, as this may help clarify how the individual wants the narrative to be understood e.g. strength or endurance over adversity, moralistic or tragedy (Elliott, 2005).

Boenisch-Brednich (2002) presents a different aspect of analysis, by using key narratives. Her research topic is migration; she believes that individuals have an indeterminate amount of set narratives available to them. Key narratives describe a deviation from the normality of life, and have been told and retold so many times
that they are delivered verbatim. Part of the analytical process involves identifying key narratives and understanding the meanings behind them, which can range from moral or redemptive to educational. An experience as life changing as widowhood may produce key narratives, and offer a degree of insight into why people did or did not feel lonely following such an event.

The role of the researcher and the research participant in narrative research

The terms pluralism, relativism and subjectivity were used by Lieblich, Tuval-Mashiach, and Zilber (1998) to describe narrative research and embody a triad of topics under dispute. The issue of interviewer/interviewee interaction is of major importance in narrative analysis. Mishler (1995) highlights the duality of narrative. According to Mishler there is an interdependent relationship between the interviewer and interviewee. Individuals use narrative to apply meaning and extract meaning. Though Mishler’s work is perhaps the most influential, there are other models of narrative analysis that give consideration to the relationship between the researcher and the research participants (Emerson and Frosh, 2004; Frost, 2009). The critical narrative analysis model makes clear the subjective role of the researcher, and allows for reflexive consideration of interview transcripts, narratives, and subsequent interpretations (Emerson and Frosh, 2004).

Squire et al., (2008) examine the influence of time and place upon the researcher. They discuss critical gerontology and the theory that variation in narrative is equally dependent upon both the research participant and the social, political, and background discipline of the researcher undertaking the analysis. Mishler (1991b) believes the researcher cannot help but bring preconceived ideas to the research, as without shared understanding there would be no expansion of knowledge as both parties in the interview would fail to convey or grasp meaning. Andrews (2008, p.95) contributes to the discussion on narrative variation by raising the point of the dynamic nature of context or “shifting ground”. According to
Andrews (2008) subtle changes occur to a narrative each time it is told. When narrative analysis is undertaken, the impact of personal experience on the process of interpretation and subsequent conclusions is unavoidable. Inclusion of subjectivity and relativity does not detract from the worth of the research, if the process is both systematic and unambiguous (Lieblich et al., 1998).

ADVANTAGES OF USING NARRATIVE FOR RESEARCH PURPOSES

The increasing popularity of the narrative research methodology brings with it both positives and negatives. The following quote explains quintessentially the main advantage of using a narrative research methodology. “We have, each of us, a life story, an inner narrative whose continuity, whose sense, is our lives…this narrative is our identities” (Plummer 2001, p.186). The universality of narratives acts as a natural common denominator, despite the differences that culture and society may impose (Bruner, 1991; Mishler, 1991). Narratives document change, from both an individual and societal perspective, and take into account the inconsistency of human behaviour, which positivism does not always acknowledge or explain (Phoenix et al., 2010; Polletta, 1998; Squire et al., 2008). Plummer (2001, p.192) argues that “old age is open to many meanings; our culture [Western] may have invented a pernicious master narrative of decline”. Cultural narratives are, however, open to challenge from personal narratives which can present an entirely different viewpoint of the same phenomena (Biggs, 2001; Fraser, 2004).

With regard to the topic of loneliness in old age narrative gerontology, may help to develop a holistic view of ageing that is a more accurate representation of contemporary life in New Zealand society (Black & Rubinstein, 2004). Narrative gerontology promotes “a way of seeing through which to investigate aspects of aging that may otherwise be overlooked” (Kenyon & Randall, 2001, p.3). Narrative gerontology brings the person to the forefront of the research and acknowledges the uniqueness of the individual and the fluctuating nature of stories and
interpretation (Hallberg, 2001; Randall 2001). Polkinghorne’s opinion regarding the metamorphic nature of life affirms the notion “my self...is something temporal that unfolds in time and whose phases I survey prospectively and retrospectively from within an ever changing present” (Polkinghorne 1991, p.143).

A central function of a narrative approach is to provide an understanding of life experiences (Frid et al., 2000). The main goal of the current research is to understand individuals’ subjective experience of loneliness. Plummer (2001) writes that narratives are about negotiating life change so that we can create understanding of the world in which we interact. Both Polletta (1998) and Murray (2000) write about narratives in a similar vein, presenting narrative as a means of bringing about equilibrium when life has deviated from the norm. Rothaupt and Becker (2007) believe individuals adjust to traumatic experiences or events by talking about them. A narrative research methodology has been used by Chambers (2005) to research life experience with older widows. Results highlighted loneliness as a primary narrative (Chambers, 2005). Chambers’ conclusion supports both De Jong Gierveld’s (1998) discrepancy definition of loneliness, and Plummer and Polletta’s assertions that narrative can assist people with adjustment. Another advantage of narrative research is the capacity to facilitate understanding of the undeclared; this would is particularly useful in view of the sensitivity associated with verbalising loneliness (Fraser, 2004). To conclude this summation of the advantages of using narrative research, narrative portrays ageing in a way statistics alone never could (Kenyon & Randall, 1999).

DISADVANTAGES OF USING NARRATIVE FOR RESEARCH PURPOSES

Misinterpretation of narrative leads to a dilution of purity, and is a major disadvantage. Riessman (2008b, p.4) believes “narrative is everywhere, but not everything is narrative”. She accuses both the media and qualitative researchers of perpetuating the problem by mislabelling common text as narrative, an action that could lead to reduced quality (Riessman, 2008; Riessman & Quinney, 2005; Salmon
Both Mishler (1991b), and Zilber, Tuval-Mashiach, and Lieblich (2008) criticise researchers for failing to consider the importance of context in the interview situation. Mishler maintains that narrative research offers richer results because the context of a story is taken into consideration. If context is overlooked the researcher runs the risk of producing data that is no more informative, in terms of meaning, than standard quantitative research. The tendency to exaggerate and romanticize the capabilities of the narrative research methodology has increased as the methodology has gained in popularity (Paley & Eva, 2005).

The issues of quality and representativeness are sources of criticism in qualitative research, especially narrative. Due to its intuitive technique, which can impact upon replication, some detractors of narrative approach view it as an art not a science (Lieblich et al., 1998). It should not be assumed that personal narratives are reflective of a cohort (Polletta, 1998). This form of assumed homogeneity can be as misleading as stereotypes, and ultimately does little to silence the critics of narrative methodology (Biggs, 2001). The matter of truth in narrative is controversial, there is a fluctuating level of discrepancy between factual truth and narrative reality (Biggs, 2001). The true self can actually be hidden from others by using narrative accounts as a defence mechanism (Day-Sclater, 2003). Mansfield, McLean, and Lilgendahl (2010) describe limited insight, where people fail to realise the significance of certain situations therefore disassociating themselves cognitively, as a further drawback. Reliance on what is spoken, over what is left unspoken, can be to the detriment of authenticity (Salmon & Riessman, 2008). Mishler (1991a, 1991b) believes that the impact of the interviewer upon the interviewee should not be overlooked. This can be useful in shaping and nurturing narratives, especially when disclosed as part of transparency in the research process. If interviewer impact is not considered or discussed, however, the degree of contamination remains unknown and automatically exposes the project to controversy. With narrative there will always be a degree of conjecture that needs
acknowledgement, if transparency is to be achieved and quality maintained (Paley & Eva, 2005; Polkinghorne, 2007; Randall et al., 2006).

There could be a propensity for bias surrounding narrative research. A researcher could develop a theory by deliberately selecting, the narratives to support their theory and argue the strengths of that theory by demonstrating that it is fixed in narrative (Grassie, 2008). From a negative perspective this means that narratives can be used to perpetuate traditions or preconceptions about cohorts that are neither accurate nor absolute (Bower, 1997). Bruner (2004) argues that the issue of verification is a major disadvantage cited by many commentators on narrative research. Bruner goes on to suggest, however, that this disadvantage when compared with the advantages does not detract from the overall depth of understanding that personal narratives impart. Not everyone is in agreement with Bruner’s summation of narrative. In response to the notion that talking can help, particularly in traumatic situations, Hendry (2007) argues that narratives can prevent some individuals from overcoming troubling experiences by preserving the trauma and compelling people to relive the moment. Hendry asserts that the deconstructive nature of narrative dissects peoples’ lives into selected narrative experiences, which when reassembled fail to recapture the whole person. To conclude, whilst the increased recognition of the narrative research methodology signifies progress, its over popularity exposes it to misuse and low quality research results. These are issues that prospective researchers should consider (Spector-Mersel, 2010).

METHOD

The previous sections have considered the complexities of choosing a research methodology appropriate to the research topic of loneliness. The method section will demonstrate how narrative research techniques were applied to the current project including areas such as ethics, sample, recruitment, data collection, transcribing, data analysis and rigour.
To recap, the main goal of this research was to understand individuals’ subjective experience of loneliness. Following careful consideration a narrative research framework was selected to investigate the research question which consisted of three parts.

1. How do older widows/widowers describe experiences of loneliness?

2. How does the experience of loneliness change over time with age and lifestyle for older widows/widowers?

3. What strategies are used by older widows/widowers to manage the negative features of loneliness? What role do health services play?

A pluralistic approach to narrative was adopted for this PhD study. As discussed earlier, a pluralistic approach combines the advantageous elements of singular methods whilst offsetting the disadvantages (Frost, 2009). The selected narrative theorists and their associated methods, along with explanations, will be described in both the data collection and data analysis sections.

Demographic characteristics were also used to provide background information about the participants. The information included age, gender, ethnicity, time bereaved, locality, driving license and was used to augment the loneliness narratives. Attempts have been made to allow the research topic to guide the choice of methodology and subsequent methods in the hope that this will improve authenticity (Cortazzi, 2001; Gorman & Clayton, 2005; Lieblich et al., 1998).

**ETHICS – CULTURAL SENSITIVITY**

The research project is situated in Canterbury on the South Island of New Zealand. The narratives are from male and female New Zealand residents (aged 70 plus). The narrators are from mixed cultures including migrants who have made New Zealand their home, and Māori and Pākehā born in Canterbury and from the
rest of New Zealand. Throughout the research project the researcher was mindful of her own cultural background [which is Northern English residing in New Zealand for 11 years having taken New Zealand citizenship], and the impact this had upon the individuals taking part in the study. During the proposal stages of the study, the design and its implementation, the researcher was cognisant of culture and ethnicity and how these differences may influence the research project (Adams, 2008; Gready, 2008; Greenwood, Mackenzie, Cloud, & Wilson, 2009; Riessman & Quinney, 2005; Squire, 2008).

The research proposal was presented to the Upper South A Regional Ethics Committee, and underwent a stringent review. Aims, validity, and significance of the study were examined with particular attention being paid to non-maleficence. An interview took place between the researcher and the Ethics Committee to allow the Committee the opportunity to clarify any issues. A pertinent question was raised with regard to the effects of the interview questions upon a proposed participant and their mental well-being. The Ethics Committee was satisfied with the researcher's extensive interview experience and 15 years in mental health nursing for older people. Recruitment forms, including an information sheet, consent form, recruitment flyer and health questionnaires along with interview prompts, were scrutinised. A copy of the consent form, the information sheet and recruitment flyer are located in Appendix A.

As loneliness is a sensitive topic that could possibly provoke disharmony or disagreement amongst families, every care was taken to ensure anonymity for participants so they could not be identified (Appleton, 1997). The conditions surrounding storage of information was explained, but also written clearly in the information sheet to reassure potential participants. Particular care was taken with the wording of the information sheet. It was written in plain English to aid understanding, so that participation in the study would be a fully informed decision (Gready, 2008). The wording of the consent form and information sheet
was considered carefully to prevent undue influence (Kirsi, Hervonen, & Jylhä, 2004; Paget, 1983). The opportunity to speak with the researcher was also offered as alternative, in the event that potential participants had sight difficulties or would prefer to discuss the study rather than read about it. The possibility of future publication was discussed with potential participants as advocated by Hill-Bailey and Tilley (2002). With regard to taking part in the research or withdrawing from the study, considerable attention was paid to the voluntary nature of participation. Both the information sheet and the consent form made it clear to potential participants that they could choose not to participate or withdraw at any time. There was no pressure to take part and no reprisal should a participant change their mind.

To avoid a conflict of interest between the research and the researcher’s additional role (Psychiatric District Nurse with Older Persons Health), no person who was a current patient of the community mental health team was approached to take part in the study.

The ethics proposal was reviewed and is supported by Elizabeth Cunningham, Research Manager for Māori at the University of Otago Christchurch campus. Although the study is not Māori research, specifically, some of the participants are Māori and the researcher wanted to observe Māori customs (Tikanga Māori) (Pere & Barnes, 2009). The researcher is committed to the principles of participation, protection and partnership articulated in Te Tiriti o Waitangi. Care has been taken to respect the importance of knowledge and the philosophies of tapu (sacred and confidential) and noa (not forbidden or confidential), and how this could impact upon intellectual property (Pere & Barnes, 2009). The research goal of understanding the subjective experience of loneliness will hopefully advance Māori knowledge as a result of the Kaumātua (respected elder or elders) who agreed to take part in the study. Ethical awareness and cultural sensitivity were extremely useful in the recruitment phase of the study and will be discussed later.
in this chapter. Ethical approval for this research project was granted until November 2014. A progress report is forwarded to the Upper South A Regional Ethics Committee annually.

SAMPLE – RECRUITMENT

The sampling strategy followed the format advocated by Squire (2008). As the research focused upon narrative fragments, as opposed to complete life narratives the number of proposed participants was larger (Squire, 2008). The intent was to recruit a participant sample that reflected age, gender, and location as these groups had been identified as underrepresented in the literature pertaining to loneliness. A purposive sampling strategy was adopted. Gorman and Clayton (2005, p.128) define purposive sampling as a sample that is “chosen by the researcher to include representatives from within the population being studied who have a range of characteristics relevant to the research project”. The sample is not

Table 1 below describes the inclusion/exclusion criteria for the research project

<table>
<thead>
<tr>
<th>Inclusion</th>
<th>Age 70 – 84</th>
<th>Urban area</th>
<th>5 male participants</th>
<th>5 female participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inclusion</td>
<td>Age 70 - 84</td>
<td>Rural area</td>
<td>5 male participants</td>
<td>5 female participants</td>
</tr>
<tr>
<td>Inclusion</td>
<td>Age 85 plus</td>
<td>Urban area</td>
<td>5 male participants</td>
<td>5 female participants</td>
</tr>
<tr>
<td>Inclusion</td>
<td>Age 85 plus</td>
<td>Rural area</td>
<td>5 male participants</td>
<td>5 female participants</td>
</tr>
<tr>
<td>Inclusion</td>
<td>Community dwelling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inclusion</td>
<td>English speaking</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Inclusion</td>
<td>Ability to provide informed consent</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Inclusion</td>
<td>Widowed for a minimum of 2 years and not remarried</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exclusion</td>
<td>Current patient of Psychiatric Service for the Elderly</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
The above groups were selected as they represent the knowledge gap within gerontological research in New Zealand, and provide a range of experience. The Ministry of Health’s ‘Health of Older People Strategy’ called for future research in the areas of environment and gender (Ministry of Health, 2002). Although this strategy is now over 10 years old, the availability of qualitative New Zealand research concerning loneliness, environment, and gender remains limited as is demonstrated by the literature search. Research into the subjective experiences of the 85 plus population is also limited (Foster & Neville, 2010; Stek et al., 2005).

As the research topic is loneliness in old age the researcher elected to invite people aged 70 and over to take part in the study. On the whole there is no legal requirement to retire at the age of 65 in New Zealand unless otherwise agreed between an employer and employee (Ministry of Business Innovation and Employment, 2014). In the researcher’s clinical experience some people have remained in the workforce beyond the age of 65 on a full time, part time or casual basis, therefore the choice of a cut off age of 70 was made to ensure the majority of participants had retired and were evenly balanced in terms of activity associated with paid employment. Participants were grouped together in terms of age, gender, and locality to ensure that the underrepresented groups as highlighted in the literature review were given equal representation. The researcher acknowledges that chronological age does not and should not suggest homogeneity (Baars, 1997). The sample is not considered to be a stratified random sample as the numbers within the groups are too small to make any generalizations and the notion of comparison between the groups was not main motivation behind the research project (Cohen & Crabtree, 2006). The researcher did not hold any preconceived ideas about the similarities or differences between groups but wanted to ensure that they had the opportunity to voice their stories. The views of loneliness from within the different groups are commented on in the results chapters.
The decision to concentrate upon older widowed individuals, and the impact of widowhood on lifestyle and loneliness, stems from Davidson (2001) and Victor et al. (2005). The experience of widowhood encompasses both physical, and psychological changes (Demichele, 2009). An inclusion criterion, of a two year period since the spousal bereavement, was put in place. As widowhood is such a sensitive issue the researcher did not want to intrude on people’s grief. The reason for this inclusion criterion was explained in the recruitment flyer. Participants did not have to be lonely to take part in the study. As discussed earlier, the stigma associated with loneliness may prevent individuals from coming forward, some individuals may talk openly about someone they have known who has been lonely rather than admitting that they have been, or are lonely (Victor, Scambler, Shah, Cook, Harris, Rink, & De Wilde, 2002). As a result of the impact of potential stigma, the researcher wanted to open the research up to narratives that included broader experiences of loneliness, not just first-hand experiences.

Participants were actively recruited and approached rather than waiting for people to volunteer, as this may have altered the balance of extrovert to introvert personalities (Gunnarsson, 2009). Participants were accessed via practice nurses within GP surgeries. A fax detailing the age group and gender of required participants was sent to all rural and urban GP surgeries within Canterbury. A copy of the fax template can be located in Appendix B. The fax included a copy of the recruitment flyer located in Appendix A. Once a suitable candidate was identified by practice nurses, a recruitment flyer was given out. An expression of interest was obtained before patient details were passed onto the researcher. The researcher contacted the proposed participant to discuss the study in greater detail. Verbal consent was obtained and the researcher arranged to meet the participant. All of the interviews took place within the participants own homes. An information sheet was discussed with the participants at the time of the home visit (located in Appendix A). Following this discussion, if the participant wanted to continue
formal written consent was obtained (Appendix A). Once a saturation point was reached within an age/gender category, faxes were sent out to the GP surgeries thanking them, and informing them that participants were no longer required for that specific category.

The response rate was high, and recruitment and interviewing were complete within a six month period. Participants’ ages ranged from 70 years to 97 years. Of the 40 participants two identified their ethnicity as Māori, one Welsh, one Dutch and the remainder identified their ethnicity as New Zealand/European. Interestingly there were no Māori participants recruited through GP surgeries. As it was important to the researcher to ensure that Māori people were represented in the project, the recruitment process was reconsidered and attempts made to incorporate Māori values as advised by Pere and Barnes (2009). A fax template was sent to a local Marae that holds a monthly luncheon for Kaumātua (respected Elder or Elders). The fax template is located in Appendix B. The researcher was contacted by the Marae and invited to the Marae to share kai (food) and to talk with Kaumātua. It was an honour to be offered this opportunity. Three women volunteered and the researcher was invited to their homes to carry out the interview. Pere and Barnes (2009, p.458) describes the process as ‘Kanohi te Kanohi’ (face to face), and maintain that Māori people prefer to see and meet a researcher before giving consent so that trust and an understanding of the motives that drive the research can be established. The researcher gave ‘koha’ (a gift) as a token of respect for the time and knowledge the Kaumātua were willing to share.

The dropout rate was low, with only two individuals not completing the interview following an expression of interest. Reasons for the first person withdrawing are unclear as two appointments were made for the interview but on both occasions the person had gone out. It was decided after the second attempt to refrain from making further contact, as the person may have felt pressured. The second individual experienced a family bereavement the day before the interview.
and was involved with Tangi preparations. It did not feel respectful to continue with the research, and the participant was thanked for their initial interest but offered the opportunity to withdraw, which they accepted.

DATA COLLECTION

To speak and be heard can hold great meaning for people, validation from being heard can be even more powerful (Martin, 1998). Martin’s opinion of narrative encapsulates the intent behind this research study, which is to present the participants’ views in as genuine manner as possible (Gready, 2008; Paget, 1983). Data collection is a significant part of achieving authenticity. The purpose of data collection is to address the research question, which as noted earlier in the chapter is in three parts. Each part relates to older people’s accounts of loneliness and what it means to them.

1. How do older widows/widowers describe experiences of loneliness?

2. How does the experience of loneliness change over time with age and lifestyle for older widows/widowers?

3. What strategies are used by older widows/widowers to manage the negative features of loneliness? What role do health services play?

Qualitative data were collected through semi structured face to face interviews. The aim of the interviews was to gain new knowledge about the experiences of loneliness and the construction of meaning, from a participant’s perspective as a widow/widower (Becker, 2001, Fraser, 2004; Tanggaard, 2009). The interview process has been criticised as being over popular, time consuming and especially prone to bias, however, interviews can also provide insightful first-hand accounts which possess a depth not always achieved through questionnaires and surveys (Gorman & Clayton, 2005; Van Enk, 2009). The issue of context was given much consideration throughout this study, particularly in the implementation and
analysis stages. Each interview was conducted with the aim of eliciting participants’ stories about aspects of their lives, and views of loneliness.

The interview framework consisted of seven questions with associated prompts (a copy of the questions and prompts is located in Appendix C). This framework followed the format suggested by Riessman (1993). The seven questions and prompts provided a structure that was neither too rigid, nor imposing. Both the open ended and closed questions allowed participants to relate their narratives of widowhood, whilst introducing the research topic of loneliness into the conversation. Several pilot interviews were undertaken with older relatives of work colleagues, but were not used in the study. The purpose of the pilot interviews were to ensure that the meaning of each question was clear and logical, but not so prescriptive that participants could not answer freely (Gorman & Clayton, 2005; Mishler, 1991b). Minor adjustments were made to the wording of the questions to clarify understanding, and improve the flow of the interview.

All interviews were undertaken on a one to one basis, by the researcher, in the participant’s own home. The researcher utilised considerable interview experience as a psychiatric nurse to ensure the interviewer/participant relationship was equal and non-threatening in terms of power. The differences in age and culture between participant and research interviewer, however, could not be ignored and were acknowledged in both a research journal and subsequent analysis (Hyden, 2008; Squire, 2008; Tanggaard, 2009). The researcher remained aware of the impact of their own background upon the data collection, and interviews were viewed as a collaborative exercise between the participant and the researcher (Frid et al., 2000; Frost, 2009; Lea Gaydos, 2005; Phoenix, 2008; Randall et al., 2006; Squire, 2008). This required adherence to the interview questions and prompts although not always in the same order, as the interviewee lead the direction of the interview and the researcher responded to the behaviour of each participant. Some participants
were more comfortable talking about loneliness than others (Hyden, 2008; Paget, 1983; Polkinghorne, 2007).

By adhering to a systematic framework of questions and prompts an attempt was made to ensure a degree of consistency throughout the interviews, but also to reduce the risk of the Hawthorne effect whereby the researcher controls the participants’ answers (Randall et al., 2006). There will always be a degree of researcher influence, as it is the researcher who has chosen the research topic and the subsequent questions (Adams, 2008; Cortazzi, 2001; Mishler, 1991b). The questions were devised to encourage participants’ to continue with their stories. A problematical aspect of narrative research is establishing an interview environment that produces narratives (Kelly & Howie, 2007). The researcher/interviewer needs to be aware of their impact and timing in terms of asking questions (Kelly & Howie, 2007). Particular attention was paid to the start of the interview. In line with the researcher’s alternate role of psychiatric nurse, the beginning of any interview or assessment should be as relaxed as possible as the more relaxed an individual is, the more open and forthcoming are the answers. Rapport helps reduce nervous tension (Miczo, 2003; Randall et al., 2006). The questions suggested by Mishler (1991b) (located in Appendix C) were used as a reference point to aid awareness.

Interviews were recorded using a Dictaphone, and lasted between 45 and 120 minutes depending on the length of the answers. To observe cultural respect in line with Tikanga Māori (customs) permission was obtained to record the interview. Māori cultural values indicate that certain information should only be collected through memory (Pere & Barnes, 2009). For the purpose of these interviews Māori participants were agreeable to the interviews being recorded, as were all other participants. Notes were taken during the interview to assist with transcribing and analysis (Gorman & Clayton, 2005; Squire, 2008). Non-verbal aspects of the
interview, such as facial expressions and manner and whether these were congruent with verbal communications, were recorded in a research journal.

For the purpose of this research project only one interview per participant was undertaken, as a single narrative can be specific to a given time and place. Revisiting a participant for a second interview increases the risk of changeability (Appleton, 1997). Clarification was sought during the interview. To maintain consistency in data collection all interviews were undertaken over a six month period from February to July 2010 (Graneheim & Lundman, 2004).

Demographic information about chronological age, gender, locality, ethnicity, and length of time since bereavement were also collected. The time period since bereavement was divided into three categories: two to four years, five to ten years, and ten years (plus). While there is an overlap between the last two categories, this did not prove problematic as the ten years plus category referred to people who had been widowed for considerably longer than ten years. Time since bereavement was divided into the three categories as it seemed inappropriate to assume that people who had been widowed within the last two to four years would present with the same experiences as those who had been bereaved for ten years or more (Greenwood et al., 2009; Savikko et al., 2005). All interviews were undertaken by the researcher to promote consistency.

TRANSCRIPTS

All of the 40 interviews were transcribed by the researcher. During the planning stages of the study, the initial intent was to use a typist as transcribing can be time consuming. A trial run was undertaken with the first interview. The researcher found it challenging to reconnect with a transcript typed by another individual. Although the spoken word was verbatim the nuances attached to hesitation, contradictions, silences and other emotional features were overlooked. The important role these non-verbal elements played in the ultimate interpretation
required recognition (Squire, 2008). Although the transcription process was time consuming, it allowed the researcher to reconnect with each interview and to marry the journal notes, taken at the time of the interview, to the transcript thereby providing more detail for analysis and interpretation (Cortazzi, 2001; Frost, 2009). Elliott (2005) describes two divergent methods of transcribing. The first approach involves recording every aspect of an interview including pauses, gasps, false starts etc. The second approach ‘cleans’ the transcript and focuses solely upon the spoken word.

For the purpose of this study the spoken word was transcribed verbatim. Reference was also made to meaningful pauses, gasps and incongruities which had been recorded in the research journal (Fraser, 2004). This method ensured that authenticity was maintained and significant non-verbal data were not omitted (Elliott, 2005; Elo & Kyngas, 2008). Kelly and Howie (2007) undertook the process of transcribing within 24 hours of the interview taking place. They maintain that the speediness of the process contributed to the richness of the transcript. The researcher trialled transcribing within 24 hours and did not notice a difference between the interview that was transcribed rapidly and the remainder of interviews which were transcribed after several days. The research journal combined with listening to the tapes several times before beginning the transcribing process, allowed the researcher to re-engage with the interview atmosphere.

During the consent process participants were asked whether they would like to receive a copy of the audio tapes. Only one participant asked for a copy of the transcript. The majority of participants preferred to be contacted once the findings from the study were written up, despite this being a project that may take several years before it is complete. The individual who requested the transcript was satisfied with the transcript contents when they were contacted several days after the transcript had been posted out to ensure it had arrived safely.
DATA ANALYSIS

This study adopted a qualitative research methodology, narrative analysis was the primary focus in particular experience centred narratives as this type of narrative provides a broader spectrum of analysis. Event centred narratives concentrate on actual past events that have been encountered by an individual (Squire et al., 2008). Experience centred narratives allow the researcher to analyse narrators’ accounts of situations that have happened to other people. This proved useful for the research topic of loneliness, due to the associated stigma. Experience centred narratives acknowledge subjectivity, and the changeable nature of narrative. An individual can provide completely different accounts of the same experience on separate occasions (Frid et al., 2000; Squire et al., 2008). Small story analysis was applied within this study. As discussed earlier there is ongoing debate about big story versus small story analysis in narrative research (Phoenix, 2008). For the purpose of this research topic, and the number of participants, it was felt that a small story approach would be more appropriate as it allowed for a review of everyday life narrative fragments, including conjectural experiences (Williams, 2004).

The decision was made not to take the transcript analysis back to the participant for confirmation. The decision to confer or not to confer with participants about transcript analysis is a matter of controversy within qualitative research (Squire, 2008). Some researchers argue consultation with participants reinforces accuracy, whilst others argue that consultation with participants may reinforce doubt (Appleton, 1997). Combined with research terminology which may be unfamiliar to a lay person, this calls into question the usefulness of presenting the transcript analysis to participants for further comment (Graneheim & Lundman, 2004). Townsend (1973), whose study of loneliness in old age is regarded as a seminal work, maintained that answers pertaining to feelings of loneliness by participants can generally be taken as reliable at that given time.
However, as with all human beings they are subject to change and therefore do not portray a “permanent individual attitude” (Townsend 1973, p. 256).

It was for this reason the choice was made not to revisit the participant. If uncertainty arose, such as assumed shared understanding, clarification was sought during the interview as the researcher knew there would be no further contact with the participant during data analysis (Appleton, 1997; Ryan & Bernard, 2003). A copy of the original transcript was offered, and participants were also asked if they wished to be contacted with a summary of findings once the study was complete. Computer generated analytical packages are available for the purpose of data analysis such as NVivo or ATLAS/ti (Schiellerup, 2008). These packages were considered but rejected, as they appeared to sanitize the interpretation process and remove the researcher from data management and theory generation.

**NARRATIVE IDENTIFICATION**

Prior to narrative analysis each of the transcripts was dealt with individually, and read multiple times to allow the researcher to develop an overall understanding of the text (Elo & Kyngas, 2008; Ryan & Bernard, 2003). The 40 transcripts were then reviewed to identify narratives. Cortazzi’s three structural categories of narrative were used to identify narratives (Cortazzi, 2001). The event structure conveys the phenomenon. The description structure augments the phenomenon by describing time, place, person, and context. Finally the evaluation structure presents the narrator’s viewpoint and reason for telling the narrative. Cortazzi’s method combined with Riessman’s entrance and exit talk, which considers specific speech patterns that signal the beginning and end of a narrative, provided a format that the researcher felt comfortable with in terms of simplicity and usability (Riessman, 1993). Once identified, narratives were separated from the main transcript to allow the researcher to focus on analysis (Riessman, 1993).
NARRATIVE SEQUENCE

The current study viewed narrative sequence in terms of emotional sequencing, as opposed to the classic format of temporal sequencing (Hollway & Jefferson, 2013). Some theorists advocate the temporal structure of narrative, maintaining that narratives occur naturally in a linear fashion (Labov & Waletzky, 1967). Certainly the experience of widowhood and the subsequent reflective elements are inherently temporal in nature. As noted earlier, however, the researcher has considerable experience as a nurse and has undertaken many interview assessments with both families and patients. During an interview situation narratives do not always flow in a neat, straight forward manner (Fraser, 2004; Patterson, 2008). Narratives may be ordered by the feelings and emotions a narrator attributes to them (Baars, 1997; Hollway & Jefferson, 2000). Emotional sequencing provided narrators with the opportunity to convey stories of loneliness that happened prior to the event of widowhood which the researcher believed provided a more accurate representation of narrative than a temporal sequencing approach.
Recurrent topics of interest within the individual transcripts were coded and developed into themes as advocated by Phoenix (2008). Coding has been defined as “determining the meaning of an isolated response to an isolated question” (Mishler 1991b, p.3). Difficulties can arise with assumed shared meaning between a researcher and participant (Mishler, 1991b). This potential problem was minimised by discussing the codes with research supervisors, and ensuring that the code definitions and corroborating transcript extracts were made explicit (Gorman & Clayton, 2005; Nygren, Norberg, & Lundman, 2007; Spector-Mersel, 2010). An example of the table of code definitions and a sample of transcript extracts can be found in Appendix D. The coding pattern in the current research followed the format suggested by Gorman and Clayton (2005).

Figure 1 below illustrates the coding format.

1. Read a narrative segment

   2. Read another segment

      3. Is it the same category?

         Yes

         No

         * Repeat steps 2 and 3 until all narratives have been analysed.

         Assign a new category

         Assign to category
These steps were repeated until all the narratives had been analysed. Coding was time consuming due to the volume of data. Linking the coding to the entries in the research journal was also laborious but helped to strengthen the developmental process. Themes were developed from the assigned codes by looking for word repetition and associations. This is an informal theme identification technique and operates on the premise that repetition indicates the importance of a topic (Ryan & Bernard, 2003). The coding categories were placed into separate thematic sections and the themes were then linked between the 40 participant transcripts. The themes at this stage were rudimentary. Corroboration of themes was achieved through regular discussion with two research supervisors. This format is similar to the one utilised by Brown and Addington-Hall (2008) who used a diagram to explain and simplify this process.

A variation of Brown and Addington-Hall’s diagram is shown below.

Figure 2.

**IMMERSION**

Read and reread transcripts. Consider research question.

**IDENTIFICATION & ANALYSIS OF NARRATIVE**

Identify narratives in individual interview transcripts. Code recurrent topics of interest amongst narratives in individual interviews.

**THEME DEVELOPMENT AND MAPPING**
Identify recurrent topics of interest across all interviews. Develop rudimentary themes.

CORROBORATION OF THEMES

Discuss rudimentary themes with supervisors. Confirm themes.

This process kept interpretation transparent and authenticated emerging concepts (Polkinghorne, 2007).
The narrative analysis framework described by Murray (2000) was applied to the identified narratives and themes. The framework, which uses four levels of analysis, is demonstrated in Figure 3 below.

Murray’s first level of narrative analysis referred to as the personal level was essential to this research topic as it allowed for examination of the individual narratives about loneliness and widowhood and the manner in which the stories were presented. This level of analysis allowed the nuances and the individuality of each story to be preserved and portrayed in the collective story. The second level of analysis considered the interpersonal relationship between me in my role of the
listener, person to person with each narrator. The effects of interpersonal interaction were evident in the way in which each of the interviews progressed in terms of the pace and direction. As noted each interview was guided by a set of prompt questions, yet the necessity for the prompts and the order in which they were delivered changed with each collaboration. The level of comfort and ease with which narrators delivered their stories fluctuated between each interview. Individual personalities may have accounted for this fluctuation.

Although loneliness is the main focus of the research, during the recruitment stage it was stated that participants did not have to be lonely at the time of taking part in the study. This statement requires clarification. As discussed earlier, the stigma associated with loneliness may prevent individuals from coming forward whereas some individuals may talk openly about someone they have known who has been lonely rather than admitting that they have been, or are lonely (Victor, Scambler, Shah, Cook, Harris, Rink, & De Wilde, 2002). The researcher felt by allowing participants the choice to talk about prior or present experiences of loneliness, it may modify the potential embarrassment associated with loneliness. Participants who were not lonely at the time of the study also provided insights into how they kept loneliness at bay. Consideration was given to the manner in which narratives were expressed. Participants’ choice of words and the intonation of their speech along with the non-verbal aspects of communication were also reviewed (Fraser 2004).

This allowed for a broader consideration of loneliness and meant that the researcher was open to a wider spectrum of views, which may support or refute existing theories of loneliness in old age (Fraser, 2004; Ryan & Bernard, 2003). Particular attention was paid to canonical narratives and their possible presence within the transcripts (Bruner, 1991). As the research topic of loneliness has previously been associated with stigma the researcher was interested in the canonical narratives, if any, that arose from a discussion on loneliness. One of the
reasons for focusing upon these types of narrative was to determine the dominant view of loneliness within the contemporary New Zealand society in which the study was set. Riessman (1993) suggests a format for locating canonical narratives by highlighting conflicting narratives within a transcript. Such contradictions may indicate the presence of both personal and canonical narratives which are not necessarily compatible. Murray’s positional and societal level of analysis proved particularly pertinent. The influence of the researcher’s social position and that of each of the participants upon the formation of the narratives was considered. The impact of New Zealand society and the individual cultures in which the narratives were shared were also examined. Both positional and societal analysis of the narratives revealed some interesting insights and shaped the collective story in terms of the renegotiation of self-identity and the coping strategies described. Murray’s framework observes the assumption presupposed by narrative gerontology namely, people construct their personal stories within the larger stories in which they live (Kenyon & Randall, 2001).

RIGOUR

The conclusions drawn from this project may help to publicise the issue of loneliness in old age. The recognised merit of these findings are dependent upon the trustworthiness of the research process (Graneheim & Lundman, 2004). The following section highlights the significance of rigour, and trustworthiness, and the measures taken by the researcher to address it.

The terms reliability, validity, and generalizability are used to describe trustworthiness in research. These terms are more frequently associated with quantitative research than with qualitative research, as they suggest that reality is singular and concrete (Hill-Bailey, 1997). As the current study was qualitative the researcher elected to use the terms credibility, dependability, and transferability to describe the trustworthiness of the study. Whilst some researchers question the gain from substituting terminology, Graneheim and Lundman (2004) believe the
terms credibility, dependability, and transferability are more appropriate to the
dynamic and subjective view of reality as embraced by a qualitative research
process.

Credibility refers to the ability of the researcher to formulate an objective
research process (data collection and analysis) that reveals the true meaning of the
research topic (Graneheim and Lundman, 2004). For the purpose of this study the
researcher wanted to ensure that the participants represented the views of some of
the older people living in the Canterbury area of New Zealand in 2010. A cross
section of society was recruited. Age groups, gender, and environment were
stratified to ensure that male, female, urban, rural, ‘young’ old and ‘old’ old were
represented in equal numbers and given the opportunity to express their views on
loneliness. All potential participants were approached so that less confident, or
isolated, individuals were not over overlooked. Coding of data and emerging
themes were discussed with research supervisors, to ensure theme development
was transparent and unprejudiced (Appleton, 1997).

Dependability refers to the degree to which the researcher has attempted to
manage the ‘unstable’ elements of the research process (Graneheim & Lundman,
2004). Narrative interviewing along with narrative analysis was selected as the
most appropriate research method for the topic of loneliness. All interviews were
completed by a single researcher with interview experience. Interviews followed a
framework and were undertaken over a six month period to promote consistency.
Interviews were taped and notes made in a research journal to assist with
clarification.

Transferability relates to the research findings and how relevant they are to the
wider population. Data collection (interviews) took place in the participant’s own
home, partly to reduce anxiety and partly to aid transferability of the findings.
Keeping the research setting as natural as possible may result in data that is more
genuine and relatable to the experiences of other older people in New Zealand
society. Every effort was made to keep the decision trail open and the processes clear. Ultimately the merit of the data collection and subsequent analysis is decided by those reading it (Aranda & Street, 2001). Strengths and limitations of analysis and the impact of these upon the findings will be discussed in later chapters (Elo & Kyngas, 2008).

CONCLUSION

The primary aim of this chapter was to describe the process of selection for the methodology underpinning the research. The main goal of this research was to understand individuals’ subjective experience of loneliness. Following careful consideration a narrative research framework was selected to investigate the research question. All of the 40 interviews were transcribed by the researcher. Narratives were identified and coded and the narrative analysis framework described by Murray (2000) was applied to the narratives and themes. The process undertaken, by the researcher within the study, to address rigour and trustworthiness was also described.
CHAPTER FOUR – FINDINGS

OVERVIEW OF FINDINGS

Throughout the remainder of the thesis the terms participants, narrators, and individuals have been used to describe the people who took part in the research. The terms are interchangeable. The taped interviews were transcribed, and the transcripts were reviewed. Narratives were identified by time, place, person and context, and based upon small story narratives with emotional rather than temporal sequencing. The narratives were separated from the transcripts and reread. Recurrent topics of interest, within the individual narratives, were coded and set aside. These recurrent topics formed the overall structure of the collective story and were supported by quotes taken from the 40 transcripts. The overarching story followed a trajectory, from the onset of loneliness, through renegotiation, to a process of adjustment. Participants reported that the collective story fluctuated between the three key areas rather, than proceeding as a linear tale with an orderly beginning, middle and end.

This chapter will give a brief description of the participants, followed by an explanation of the apperception of loneliness through context based life events, which for the purpose of structure represents the onset of loneliness and the beginning of the story. Chapter five will cover loneliness and the renegotiation of self-identity (through individual ageing, widowhood and societal expectations). This is a progression of the collective story of loneliness, and relays how individuals made sense of the experience in relation to their own circumstances and the society in which they live. Finally chapter six will describe the spectrum of adaptive/maladaptive coping strategies individuals employed, to address loneliness or keep it at bay. Chapter six could be considered the climax of the story;
however, the experience of loneliness is a continuum of integration and adjustment. It should be noted that not all individuals reached the stage where they were free from loneliness. Some individuals remained feeling lonely but they were able to tolerate the feeling to varying degrees.

DESCRIPTION OF PARTICIPANTS

All participants were given pseudonyms to maintain anonymity. Demographic characteristics were collected from each participant. Information included age, gender, ethnicity, time bereaved, locality and driving license. The purpose was to provide background information about the participants so as to augment the narrative interviews. Participant ages ranged from 70 years to 97 years. Fifty percent of the sample was female and 50% male. Half the participants were aged between 70-84 years, and half were aged 85 plus. Half of the male participants and half of the female participants were living in rural areas, whilst the remainder resided in urban areas.

All participants were living independently in their own home, or a rental property. All participants had been widowed for at least two years. Forty percent of the sample were widowed 2-4 years, 17.5% 5-10 years, and 42.5% 10 years plus. Ninety percent of the sample identified their ethnicity as NZ/European, whilst 5% identified themselves as Māori, 2.5% Dutch, and 2.5% Welsh. Eighteen of the 40 participants did not drive (6 male, 12 female). Of those participants who did not drive, all males and a majority of the female participants had ceased driving due to physical health deterioration, although three of the females had never driven and had depended upon their husbands for transport.

Participants have been divided into eight groups based upon the demographic characteristics of age, gender and locality. As discussed earlier the purposive sample included underrepresented groups as highlighted in the loneliness literature, the researcher did not hold any preconceived ideas about the similarities
or differences between groups but wanted to ensure that they had the opportunity to voice their stories.

*Rural Female Group (85 plus)*

Rural Female Group 85 plus

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Time bereaved</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>Diana</td>
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</tr>
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<td>Jean</td>
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<td>2-4 years</td>
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</tr>
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<td>Lucy</td>
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<td>Violet</td>
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Table 2.

*Rural Female Group (70-84)*

Rural Female Group 70-84

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<th>Age</th>
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<tbody>
<tr>
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<tr>
<td>Eunice</td>
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<td>Alison</td>
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</tr>
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<td>Heni</td>
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Table 3.
### Urban Female Group (85 plus)

#### Urban Female Group 85 Plus

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<tr>
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<tr>
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<tr>
<td>Joan</td>
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<tr>
<td>Elsie</td>
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<td>10+years</td>
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<tr>
<td>Margaret</td>
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Table 4.

### Urban Female Group (70-84)

#### Urban Female Group 70-84

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<th>Ethnicity</th>
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</thead>
<tbody>
<tr>
<td>Elizabeth</td>
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<tr>
<td>Isobel</td>
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<td>NZ/Euro</td>
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<td>Alice</td>
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<td>Huia</td>
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Table 5.
### Rural Male Group (85 plus)

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<tr>
<td>Eric</td>
<td>89</td>
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<td>Alistair</td>
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<tr>
<td>Hugh</td>
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<td>NZ/Euro</td>
<td>2-4 years</td>
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</tr>
<tr>
<td>Graham</td>
<td>86</td>
<td>NZ/Euro</td>
<td>2-4 years</td>
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Table 6.

### Rural Male Group (70-84)

<table>
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<tr>
<th>Name</th>
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<th>Ethnicity</th>
<th>Time bereaved</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Michael</td>
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<td>NZ/Euro</td>
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<td>Yes</td>
</tr>
<tr>
<td>David</td>
<td>76</td>
<td>NZ/Euro</td>
<td>10+ years</td>
<td>Yes</td>
</tr>
<tr>
<td>Jack</td>
<td>83</td>
<td>NZ/Euro</td>
<td>10+ years</td>
<td>Yes</td>
</tr>
<tr>
<td>Colin</td>
<td>81</td>
<td>NZ/Euro</td>
<td>5-10 years</td>
<td>Yes</td>
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<tr>
<td>Bob</td>
<td>82</td>
<td>NZ/Euro</td>
<td>2-4 years</td>
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Table 7.
**Urban Male Group (85 plus)**

Urban Male Group 85 plus

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Ethnicity</th>
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<th>Driving Licence</th>
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<tbody>
<tr>
<td>William</td>
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<td>NZ/Euro</td>
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<td>No</td>
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<tr>
<td>John</td>
<td>96</td>
<td>Dutch</td>
<td>2-4years</td>
<td>Yes</td>
</tr>
<tr>
<td>Arthur</td>
<td>87</td>
<td>Welsh</td>
<td>2-4years</td>
<td>No</td>
</tr>
<tr>
<td>Max</td>
<td>91</td>
<td>NZ/Euro</td>
<td>2-4years</td>
<td>Yes</td>
</tr>
<tr>
<td>Alan</td>
<td>89</td>
<td>NZ/Euro</td>
<td>5-10years</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 8.

**Urban Male Group (70-84)**

Urban Male Group 70-84

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Ethnicity</th>
<th>Time bereaved</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Walter</td>
<td>81</td>
<td>NZ/Euro</td>
<td>5-10years</td>
<td>Yes</td>
</tr>
<tr>
<td>Patrick</td>
<td>84</td>
<td>NZ/Euro</td>
<td>2-4years</td>
<td>Yes</td>
</tr>
<tr>
<td>Joe</td>
<td>82</td>
<td>NZ/Euro</td>
<td>10+years</td>
<td>Yes</td>
</tr>
<tr>
<td>Peter</td>
<td>76</td>
<td>NZ/Euro</td>
<td>5-10years</td>
<td>Yes</td>
</tr>
<tr>
<td>Tim</td>
<td>80</td>
<td>NZ/Euro</td>
<td>10+years</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Table 9.
THE COLLECTIVE STORY - THE APPERCEPTION OF LONELINESS THROUGH CONTEXT BASED LIFE EVENTS

Narrative fragments, which related to loneliness, were gathered from the individual stories. The apperception of loneliness, through context based life events, emerged as the introductory component of the collective story. The key life event, for most narrators, was the experience of widowhood as it encompassed both physical and psychological changes. Further analysis revealed that stories consisted of memories of personal experiences of loneliness, and also observations of other people’s experiences. A key finding described in this chapter, is the revelation that the event alone did not predetermine loneliness. The degree of meaning ascribed to the event by an individual shaped a new understanding of loneliness.

Two questions out of the seven prompt questions, used to support the narrative interview, asked participants to recall a time of loneliness, and what does it mean to feel lonely? Most participants relayed a tale of a past event, but rather than following a temporal sequence it was emotion that structured the story. Despite there being a considerable time lapse since the event had taken place, when telling the story out loud, feelings of loneliness appeared to resurface. The stories included the narrators’ own experiences of loneliness and their observations of other people. The narratives that emerged from the prompt questions were coded and contributed to the recognition and understanding of loneliness. For the purpose of clarity the topic has been divided into four areas of personal, social, functional and emotional meanings.

The following section has been divided into four main headings under which are included subheadings, the four main headings are personal, emotional, social and functional stories. The headings and subheadings retell the story of loneliness in relation to the key life event of widowhood. Narrators described the ways in which their views of loneliness were shaped by their experience of widowhood.
PERSONAL STORIES

Personal stories described the memories, and meanings ascribed to life events, such as spousal illness and bereavement. The meanings and memories were shaped by subjective occurrences such as, convenient contact, the change in a daily routine, and the role an individual assumed within a marriage. Personal stories brought the life events of spousal illness and widowhood to the forefront. Narrators referred to intimate aspects of everyday life; moments that were ordinary but significant as they were shared with a spouse. Narrators created the context and determined the degree of meaning both key and everyday events held, and this in turn appeared to influence loneliness. Interestingly male narrators appeared to assign great meaning to endurance and suffering during their spouses’ illness. Following widowhood, the sense of suffering and endurance that was linked to spousal illness was replaced by loneliness that also had to be endured.

Spousal Illness and Bereavement

The relationship between the drawn out illness of a spouse and feelings of loneliness was complex. For some participants the caring role was a manifestation of their devotion yet became all-consuming and isolating. The undivided attention given to loved ones during their illness was to the exclusion of other interests. The interesting point about these narratives is that the narrators only appeared to recognize the adverse effects of withdrawing from activity on hindsight following bereavement. Alternatively the unexpected death of a spouse also exacerbated feelings of loneliness. Narrators commented upon the abrupt change to their world and their existence with the sudden removal of a key person.

We were trying to make it 60 [years of marriage], but her poor heart got the better of her. In May it will be four years [since spouse’s death]. Two days after her 85th birthday. So it was a bit shattering. She’d been poorly for about two and a half to three years and I’d been
a live in nurse, if you’d like to put it that way. She had my full attention, the garden suffered badly, but that didn’t matter, eventually it’s been more or less retrieved (Eric).

For some narrators the caring role became their only sense of control over an illness that could not be controlled. The demands the well spouse placed upon themselves, to meet the needs of their loved one, led to physical and emotional stressors that exacerbated feelings of loneliness and impacted upon health.

Well she was diagnosed as having Alzheimer’s…would have been a year or 18 months and then she began to deteriorate…so I battled on for I suppose another year. It transpired that when she went into the home, I had to arrange all that… I could see that it was getting too much. It was mammoth, I lost weight and everything…. No it was lonely [coping with wife’s illness] (Michael).

For male participants in particular, commitment appeared to equate to endurance and the degree of resistance a person was able to tolerate.

I looked after my wife for a couple of years before she died. She had emphysema, she fought for every breath. My wife was on oxygen for 24 hours a day at the end. She had a machine in the spare room. It was very exhausting, oh yes, I did everything all the cooking (Patrick).

The sense that suffering was to be expected and loneliness was a spousal lot was a strong feature throughout the male stories. Some of the men experienced a significant change in the demands upon their time following the death of their wives, particularly when they had altered their routines to accommodate the caring role.

Oh you know when my wife died that was a lonely time...I mean it was quite a trauma, but it was to be expected you know, but she’d been ill so long and I’d been trying to look after her, and doing all the other jobs around the place, you know, it was a lot to deal with so when she died it left quite a gap for a while and I felt at a loose end… I tried to look after her and it really got me down you know. I had to let go of a lot of my hobbies at that time,
so that was pretty lonely to begin with. You lose touch with people…the minister was good (Max).

The impact of withdrawing from hobbies or pastimes was subtle yet profound once a spouse had passed away. For the short term reducing the pressure of multiple activities may have been beneficial, but prolonged withdrawal disrupted the balance of social contact or distraction and removed meaning and structure from everyday life thus instigating loneliness.

Oh it would be…pause…hard to tell, 10 -15 years [of sickness] I suppose yes. Well my husband gradually got sick you see, I just couldn’t do you know everything like the garden, the painting, little bits I wanted to do so…. (Rose).

Spousal illnesses led to perceived enforced alienation from routine social groups. Narrators hinted at abandonment as people did not remain in contact once they stopped attending the groups and they encountered decreased social interaction.

Well since [husband] got sick I’ve had to leave all [social groups], if you’re in bowls you’re with a big group and doing things all the time, but what I could never understand is that when you’re not in there you never see them. I never saw one of my friends from bowls when [husband] got sick and I could never understand that (Judy).

Participants gave vivid accounts of loneliness, despite it occurring many years ago. They recalled, in particular, the isolation following bereavement, and though self-enforced described it as a significant time of loneliness.

Well for a time I was most surprised [loss of husband], but I didn’t want to see anybody or go out. And the first time I ventured out I went to get milk and I almost ran up to the grocers and ran back home so that I didn’t have to speak to anybody, which was a bit ridiculous really. I’ve no idea [why I isolated myself] because I don’t really know why I didn’t want to be with people, it was most unlike me you know (Eunice).
Narrators talked about feeling unprepared for the changes brought about by bereavement. The normality of bowling, and death in the same month, were an incongruous juxtaposition that reinforced disbelief.

*My husband died very quickly. He played bowls one week and on the Monday he felt ill, and he played on the Wednesday, and the following Monday we found out he had cancer, and 15 days later he was not with us. It was very quick and quite a shock… I mean a big change was when I lost my husband so suddenly… it was all such a shock and happened so fast that I don’t think I was properly with it to be honest…* (Alison)

The notion of astonishment was present in multiple stories. Participants were surprised by their own reactions to bereavement, especially loneliness. The recollections suggested that loneliness was an alien feeling to them.

*Well I did [felt lonely] after my husband died. That was something I wasn’t prepared for. Oh it’s 20 odd years now. That was through an accident on the farm. It was very sudden* (Rita).

The gradual withdrawal from socialization, or activity, as a result of a spousal illness and the demands of the caring role were evident in some of the narratives. Loneliness was present, but less noticeable, during the time that an ill spouse required nursing, prior to their death. Loneliness was, however, less subtle following bereavement, as participants commented upon the change in the demands on their time and attention. Narratives alluded to a sense of disbelief at the suddenness and finality of the situation, accompanied by feeling lonely. Despite the passing of years since their bereavement, participants gave vivid accounts of their experiences.

* Convenient Contact

The mere presence of a familiar provided comfort and convenience for narrators. Spousal contact facilitated spontaneity as a spouse was usually present. Presence was both verbal and non-verbal and helped to divert thoughts and
ultimately keep loneliness at bay. Several stories mentioned the difference in sounds around the home following spousal bereavement. Narrators described loneliness as an unobtrusive presence that manifested itself through the disappearance of familiar sounds. Emphasis was placed upon a perceived emptiness that was reinforced through decreased background noise. The loss of convenient company previously provided by a spouse, formed the personal meaning of loneliness for multiple participants. The impact widowhood had on simple activities, such as buying new clothes, was evident in some of the stories.

*I find it so lonely not being able to go anywhere you see...I haven’t bought any clothes since my husband died. I haven’t bought a thing for myself and I feel terrible sometimes, but if only someone would come and say come on we’ll buy a frock today or we’ll buy a coat today it would be just lovely I’d enjoy it you know...I miss laughing, my husband was always telling me jokes (Rose).*

Loneliness was a daily occurrence for some narrators, which manifested itself through music or an activity and reminded participants of their late spouses.

*I do get pretty lonely now because of [wife’s death] It’s every day I can’t get her out of my mind...Yes I do, but sometimes, it usually happens at the end of the day when I’m tired and I put some music on and it reminds me of her. When I’m working in the garden I come across something that reminds me (Michael).*

Narrators commented on the close, lifelong physical and emotional contact that marriage provided. The noticeable absence of intimacy shaped their personal meaning of loneliness.

*I definitely get lonely, you can’t live that long with one person without getting that way I’m sure. We didn’t necessarily talk a great deal, it’s just having somebody to reach out and touch in bed at night somebody to say are you having trouble dear (Eric).*
The longevity of a relationship and the familiarity of the company were commented upon as a personal meaning of loneliness. Participants described the intimacy that accompanied living with one person for the majority of a lifespan.

*It’s been hard, I didn’t get used to her passing very well. Not well, no. I still miss her just as much. We were married 54 years, well you know that’s a long time to be with someone, but it wasn’t long enough. We used to enjoy one another’s company (Alan).*

Several stories of widowhood referred to conversation or the lack of spontaneous small talk and the subsequent feelings of loneliness.

*Oh terrible you just feel [loneliness] as though it’s the end of the world, [I] get down sometimes mm… it just comes on sometimes and I feel terrible… I miss somebody to talk to, it’s hard to say….all sorts of things oh yeah we [spouse] had a lot in common (Tom).*

The despair of loneliness was missing the many small things that strengthened the connection participants had with their spouse.

*I think really we all have times [feeling lonely]. I think when I probably feel lonely is when something perhaps interesting has happened, and I’ve met someone of interest, and I think I must go home and tell him go and discuss it with him, and I suddenly think oh he’s not here so sometimes. I even say out loud well I hope you are listening (Lois).*

Participants highlighted the need for interaction to bring meaning to their daily experiences. The lack of communication, particularly for an extended period, created feelings of loneliness. Spontaneity was associated with the presence of a spouse and highlighted as a preventative factor against loneliness. Narrators missed this type of causal exchange.

*…It [loneliness] does catch every now and again. You see something nice and it would be great to turn around to someone and say look at that, and I suppose that’s when I feel lonely then. You don’t laugh as much, when you’re on your own. You see something funny and you think oh that’s funny, but you need someone there so you can say hey look at this…Well*
the thing I think would cause the loneliness, is the fact that you’re on your own for long periods of time (Margaret).

Conversations that took place between spouses were significant in the sense that they prevented both parties from feeling lonely. Following bereavement similar topics of discussion were not considered relevant enough to warrant contacting a less intimate person who was not in the immediate vicinity. This heightened feelings of loneliness.

It’s the lack of conversation, well not even conversation just chit chat. Some days you can go without speaking to anyone, not often just some days. And that’s a bit sad really, not having anyone to say hello to. Before my wife got ill I had somebody of course and I suppose you just get into a routine with someone you live with, but that changes and it changed even before she died. But I visited because she was so near and I talked to her, err (pause), and I talked to the carers, but when she died I had no reason to visit anymore (Hugh).

Participants referred to the notion of convenient accessibility that went hand in hand with being married; widowhood robbed the surviving spouse of convenience and spontaneity and led to feelings of loneliness.

Yes it was very [isolating when wife died]…It was quite lonely, of course, there was no one to talk to particularly in the evening which is the time when you could do with someone to talk to, especially after losing someone so close like the wife. Erm it was particularly bad in the first year after she died, because then you can see all the problems (Walter).

Loneliness was the unfamiliar quiet within a family home and the recognized permanency of this noiseless surrounding.

When I lost [my wife] when did she go, erm, that would be about (pause) five years ago, that was hard I was definitely lonely then. I didn’t manage that well, no, that was not a good time…I suppose it took at least a year just getting used to the quiet. Well that sounds like we were a loud couple, we weren’t but it just seemed much quieter when she’d gone…Yes, that’s right (pause), living on your own. I don’t think you can help it [feeling
lonely] sometimes… (Pause) The quiet room was a change, when my wife had gone. I think I knew that would never change that was permanent really, erm, so that was different (Colin).

The simplicity of presence was deceiving, and it was only with absence that its significance became clear. Stories revealed an unmet desire for lost spontaneity, and the convenient familiar presence of a late spouse. Company was both verbal and non-verbal and the mere presence of an intimate other helped to provide a distraction from isolation and loneliness. A spouse may or may not have engaged in conversation but provided background noise that was significantly noticeable when absent. Loneliness was a longing.

**Daily Routine**

Everyday routine changes were significant for the participants in terms of loneliness. Most narratives referred to the small daily events, which held great meaning for the participants as the routine invariably included their spouse. There were numerous references to the abruptness of the change in routine, the rapidity with which routine changed from busy to quiet, and more specifically the time of day.

*I felt more isolated when my wife died…The days were ok the nights were different again, because of course, I had a routine with the wife and because she had needed more and more care towards the end and so I was busy and then suddenly it was all over. So it was the quiet that really hit home, and then feeling as though I was completely by myself (Walter).*

Participants described an absence of meaningful structure to their daily routine following the death of their spouse. Time which had previously been devoted to the specifics of caring for a spouse who was unwell was in excess following bereavement and difficult to modify.

*Well since the wife died it’s been lonely. I’ve lost my routines and I find myself without a purpose, you know. You’re always looking forward to something, like going somewhere, or*
doing something, or getting something, or whatever, now there’s nothing to look forward to really. I looked after her for a good few years you see, and right at the end I was running backwards and forwards, cause she had a lot of appointments to go to as well blood tests and to the day ward and she used to have infusions for four hours at the bone marrow place. So we were just running backwards and forwards, it filled the day, and by night time I was pretty tired to say the least. I did that for three years and then when she died it just stopped. (Bob).

The relationship between the co-dependency of spousal routines and feelings of loneliness was highlighted in some of the stories. The more structured a routine, the more noticeable the loss and loneliness.

I lost my wife two and a half years ago. That was hard to adjust to that was the worst part of it… I did [feel lonely] at the start when my wife first died…I don’t think of myself as a lonely person, not until my wife died. I can’t think of any other time I’ve felt like that, even when I was a child. I’m used to just getting on with things, even when life gets hard which it does for anybody at times through life, I just used to wait for things to pass…When I lost my wife I knew that things were never going to be the same again, and that worried me because when I felt lonely I thought it would never go away. I spent a lot of time with my wife because I couldn’t drive and she had to take over a lot of things, so when she died there was a huge gap in my life (Graham).

Participants identified different times of the day with loneliness depending upon their own personal routine. The time of day may have held an associated meaning for a person in the form of comfort or conversation. Some narrators associated night time with being a particularly vulnerable time of day for loneliness.

It [loneliness] can come on any time really, night time is particularly bad of course especially if I go to sleep for an hour or two hours or something and I wake up…She was
just one lovely lady, I called her my treasure that was my nickname for her. The downside of a wonderful marriage is that you miss them so badly. We were good pals (Eric).

Others felt that afternoons and evenings exacerbated loneliness as they missed aspects of their marital routine such as the conversation.

Yes [I get] very lonely, well, I just get lonely (pause). It’s got much worse [as got older]. Afternoon and evenings I’d say, I miss talking to someone (Patrick).

Narrators identified times of their daily routine that were more significant to them. Widowhood removed a key component from the routine leaving a void that was filled by loneliness. Evenings proved particularly challenging as narrators found it difficult to distract themselves with alternative activity.

I manage alright, yes, but it’s lonely at times yes. More in the evening, I miss the company the most. We used to talk a lot and now when I am sat watching telly, on my own, I have no one to talk to. It’s not so bad during the day, especially, if it’s a good day you can garden yes (Arthur).

Loneliness was much more apparent to narrators when they felt less occupied by a specific activity or routine, and more so during the period prior to going to bed.

Ha you’d be surprised, err, a little [lonely] occasionally but I make myself throw it aside it is not a feeling that I welcome. Err I’ll get a book and make sure I concentrate on it until that feeling goes away, or I’ll find something else to do. Err the time I feel a little lonely is probably from 6.30pm, 7.30pm at night until I go to bed which would be any time from 10.30pm until 2.00am (Alistair).

Although some of the stories acknowledged a particular time of day with loneliness, narrators were quick to point out they had never experienced loneliness, which suggest that they may have been uncomfortable admitting to the experience.
It’s hard to describe [loneliness], because it’s not something I can really say I’ve experienced. I’ve never been lonely, no, my door’s always open and I get plenty of people calling in so I’m very lucky… Sometimes at night, a person can get lonely if they are awake. I read if I’m awake, so I’m not lonely or nervous (Jean).

Participants identified the small daily events that held great meaning for them, as a significant source of loneliness. Meaning was usually ascribed as the routine included their spouse. The time of the day was also highlighted as a factor which made loneliness more evident. The time of the day was highlighted as a contributory factor of loneliness, but was invariably linked to a routine that narrators had previously shared with their late spouse.

Role

When asked to recall their memories of loneliness, change of role was a topic that was mentioned by multiple participants. Loneliness was associated with practical disadvantages that stemmed from the gender role divisions that were established in the generation into which they were born.

I think that’s the difference about having a husband, they are there just like driving, you take it for granted and when they aren’t there that’s when there’s a void. It’s not as balanced life now… We have no family [children]… There were financial things that had to be attended to, and I didn’t know how to do them or what to do because [husband] belonged to the generation where women don’t need to know (Lucy).

Female participants described the anxiety associated with a complete change of role. However, for some widows there was also the necessity to return to work, which helped them negotiate the difficult time. Through the necessity to work the younger widow had greater opportunity to adapt.

Oh you know when my husband died it was hard going and I felt alone with three kids, but life kind of took over. I had to go back to work and so I had the company of the people I worked with, so I didn’t feel lonely for long when I went back to work (Margaret).
The male participants’ narratives also focused on gender roles, but generally related to culinary skills. The role of the cook in a household was linked to comfort and familiarity, and was largely a female role. Change of this significant role heightened feelings of loneliness, as it was a frequent reminder of the permanency of the narrator’s loss.

Oh it must be…erm three and a half years [since spouse passed away]…yes, yes I think it is. I miss her, erm, I don’t like cooking, and it’s funny without her. I went to the doctor and asked can we live on just bread (laughing), and he said I don’t see why not (John).

Despite an attempt at humour, the narrator projected an underlying sadness when he recalled his memory of loneliness. The lonely void left following a spouse’s death was magnified through the absence of marital roles, which were previously performed by the absent party.

I suppose when my wife died I felt very lonely and still do at times, but I think I would have felt that way if I’d been younger. I don’t cook, she did all the cooking, [and] I’d rather starve than eat my cooking (laughing). I miss her cooking. Erm it [loneliness] still gets me now it’s a long period between dinner and bedtime and it’s hard to find something to do yes (Arthur).

Interestingly the majority of the narratives were from the 85 plus age group. This suggests the longer a person had been embedded into a particular role the greater the difficulty to adjust. Narrators were frequently reminded that their significant other was missing, when they had to perform an unfamiliar role. Reminders manifested themselves through daily chores, such as finances, and cooking, but also encompassed wider issues such as gender role divisions and employment.

EMOTIONAL STORIES

Emotional stories considered the poignancy of grief, helplessness, and emotional isolation. Narratives that referred to deeply personal feelings in
response to a life event, were categorized as emotional narratives of loneliness. These stories were separated from personal narratives as they focused upon internal processes that were distinctive to the individual, rather than the particular external processes such as routine or bereavement that triggered the personal loneliness narratives. Emotional narratives include feelings of helplessness, grief, and emotional isolation.

*Helplessness*

The lack of control and isolation respondents felt, when they witnessed the trajectory of their spouses’ illness and subsequent passing, was highlighted in the narratives. Even though illness and bereavement are a common occurrence, respondents felt that their experience was peculiar to them alone and no one else truly understood what they were going through, hence the resulting loneliness.

Narrators referred to changes in their spouse’s character as a result of illness. For some narrators the loss and sense of loneliness and isolation began with their spouse’s illness, not their death.

*Yes [felt lonely] when he [husband] died. I must say I don’t hold the date in mind it’s important not when he died but because he died, that’s important to me and he had many strokes. It didn’t used to be called dementia, or so I understand, I think it was the front lobe. He had the many strokes and it wasn’t like him at all, but he did change in character (Elizabeth).*

A parasitical relationship appeared to exist between with feelings of helplessness, powerlessness and loneliness. Narrators described vividly the experience of watching someone close slip away and expressed the sense that no one fully understood what they were going through, which led to loneliness.

*Adapting here yes it took a long time, you see my husband died three years ago and from cancer and he was ill for about a year but battled on…It was an awful business watching him go downhill and not being able to do anything, there was no cure they couldn’t do*
anything it was too advanced. So then it was up to me and, erm, one thing at a time, one day at a time (Lucy).

Participants described frustration and resentment on behalf of their spouses. They were able to adjust to loneliness, however, through a process of social and temporal comparison.

I watched my wife get very unwell and sometimes I thought why her? Why not me? But now I think I have been very lucky through my life, and I don’t think I am as lonely as some people my age…(Hugh)

Other narrators had to endure a process of feeling worse, before they felt better. They experienced feelings of loneliness, which exacerbated their frustration to the point of depression. Narrators’ inability to change the situation was controlled, to a degree, through constructive activity.

It was a bloody shit [losing wife] if you pardon my language, it was bloody awful. Well I got really depressed for a while so I just kept working to keep my mind off it, it helps a little but it’s hard (Tim).

Helplessness was a recurrent topic throughout the narratives. Participants described the isolating effects of helplessness as to them it felt as though no one truly understood what they were experiencing, which led to increased loneliness.

Grief

Along with helplessness and lack of control; loneliness developed a parasitical link most prominently with grief. Participants described a void left by the death of a spouse, which was filled to a degree by feelings of grief and loneliness. Grief and loneliness were sometimes symbiotic, and were generally managed through avoidance.

About three years (since husband’s passing), but I don’t like talking about that it’s something you never get used to, I miss my husband (Jean).
Spousal bereavement was a key memory of loneliness, although the unpredictable nature of loneliness was commented upon. The feelings of loneliness ebbed and flowed, and were unpredictable in their arrival and their intensity.

*I miss my husband, we were only here for a year before he died and even though it’s nice, I do think about him a lot…Oh yes after my husband died, I used to cry, I felt so lonely…And then some days you can get a lonely feeling sweep over you out of the blue. The other day I was standing over there, washing the dishes, erm, and a tune came over the radio. It’s an old tune and I thought of my husband and I started to cry, and so it’s every now and then that it catches you, but you have to make sure that you get out and be with other people. My husband wouldn’t have wanted me to be lonely* (Huia).

The intensity of grief and loneliness meant that narrators were not always able to distinguish between the two, so entwined were the feelings. Narrators spoke of their uncertainty between feeling lonely, and grieving the death of a spouse.

*Well it was certainly lonely when my wife passed away…I don’t know whether I’d say lonely or grieving, it certainly felt lonely after my wife died I suppose. I don’t know about lonely, but it was certainly the lowest point in my life. But you see, I possibly had an apprenticeship about what was to come because my wife had a stroke so I was sole carer from then until she died* (Alan).

Common to the respondents’ stories was a sense of loneliness embedded in the process of grieving. Interestingly, whilst grief was easy to acknowledge, participants appeared to be less certain admitting to loneliness.

*Emotional Isolation*

Emotional isolation is a figurative term, related to individual perception. Narrators were not physically alone, yet described feeling isolated as a result of their circumstances which in turn increased their feelings of loneliness. Emotional isolation was encountered by some participants during their spouse’s illness. Participants described familial conflict over decisions that had to be made about
care. Narrators felt the consequences of making unpopular decisions exacerbated loneliness, as no one appeared to understand.

We only had about four or five years together before he [husband] got this dementia, but it wasn’t like that, he had a good memory he realised it was going so I nursed him at home for about eight and a half years. And then he got so bad because he didn’t talk for the last about four or five years…The family fell out with me, because they wanted to put him in to hospital…Nobody, my mother didn’t want to know and (husband’s children) didn’t want to know so I really didn’t have anybody…(Judy)

Emotional isolation was experienced along with physical isolation for some female narrators whose spouses were away at war. Participants felt lonely despite being occupied with new roles such as motherhood. The lack of desired adult interaction resulted in a loneliness that could not be assuaged by the company of a baby.

[Remembering a time when lonely] Probably the only time that stands out was when my husband was away during the war. I’d married very young and then before I knew I had a baby, and no husband because he was overseas, and I remember thinking how on earth am I going to manage. I wasn’t close to my mother so I couldn’t turn to her, and well I’ve always preferred my own company, so I kind of put all my energy into my son. Well when they are babies they don’t do much do they (Elsie).

Changes in location also led to feelings of emotional isolation. Participants explained that they felt disconnected from their friends, and lonely following a move in location. Although they had the support of whanau (family), they longed for the group affiliation that they had experienced prior to the move.

As I said before when I first moved down here it was very lonely. My whanau saved me but there were still days when I felt adrift, I couldn’t anchor myself to a group or a friend it was scary. It was so different to being up North (Heni).
Participants who identified distant memories of loneliness referred to a locational shift together with a change in family structure. The loss of an established reality resulted in a sense of emotional isolation and loneliness, despite having a husband.

_We moved to the farm, and my husband would have been about 50 at that stage, and I was in my 40s. Some of the children were grown up, and my daughter was away, and two of the boys were at college…and then one moved to England (Lois)._}

Each of these narratives described a change that may not have left the respondent physically isolated, but removed them from a sense of familiarity and induced a feeling of emotional isolation, which in turn created a memory of loneliness.

**SOCIAL STORIES**

Social stories referred to decreased social circles following widowhood, the issue of loneliness in the company of others, and the notion of isolation versus solitude. Participants’ stories described the perceived change in friendships and networks since widowhood, and the relationship with loneliness. The element of choices featured heavily with regard to social support, and engagements. Stories that referred to the social component of loneliness made reference to decreased social circles, isolation versus solitude, and the feeling of being lonely but not alone.

*Decreased Social Circles*

During spousal illness or following widowhood some participants experienced a reduction to their social circles. They also described a void that exacerbated feelings of social remoteness and loneliness. The absence of friends was considered, by some narrators, a sign of loneliness in others and viewed with a degree of pity.
For me a lonely person is someone who is missing friends…I think people who find it hard
to keep in touch with friends are probably lonely…There’s one woman here and somebody
said to me have you ever seen friends at her place and you know I haven’t, and I think people
like that are lonely. She would be one that I would say should be lonely, but then she’s got
other interests and she might like being alone (Alison).

For some narrators the decline in social contact they experienced during their
spouse’s illness, was gradual. Narrator’s described difficulty re-establishing social
connections with others following the death of their spouse.

I managed for a good eight years at home, but that stemmed [led] to me not going to bowls.
Before he [husband] got sick I was going to bowls, I was in a singing group, I even did
music halls on the stage, erm, because it was mainly with people I didn’t know, erm, but
then I had this isolation. Oh about six or seven years I’ve stayed in it, when he died and, I
haven’t been able to go back to bowls. It’s very hard when you leave something for a long
time to go back, I find, to the people that you knew. Erm, so what I’ve done is stayed in my
isolation…I’m in the same hole as I was when he was sick, so that’s where a bit of loneliness
comes in and the social phobia has got a bit worse (Judy).

Narrators also described how they disengaged fully from the social scene,
following widowhood. They considered their social group to be made up of their
late spouse’s friends, and without their spouse they felt incomplete and somewhat
alienated, which in turn caused them to feel lonely.

They were all his friends you see, that’s a part of my life that’s very wrong because I’m here
now on my own and erm I don’t have any friends to come and see me…He was the one who
sort of made friends and very easily you know where as I didn’t, well I had lots of friends
but I haven’t seen my friends now for years. We went…everywhere together. We did
everything together, really we liked it. I mean we didn’t do it because we had to or he had
to, we just loved each other’s company (Rose).
Several stories touched upon the notion of a diminishing social community, or the feeling of restrictions especially in relation to death and finances. The death of significant others or confidantes impacted upon narrators’ opportunity to interact, and created a perception of excess time.

A little [lonely] probably. I mean people you know and care about die, and that’s just part of life, and children grow up so things change but generally I have a supportive family and good friends. But I definitely have more time on my own now, and it’s the times when I have too much time that I feel lonely. I’m not sure what to do or where to go and I’m always used to planning and organising (Bob).

Narrators felt their social world was also restricted by their financial income, which was greatly decreased following widowhood, as they did not have access to a combined income.

Mine [social world] is closing down and I think that’s what loneliness is, as well not having the money to go out and do the things you want to do because it’s too expensive (Heni).

Narrators identified decreased social circles as a source and meaning of loneliness. Decreased social circles equated to a decline in opportunities for social interaction, and were linked to widowhood and financial restriction.

Sense of Isolation versus Solitude

When contemplating the meaning of loneliness, narrators alluded to isolation versus solitude. Most stories described isolation as enforced, whereas solitude was optional.

Wellfunnily enough, I associate loneliness with being isolated which is different than being alone. I can choose to be alone be in my own company and when I’m busy with my cine films I like solitude because I can concentrate, isolation is different and that’s when I feel lonely (Walter).
The difference between loneliness and being alone was largely a matter of having the ability to choose to have company or not. Narrators equated the restriction of choices to feelings of loneliness.

I think that’s just it really, if nobody came I would be alone but feel dreadfully alone and that’s just awful. I am alone now or rather I live alone, but I’m not lonely because I have so many friends and family around me who like visiting and coming to see me (Alison).

A sense of restriction was imposed primarily through widowhood, but also by innocuous events such as weather. Narrators felt lonelier on winter days, as this restricted the number of people they encountered when out walking.

I hate the dark and you never seem to see the light and that’s when I feel lonely. I don’t think its depression, I miss talking to people in the park. As long as the sun’s out I’m happy, you can talk to people, but when the weather’s bad there doesn’t seem to be many about or they don’t stop and talk and it’s cold (Elsie).

Days of the week also impacted upon loneliness for some narrators, as certain days, particularly weekend days, gave participants the impression of having no control over social interactions.

Erm Sundays can be a bit lonely, well you go to church in a morning and we stay and have a cup of tea after church but, well I don’t always find it [helpful], but on some occasions I’ve just thought well there’s nobody around (Lois).

Narrators felt dependent upon other people’s routines as social interactions were to a large extent based upon other people. This reinforced a sense of confinement and loneliness.

Well I do at times[feel lonely], because of course you can imagine the trouble around here is you’re in an area that is made up of elderly people ...In the winter they can’t go out very much…It makes it a very lonely place to be around here in the winter. You hardly see anybody...So it’s awfully quiet around here at times. I never thought it would be like this
when we bought the unit, I thought that your neighbours would just be there, but of course I never planned that they would only be there part of the year because that’s something you don’t think about or I didn’t (Hugh).

Some of the narratives also reinforced the notion of vulnerability, which increased feelings of isolation and powerlessness to change the situation. I’m an older woman, but I don’t feel old and I still like to meet new people. But you can certainly tell the different generations when it comes to respect, I’ve never encountered that before now… I think it’s a sense of not belonging, not feeling akin to people, to your whanau. I think it’s much more than people not being nearby. I think loneliness is losing your people from your heart…I think sometimes I get very lonely because I’ve always been used to having people around me, like in the Marae… So when things change and I don’t know people, or people don’t seem as friendly, that’s when I notice what I’d call loneliness… (Heni).

Participants felt that loneliness was linked to enforced isolation, which arose when choices were removed or limited. The lack of consistency and control of access to other people increased narrators’ sense of restriction and dependence, especially following widowhood. In contrast, solitude was a conscious decision to spend time alone.

Lonely but not alone

An alternative social meaning of loneliness, which was the opposite of isolation but as equally troubling, was the loneliness participants felt despite having access to others. This usually applied to the relationship between widowhood and the role of families, friends and acquaintances.

Narrators acknowledged the conflict they felt over missing their late spouse, despite the presence of families which did not ease the sense of loss. Participants were unsure if this constituted as loneliness.
I do think that you can feel not so much lonely as missing your partner that’s gone. Your children are there, but they have a different role. I mean they’ll advise me and help and this sort of thing and support me, but it’s still not the same (Lois).

Narrators talked about the loneliness they felt when with groups of unfamiliar people. The group’s supportive role was acknowledged, but the experience was still daunting and at times alienating.

I mean if you are lonely… if you are able you can get out and there are plenty of clubs to join, but even then you can be very lonely in a group or if you’re going to a meeting on your own…I think it can be very difficult for people joining a group unless they have got somebody with them, and then you find little groups of people within groups you know cliques…I’ve felt lonely because I haven’t known anyone there and nobody spoke to me. So I know when I’ve met other people in the past at the hospital I used to work at you can’t just fix someone quickly if they are lonely, it takes time to get know people, erm yes, I think that can be a problem (Ruth).

Participants described feeling lonely, despite being surrounded by other people including families. Loneliness was specific to widowhood and the loss of a significant other. This created a sense of conflict for narrators who recognized the need for interaction, yet did not always find a reprieve from feeling lonely when amongst other people.

FUNCTIONAL STORIES

Functional stories described the practical impact of key life events other than widowhood, and the relationship to loneliness in terms of physical isolation. Practical changes to a familiar lifestyle were linked to loneliness. The physical separation from a significant other, through a key life event, was described as a memory of loneliness by multiple narrators.
Physical Isolation

Physical isolation refers to the actual state of being alone, a concrete experience. The narrators described experiences of physical isolation, where they were logistically apart from significant others. These incidents appear to have occurred mostly in childhood, or young adulthood, and impressed a memory of loneliness. Separation from parents, and lack of interaction, formed the basis of some of the loneliness narratives and suggested feelings of abandonment.

*Oh yes [feeling lonely], I think it goes right back to when I was a child. I had diphtheria. I was about seven and I think I had my eighth birthday, and roughly about that age and err, I was in hospital for I think about six months and I can remember being there and nobody talked to me… I was the only one person in that ward because it was isolation and I saw my parents once… (Isobel)*

Separation from siblings, secondary to an age gap, was also described as a memory of loneliness. This was probably quite normal, but from a child’s point of view the sense of abandonment seemed quite profound.

*When I was a youngster my two brothers being 10 or 11 years older than me…they never seemed to be there when I was young. We had a long garden and I can remember feeling so lonely, I so desperately wanted some friends and I used to invent people to play up and down the garden with on my tricycle, so there was that time (Walter).*

Participants described early adulthood and how they replaced existing familial relationships with new relationships such as marriage. Some couples had separate commitments and narrators found the process of adaptation to the new living arrangements lonely. They moved from the familiar relationships they had known to the unfamiliar, and had difficulty adjusting to the new circumstances.

*…When I was younger I was quite lonely, my husband was doing his thing and to a large extent I was doing mine but that’s ok. I found it, erm, there were patches of loneliness but I just worked through them (Lucy).*
The notion of familiar and unfamiliar is repeated throughout several of the narratives. Participants emphasized the isolative nature of their work, and how they felt physically removed from the familiarity of the noisy interaction of the family.

Oh I suppose I was [lonely] years ago when I was driving a bulldozer, in the back of beyond that was a pretty lonely job day in day out. I used to dig lime out, lime rock and crush it. It was pretty lonely, but I had a family to come home to and I think that was why it might have felt lonely because it was always a busy household very noisy (Colin).

The impact of perceived segregation and loneliness was highlighted, not only through work and marriage but also emigration as some narrators had moved away from their native home. They described the physically isolating effects of the language barrier, and the loneliness associated with a departure from the norm.

[Remembering a time when lonely] I got married and we moved to Indonesia. That was hard at first, we were limited with language, and we could only talk to each other. We picked words up. When we moved to New Zealand we learned a lot of English from the local children, it wasn’t as bad as making a mistake in front of an adult (John).

Each of the narratives pertaining to physical isolation describes a sense of logistical separation, and limited meaningful social contact, significant enough to have formed a memory of loneliness in the narrator.

CONCLUSION

The collective story was developed from the narratives of 40 participants. The apperception of loneliness through context based life events is the first chapter of the story. The story highlighted the complexity and subjectivity of loneliness, through meaning and memory, in relation to widowhood. Respondents’ narratives revealed through the key life event of widowhood that whilst loneliness commenced with a past event or change to an established lifestyle, it was the meaning ascribed to and subsequent memory of the event that determined
loneliness. For the purpose of clarity the narratives were subdivided into four categories: personal (spousal illness and bereavement, convenient contact, daily routine and role), emotional (helplessness, grief, emotional isolation), social (decreased social circle, lonely but not alone, isolation versus solitude), and functional (physical isolation). The impact of gender was particularly noticeable in the personal stories relating to role. Male participants commented on missing the familiarity of their wives cooking which, in turn, highlighted a deviation from a familiar routine and person and lead to feelings of loneliness.
CHAPTER FIVE – FINDINGS


Chapter four retold the narrators’ stories of their personal memories of loneliness. Through context based life events, namely widowhood, loneliness was identified and ascribed meaning. The stories identified the subjectivity of loneliness, as it was the degree of meaning ascribed to the event that influenced loneliness not the event itself. The retelling of the stories revealed the unpredictability of loneliness, an unsolicited feeling, the duration of which was indeterminate. Chapter five covers the central component of the collective story. The main body of the story focused upon the actual experience of loneliness, and what it meant to the narrators. Narrators described circumstances that further influenced the intensity of loneliness, as they renegotiated their self-identity following widowhood. The main factors that influenced the experience of loneliness were the personal impact of the ageing process and the perception of societal expectations of older people. Throughout this chapter reference will be made to key gerontological concepts. At the point of reference a definition will be provided to clarify the meaning and context in relation to this study of loneliness.

These factors were identified within the participants’ stories. For the purpose of clarity this chapter has been divided into two sections. The first tells the stories of ageing and the relationship to loneliness. The subheadings describe elements related to the personal impact of the ageing process. The second section covers the canonical stories that related to society’s view of ageing and how this influenced the narrators’ perception of loneliness. Again the subheadings describe the different ways in which old age is portrayed within contemporary New Zealand society.
It is important to note the relationship between these two factors in terms of the micro and macro sociological theory, as this explains the need for the two sections within this chapter. Crothers (2013, p.9) defines micro level relationships as the “interactional order in which people face each other in sequences of social situations.” Narrators used a micro perspective from which to deliver their stories of widowhood, ageing, and loneliness as the stories were particular to their own personal experiences and the impact ageing had upon everyday social interactions. Alternatively, when narrators described their perception of societal expectations they used social comparison as a means of understanding self in the context of the wider community, and adopted a macro perspective of widowhood, ageing and loneliness. Crothers (2013, p.9) defines macro level relationships as “the broader web of enduring and larger scale relationships which bind social entities together.”

AGEING AND LONELINESS

Ageing, like bereavement, is a natural event that all living beings encounter. The process of ageing can be modified through such things as good health and positive well-being. For some narrators, however, the ultimate sense of impermanence served as a constant reminder that loneliness was only another loss away. In order to sustain narratives, participants were asked ‘Has your experience of loneliness changed at all with age?’ The prompt question elicited a steady stream of narrative, pertaining to ageing and loneliness. In an effort to make sense of the stories, whilst maintaining authentic interpretation, five topic areas were developed. These five topics were; sense of being a burden, changing health, outliving social networks, driving (access to transport), independence and choice (financial restriction).

Sense of Being a Burden

The dread of becoming a burden to friends, family or acquaintances, was a topic raised by participants. Avoidance was the link between this form of anxiety and loneliness, as narrators would rather forego what they needed or required than
ask for or accept assistance. The inability to complete tasks as a result of bereavement, or ageing, was demoralising and resulted in feelings of isolation and loneliness. Narrators described a sense of shame with regard to the need for assistance, as there was a potential for dependency.

*I mean you have friends, but you can’t dwell on them forever. And there’s a nice man up the road…He said now ring me anytime you know, but that I mean he’s got his problems now…you can’t call on people like that, because you’re blaming yourself. You’re getting older and might become a burden on somebody* (Daphne).

Widows in particular appeared conscious of the additional obligations that people had in their lives, and the effect their need for help would have on others. Intriguingly offers of help were interpreted as being pity driven, rather than genuine.

*My friends’ husbands used to come around and say look if there’s anything you want done any rubbish taken away we’re happy to help, you know, and I’ve asked on the odd occasion and it’s been no trouble but I don’t ask if I can help it. I don’t want to intrude too much…people are working longer retiring later, so people who you think you could rely on you can’t always because they have other obligations* (Alison).

The sense of burden surrounding moral duty was also applied to familial obligation. Narrators were mindful of their demands upon their children. Despite children volunteering their time, these offers were refused and replaced instead with paid labour. This may have enabled participants to retain a degree of control.

*He (son) was mowing the lawn as well but I’ve stopped him doing that, I get the gardener in to do it, because it’s just too much so that’s sort of where we are at I suppose now* (Rose).

The notion of pride and sense of independence featured in several of the narratives, relating to burden. Participants described a feeling of dependence if they were unable to function to a level they desired. Although there was no
evidence to support the belief of burden, such worries created a potential for avoidance that in turn increased the risk of isolation and ultimately loneliness.

Oh it’s how I feel not other people, I’m quite sure that they all love me very much. I’m used to being independent, so my sight and hearing loss are difficult. Even bus drivers when I’m getting off buses are very careful to watch me getting off the bus and on to the paving…Generally speaking I’m a fairly positive sort of person. I want to…be around without being a damned nuisance to other people and myself as well (Eric).

Enforced reliance upon others, through functional decline, was detrimental for individuals despite the willing offers of assistance. Participants felt confined by their situations, as their health left them with no alternative but to accept help, which exacerbated the sense of burden and loneliness.

Well that’s it you see, when I could get out and hop on a bus and that sort of thing I didn’t mind as much. But now I can’t even get on a bus and I have to rely on other people, and other than family coming to see me there isn’t really anyone and, that’s very frustrating (Eunice).

Physical limitation created a power imbalance within interpersonal relationships. Relationships were perceived as one sided, rather than reciprocal. Participants felt that their functional decline changed them from an equal to a dependent, which lead to an increased sense of being a burden.

I am very limited with my mobility…I have my friends who will take me out if I want to go, I don’t like to be a burden to them though, if they offer I usually accept but I wouldn’t trouble them because then the friendship is not a friendship it’s an obligation (Alistair).

Widowhood highlighted a sense of dependency, as most long-standing marriages were built around implicit mutual support. The sudden need to ask for assistance left some bereaved spouses feeling as though they were a burden. The need to ask for assistance was a trigger for loneliness, as it reminded participants of widowhood and drew attention to aloneness.
Oh yes I can’t do as much for myself and I need to ask for help and when you haven’t got someone to hand that’s when you feel lonely (Huia).

Participants’ sense of pride exacerbated the shame of becoming a burden to friends, families, or acquaintances. The sense of shame shaped how participants perceived offers of help, and led to the refusal of genuine offers that were interpreted as pity driven. Narrators would rather forego what they needed, or required, than ask for or accept assistance. Such avoidance, combined with an uncompromising need for assistance, reignited feelings of loneliness and aloneness.

**Changes in Health**

The significance of health was a prominent topic in the narratives and filters through the chapter as a whole. These narrative fragments have been selected specifically, as narrators commented on the negative aspects of health and ageing. The restrictive nature of poor health appeared to highlight a sense of isolation and limited opportunities for distraction. This, combined with the absence of their spouse, exacerbated feelings of loneliness.

Some stories conveyed a feeling of longing and alienation. Participants described their observations of strangers. Active older people, in particular, were a source of comparison that highlighted health deficits and resulted in longing and loneliness.

*I watch the ladies walking past...It’s a pretty street to live in and I’ve noticed they are out walking tremendously, and they’re filling in their day and getting a little bit of fresh air I think. But I’ve got a bad leg so I can’t walk too far* (Daphne).

Widows and widowers felt the negative aspects of living alone when they were unable to partake in social activities as a result of their changing health. Their own personal health changes plus those experienced by friends, restricted opportunities for socialization.
Course a lot of them [friends] can’t [get out to socialise], lot of them can’t drive the car up the hill, others can’t walk up the hill and I can’t walk down the hill at the moment. I’m quite slow in the morning…the asthma does slow me down in a morning (Rose).

Limited social interaction was not the only problem participants’ encountered. Individual activity was also curtailed by deteriorating functioning.

I did gardening right up until last year, but I can’t do it anymore. If I get down on my hands and knees I have a terrible job getting up again (Tom).

For some narrators there was a direct connection between health status and levels of loneliness. Participants felt more vulnerable during times of illness, particularly when they were unable to participate in hobbies. These times of vulnerability accentuated the implicit support which was previously provided by a deceased spouse.

When you’re unwell that’s when you are a bit I feel [lonely] but there’s good support around I got a lot of friends well I haven’t got a lot of friends but the ones I got are good…Erm I played [bowls] pretty heavily for a while, till I had two lots of heart surgery (David).

Despite the negative health changes which were related to ageing, several participants emphasised the need to persevere and to remain as active as possible. The stories conveyed the view that it was better to be selective and discontinue some hobbies or activities, rather than stopping the majority. Narrators felt discontinuing all hobbies could make an individual prone to loneliness.

I think there are more chances of being lonely if you stop doing a lot, so I make an effort to keep some interests going just not as many…I have a walking stick now, a little bit of support. I can’t do as much but then I can get by on what I can do (Rita).

For some participants life challenges were met with an outlook of purpose, in the face of adversity. They resigned themselves to the fact that their health was not good, but if they proceeded slowly they could still engage in certain activities.
It’s not good [sight] but I plod on. It slows me down erm. I take a [reading] glass with me and it’s good that I’ve got it but I have to read things a word at a time, with a bigger glass I can get three words at a time but I have been a reader all my life use my eyes a lot but never mind…My hearing isn’t all that wonderful either… (Eric).

By making an attempt to focus upon the positive attributes of health, participants’ were able to actively participate in some level of activity. Narrators contemplated their health strengths and weaknesses, and remained involved despite having to contend with deteriorating physical health.

I like to be involved, my head is fine, my feet are fine, everything in between is a bit ropey (laughing). I’ve lost the flexibility in my spine and I do regret that I can’t walk as I used to. I’m quite disabled with it, it’s [spine] deteriorating always and of course I’ve abused it over the years (Elizabeth).

At times narrators found their personal health circumstances frustrating, despite attempts to stay positive. This frustration was linked to their perceived inability to be independent, and highlighted functional deficits as well as the absence of their spouse. Participants found their levels of tolerance lessened with age. They may previously have found solace in their spouse, as a person to vent to or a person to accept help from.

I think I’m more impatient now when things go wrong. If I can’t do things I get a bit cross you know. Frustrated really. With me it’s a balance thing…I think my mobility is worse and when it goes it’s frustrating, but it’s not really stopped me from doing things (Isobel).

Narrators commented on the significance of their changing health, with regard to senses and mobility, and that of the people around them. Again these perceived deficits drew attention to loneliness. The parasitical nature of loneliness was evident as it appeared with limitation, deteriorating health, and widowhood.
I’ve got a really good neighbour at the back she’s great so if I ever really want anything she’s always there. But she doesn’t have a car either so you know we are limited. I can walk up the street. I can’t walk very far; my arms and legs get a bit tired (Eunice).

Participants’ viewed ageing as both a positive and negative experience. This is significant as perception of ageing affected the degree to which narrators felt they had control over their lives. Some participants saw ageing as a process of adaptation. Possibly as a result of this approach, their reaction to changing health did not appear as distressing as some of the other narratives.

I used to like reading as well but lately I’ve had to resort to magazines and large print because my eyes are getting worse. Well that’s an ageing thing. I might not make quite a good job of things or it may take me a bit longer but I still do things (laughing). You have to accept the inevitable you can’t fight everything (Diana).

For those participants who found the ageing process challenging, the experience was much more negative and they felt their options were restricted. Ageing was viewed as a series of losses, secondary to health changes. This seemingly pessimistic view of ageing and health appeared to dominate participants’ entire outlook towards pastimes and activities. Understandably, such negative thinking can increase the risk for loneliness.

I find it difficult now[meeting people] because I’ve got bronchiectasis, so my breathings awful…I used to be in a singing group and I loved it, and the lady in charge said to me well you’ll have to stop because you don’t sing loud…Lots of people don’t like me anymore because I can’t walk fast. I was in a walking group and they got impatient because I couldn’t keep up. I went to exercises and had to give those up, all this since Christmas time…I suppose it’s different because I’m older and I can’t always depend on being able to do things, or see people, when I want to (pause)…I don’t know if it’s loneliness because I miss people when they aren’t here, but I’m tired when they are…I can’t do things as much as I used to. I used to go to cards and I don’t do that now my concentration, you see, I’m not very good
at it I’d much rather sit at home and do gardening. I love gardening, I love it, but I can only do a bit because I keep falling over (Alice).

The health restrictions associated with certain age related diseases can certainly narrow the range of activities available to older people. Participants talked about the need to replace activities they had stopped as a result of age related health changes, with other pastimes that kept them busy and involved.

I used to play bridge, but I don’t anymore because my back was aching, and I’ve had to stop. Probus seats are too hard…I used to love sewing but I can’t do that anymore because of my hands, I believe its arthritis. They get stiff and very cold. But I enjoy going to the library for my books. And I keep in touch with friends and family. I do a lot of things on the phone (Jean).

Participants acknowledged that they would have liked to participate in certain pastimes that were unavailable to them because of their health. This in turn had the potential to create loneliness. Narrators also commented on types of health conditions that impacted on communication, which they felt could lead to a reduction of existing pastimes, diminished networks and loneliness. There was an element of fear of developing these conditions.

My health does impact upon what I can do… I would have joined the walking group otherwise…I think health may have something to do with it [loneliness] otherwise people would go out and do a lot more things, well some would, maybe the ones who’ve been able to do things and then can’t that would be hard going. You’d miss it [routine] more if you were used to doing something…I think people who find it hard to keep in touch with friends are probably lonely. I don’t know what I’d do without the telephone, and can you imagine what it would be like to deaf and, I’ve several friends who’ve become hard of hearing as they’ve got older but their families have got them hearing aids…Some people may not have that luxury though, and their lives get so small and involved only in themselves… (Alison).
The process of adjustment to age related health changes was difficult for some participants, particularly those with multiple losses. Narrators referred to the need for flexibility, and for living life in the moment.

"I have to go with the way I feel, and at the present moment I’m feeling frustrated because last December I had a cataract done… I still have slight vision in my other eye but it’s like looking through a mist… I can’t read for very long, so that restricts some of my leisure, I still read but I can’t read for long… I suppose you know as we grow older we find one by one by one our ability, our thinking, other people’s regard for us, changes. It’s like death by a thousand cuts, you know, I mean it’s not quick but you are losing things one by one by one or that is how it feels a little bit at a time you adjust to one thing and then along comes another (Lucy).

Age related hearing loss was a specific health condition participants found hard to adjust to. The potential for embarrassment lead participants to avoid conversation. The reduced opportunity for socialization, combined with widowhood, left individuals isolated and more susceptible to loneliness.

"Well we do keep in contact over the phone, but it’s a bit hard because of my hearing, it’s hard to hear on the phone now err. I had my hearing aids updated just a while ago, but they are still not quite right and it’s hard to listen and concentrate on what people are saying on the phone. You don’t like to ask them to repeat things… I find it a wee bit difficult at times, it’s ok if somebody speaks slowly and clearly that’s quite good but anyone who talks quick well I get a bit tangled up. So I don’t bother having conversations as much. Sometimes I’d like to talk to someone about something I’ve read in the paper, but like I said the conversation gets tangled up and it’s too hard so it is a bit bothersome (Jack).

Both hearing and sight loss curtailed activity, and left older participants feeling cut off from their social world. The degree to which health losses impacted upon narrators lives was not always appreciated and sometimes dismissed as a natural consequence of ageing.
My health is a problem, my sight and my hearing and the falls, that limits what I can do and my daughter always says people like my doctor don’t realise the impact this has upon me. It is hard, I do less and I know I do less, but I’m not sure what I can do about it unless they fix my eyes and ears. The falls are from my low blood pressure and they haven’t been as bad since I stopped the blood pressure tablets, but I am more careful I don’t want to end up in a home and I’m frightened about that (Graham).

For male participants in particular, musculoskeletal degeneration had a significant impact upon their pastimes and their control over feelings of loneliness. Narrators found it challenging adjusting to a loss of physical function. As they aged they found difficulty undertaking tasks they had previously been able to complete. The pastimes that were lost to health decline may have formed part of a repertoire of activity which helped to prevent loneliness.

I have trouble with the knees, getting up and down to do anything now, there’s always a danger I’m going to fall over so you have to slow down. That’s probably what you said before about loneliness changing with age, I’m probably lonelier now because I can’t do all the things I used to do (Walter).

The decline in health and function was a surprise for some participants. This was particularly so for those participants who enjoyed a reasonable level of fitness into old age. Deteriorating health wasn’t given much thought until it started to happen. The narratives gave the impression that narrators had a sudden revelation of their own frailty and mortality. With this revelation came a feeling of loneliness, as they could no longer do the things they had taken for granted for so long.

Oh yes without a doubt [feel lonelier as getting older]. I have always been quite fit right up until the last few years and it’s not something I really thought about until it started to get worse and I haven’t been able to walk. I was walking for about two hours a day until this heart problem started, so it’s a huge change and it wasn’t gradual it just seemed to happen very quickly… I feel much older and, how would I describe it, frail. This heart business has
knocked me sideways and it has stopped me doing things and I am lonelier, as to whether I am lonelier than others I’m not sure, I think I have done pretty well staying at home (William).

The failure of a body that had previously proved dependable, and the threat to personal independence, was a shock for some of the participants. Narrators no longer recognised their own body, which was unfamiliar to them, due to the sudden change in functioning. For older male participants, a sense of independence was integral to their view of masculinity. Merely looking at the garden they used to tend to was not enough to remove feelings of dependence or distract them from their loneliness.

*My legs are not reliable. I can get down but not up. I used to garden a lot more. I still have kale in the garden and potatoes…I like to look at it, but it’s not the same as digging in it yourself. It used to keep me busy but not now… (John).*

The comparison between past and current functioning left some of the participants’ feeling despondent with the ageing process and the challenges it brought with it.

*I do less than I used to. I get pain in my hips and it slows me down, stops me walking far. I used to love walking, I can’t walk far now…I get out of breath very easily. I still get things done but it’s much harder… (Patrick).*

Participants described a form of separation between themselves and the activities they once did. They felt age related health conditions had robbed them of the activities they used to enjoy in their youth.

*My health means I have to consider what I do differently and that can sometimes be lonely because my independence is challenged, err, it’s a fleeting feeling but I certainly notice it more now I’m older than when I was a younger man and could roam around the country and not think anything of it (Alistair).*
Changing health was a key topic in the stories participants told about ageing and loneliness. Personal health changes relating to sight, hearing, and breathing restricted the degree of control narrators felt they had over their lives. Participants’ health decline removed them from the familiarity of routine, as some narrators were no longer able to complete functional and social activities because of health. Poor health also limited opportunities for distraction and highlighted the impact of widowhood. Such changes, combined with the absence of their spouse, added to the overwhelming sense of loss and exacerbated feelings of loneliness for participants.

*Driving (access to transport)*

One of the more prominent topics to emerge, from the ageing and loneliness component of the stories, was that of driving. Participants’ stories highlighted the significance of driving, particularly after they encountered a deterioration in their health. At the point of cessation or soon after, participants’ recognised the important contribution driving had made to their social and functional lives particularly in rural areas where public transport can be an issue. The void left by driving cessation was reminiscent of the stories narrators told that described the pending or sudden loss of their spouses.

The ability to drive was defined as a connection to the outside world. It was also a skill that participants’ prided themselves on, and sometimes took for granted. Driving was embedded into narrators’ lives so much so, it wasn’t until they lost the skill that they realised its social and functional value. For some, the loss of driving was comparable to losing the function of a body part.

*I used to use the car a lot, I got my licence in 1939, you know. Yes that’s right, I do miss it. I think it’s a connection to the world it’s part of you, it becomes automatic, you don’t realise until it’s gone, it’s like losing an arm or a leg. Well I’m afraid I used to take it for granted (Lucy).*
Deteriorating health, secondary to ageing, was the main reason for driving cessation. Driving was perceived as a vital part of daily living, to the extent that narrators put off making the decision to stop driving for as long as possible, despite being in pain.

…I had this cellulitis in both legs, and my doctor he’s kept me alive well you know he really did, it scolds like a burn and oh it is painful…I gave up the driving when I was 93, no, I don’t drive now you see because my knee was broken and it’s got arthritis… (Joan).

The decision to stop driving took time, and was a drawn out process similar to a grieving process. Participants admitted that their deteriorated health meant they should probably have stopped driving at an earlier date. The decision was difficult, however, as the inability to drive further restricted activity.

I stopped when my eyes had gone. I stopped when I reached 88. I probably should have stopped a bit earlier, but I still had my licence. I didn’t though. When I reached 88 that’s when I was due to have another test…I certainly can’t do as much as I would like to my sight is very hazy…it’s very trying (Eric).

For other participants the decision to stop driving was so overwhelming, they left the final outcome to fate. GP intervention, in the form of driving test referrals, caused some narrators to let their licence lapse rather than face test conditions. Driving cessation led to feelings of regret, as narrators felt limited and lonelier without spontaneous access to transport.

I haven’t got the car now and at the time it conked out I had to have a medical you know. And I asked the doctor if I could still drive and he said well he wouldn’t say no but he would send me to town to have a test, but I didn’t have a car so I let it slide. I wish now I hadn’t. I do miss driving. It is lonelier because you can’t just go out like you can when you have a car. You can pick and choose what to do, who to see, how long to take but not anymore (Eunice).
Participants’ stories relayed the adjustment process they went through after they stopped driving. The accounts were not dissimilar to the functional changes described in their widowhood stories. Some narrators recalled the amount of time since they stopped driving, in a similar fashion to the way they recalled the anniversary of a spouse’s death.

*I can’t get to the next town by myself, I don’t drive anymore. It’s been three years. I had to stop because of my eye sight. It restricts you not being able to drive, but people are very kind and will take you places* (Jean).

Participants referred to the impact a sudden change in functioning had upon their lifestyle particularly driving. Even temporary changes made life harder, in terms of planning.

*It’s a bit harder now because I can’t drive I collapsed you know so I can’t drive for a month, so that’s put a bit of a spoke in the wheel. I got a pacemaker fitted when I fell into the bushes* (Arthur).

Those participants that could still drive were especially grateful and acknowledged the important role this skill played in their lives. Driving was described as a link to civilisation. Feelings of gratitude appeared to minimise susceptibility to loneliness.

*I’m still able to drive thank goodness, that’s a lifeline. I could do with a new one but I’m not complaining I can get out. I guess it’s learning to slow down that’s hard, I don’t mean driving, I mean the amount of things I used to do* (Walter).

Driving or access to transport played a key role in narrators’ ability to function, and connect to the outside world, this was particularly evident in the stories from rural participants. Stories highlighted the deviation from routine, in a rural area a car was featured heavily in a number of daily routines. Declining health and functioning, secondary to ageing, compromised participants’ ability to continue driving. When faced with cessation, the significance of the driving role appeared
to increase. Narrators’ stories described the impact of driving cessation, and were not dissimilar to the stories told about grieving and losing a significant other. Loneliness was associated with the loss of convenient access to transport and spontaneity.

**Outliving Social Network**

When participants told their stories about ageing and loneliness, they included their experiences of friends’ deaths. There was a noticeable difference between narrators’ stories of widowhood, compared with the death of a friend. Widowhood is accepted within most societies as a major life altering event; all participants described their own personal experience as such. Outliving ones social networks generated feelings of being left behind. Each loss reinforced impending mortality. The impact of diminishing social networks was poignant. Stories gave the impression of a shrinking social world, over which narrators had little control. This in turn impacted upon feelings of loneliness.

...*I don’t know you slow up a bit… yes that’s what happens, one by one [friends], they drop off I’ll say* (Tom).

Whilst widowhood was experienced only once by the majority of participants, the loss associated with the deaths of friends was experienced multiple times. This repeated bereavement was likened to a life sentence that had to be endured.

*Many of them have passed away. I’m 90 in May, perhaps that’s a penalty for me. I sometimes wonder what on earth am I doing here, have I been condemned to live. I usually push those thoughts away to one side though, because it’s negative* (Eric).

Participants commented upon the disorder that death brought into their lives. Narrators remarked upon the number of people they had known, and the lack of control they had over their passing. For some, faith kept loneliness at bay.
Well, all those people on that photo [on lounge wall] they are gone now, well nearly all of them. The flower girl is still alive and my best man, but the others have passed on. He [best man] and I are the last two of the men, (sigh), so I’m starting to feel that I’m the last of the Mohicans. Yes, the wife has gone and my friends are dwindling. It’s a very peculiar situation that you don’t really understand until you are going through it…To a degree, it’s the sense that you have no real control over who you are going to lose next. I make the most of the friends I have left, (laughing), even though I wouldn’t have necessarily chosen them to go in that order. You slowly go down in the number of people you know…. Now I find myself getting older and losing family and friends, yet I don’t feel lonely I find my strength through my faith (Joe).

Despite death being a natural consequence of life, and change being a part of the life course, the adjustment process brought with it feelings of loneliness for several participants. Time was viewed as an excess, rather than a luxury.

A little [lonely] probably, I mean people you know and care about die and that’s just part of life…I definitely have more time on my own now, and it’s the times when I have too much time that I feel lonely I’m not sure what to do or where to go (Bob).

Narrators commented upon the changes to the size and composition of their social networks. They felt their world was shrinking as they aged, as the people they had previously had things in common were unavailable.

Oh you know your world seems to shrink, well not your world, the amount of people you know drops off…You know as you get older people drop off and eventually I couldn’t find anybody to play with, so it was a bit of a pain most of the folks I took up golf with moved on or got sick (Margaret).

Compositional changes to social networks occurred as a direct result of widowhood, and because of ageing. Participants noted the difference in the group of friends they had whilst their spouses were alive, compared with the ones they
had at the time of interview. The dynamic nature of social networks was commented upon.

*It’s strange, I seem to be developing friends or acquaintances totally different to those that I knew when my husband was alive. I suppose it’s the difference in age, and I belong to all sorts of organisations, and I found I’ve outlived a lot of my friends and err a couple died the other week* (Lucy).

A further age related concern was the problem of lost opportunities, secondary to diminishing social networks. Narrators worried that they would not be able to continue the activities they enjoyed, if there was no one available to enjoy them with. Also participants felt the opportunities they had available to them throughout youth and middle age were limited as they aged, particularly with regard to meeting new people.

*I worry about that sometimes that I won’t be able to do what I have always done, not a lot, but it is a thought that crosses my mind. I’m not sure what I would do if I couldn’t keep busy…I do go to different things here and I’ve made quite a few friends. I used to know more people when I was younger or that’s how it seems* (Violet).

Narrators’ stories about the passing of friends differed from their stories of spousal bereavement. The multiple losses associated with the death of friends had a dual effect upon participants. For some it reinforced their sense of mortality, whilst for others it generated a feeling of being left behind. The impact of diminishing social networks challenged participants’ sense of control over their lives. This in turn led to increased feelings of social isolation and loneliness.

*Independence/Choice (financial restriction secondary to ageing and widowhood)*

Narrators reported practical changes to their lifestyles, subsequent to their loss. The more restrictive practical elements included the loss of a spouse’s income. As the participants were over 70 most were already surviving on a reduced income, which made a further reduction all the more noticeable. Cutbacks to perceived
luxuries invariably included social activities. For some participants their widow’s income did not extend to cover transport costs, especially if they were taxis. Families were not always available to assist with transport, and although narrators stated they would use taxis if they needed, the prices were off-putting. The fact that cost had to be contemplated suggested that outings were determined by financial circumstances.

*Oh yes I do [use taxis as a mode of transport] but it adds up and you need a lot of money for them [taxis] and they charge different prices it makes you look at them sometimes. Oh no I’d get more if I wanted to, but I don’t know, I don’t know what to do at this stage (Rose).*

The cost of running a car was also a considerable drain upon superannuation. It was much harder for some participants to manage on a single income and to run a car, than when they had a combined income with their spouse. The pressure of living on a single income led some narrators to curb their activities.

*The other thing that gets hard is travel. When you are older and living on your own, and you’re only getting one income, you try your hardest not to use your savings for things. I try to live on the benefit for old age but you can’t really cope with everything…you just see your whole fortights money go in one hit. Keeping your car running is not cheap, not to mention your petrol and your warrants and all these things it’s quite a bit of money. It’s all on to one of you, when there were two of you even if you are both on the senior income what do you call it superannuation, coughing, it’s much easier to cope with it then…There are a lot of things you suddenly feel you need to get done…When you’re younger it’s so much easier to get those things done somehow, I suppose you have the income and don’t notice it but it does hit you as you are getting older…(Lois).*

In some instances narrators had the financial demands of mortgages or rent. These types of payments placed greater pressure on an already tight budget, and left little money for leisure. The combined stress of losing emotional and financial support intensified feelings of loneliness.
We still owed $30,000 mortgage on it[when wife died] so I was having to pay that and of course when you take the wife’s money away that reduced the money we had by half. That was a serious aspect of things probably, and of course, the fact that you haven’t got a companion to discuss things with (Walter).

Although benefits are available for those individuals on low income, they are generally aimed at covering the costs of basic necessities such as food and shelter. There is little money left over from a basic benefit, to cover the cost of activities. Participants felt that the government did not acknowledge the need for activity or socialization in their benefit calculations.

Living on a pension is hard you have to budget and the government don’t accommodate activities, they’re a luxury. So you don’t have the opportunity to walk into a café and buy lunch whenever you want to because you can’t afford it, you know lunch is expensive...(Heni).

Participants’ stories provided insight into personal experiences of ageing, and the relationship between growing older and feelings of loneliness. Stories covered the social, emotional and practical impact of widowhood and how this shaped the participants’ views of old age. Primarily narrators linked bereavement with loneliness in terms of reduced emotional support. However, the practical difficulties secondary to a reduced income were also highlighted as a potential cause of loneliness in old age. A combined income meant participants could afford everyday luxuries, and had a significant other to share with. Spousal bereavement took both the person, and the combined income the couple shared. Luxuries such as social activities were some of the first cutbacks. This increased the potential for isolation and loneliness.

SOCIETAL EXPECTATIONS AND SOCIAL COMPARISON

Participants’ used social comparison as a means of understanding their self-identity, in the context of the wider community. Festinger’s theory of social
comparison defined it as “the drive for self-evaluation and the necessity for such evaluation being based on comparison with other persons” (1954, p. 138). The way participants’ perceived widowhood, old age, and loneliness in others, to varying degrees, shaped their own experiences. For example some participants appeared to take comfort from viewing other people as more frail or lonelier than themselves. Narratives were both canonical and personal as they reflected the contemporary views of ageing in New Zealand society and the participants’ personal views of ageing. Societal expectations and social comparison was divided into five components that reflected the spectrum of opinions towards widowhood and loneliness. The extracts from stories termed stereotypical, depicted loneliness as a consequential condition of old age and widowhood. Sympathetic stories fostered a sense of compassion for others, which appeared to promote self-compassion. Acquiescent stories portrayed resignation and mild reluctance to comment upon experiences of loneliness and widowhood. Stoical stories demonstrated neither acceptance, nor sympathy but suggested a need to be resilient. Finally stigmatic stories presented loneliness in a condescending fashion, which alluded to a sense of shame for those who experienced it.

*Stereotypical stories of widowhood, ageing and loneliness*

Several stories that related to ageing and loneliness were underpinned by views of old age that could be considered stereotypical. According to Hilton and Von Hippel (1996), “stereotypes are beliefs about the characteristics, attributes and behaviours of certain groups” (p. 240). Randall (2012) argues that the stereotypes of old age range from a sense of powerful, privileged, greedy or self centred group to powerless, decrepit, vulnerable, poor and needy. Little thought is given to homogeneity in the face of such stereotypes. Participants commented on society’s portrayal of older people, and how this shaped their own expectations of ageing and how they should behave.
The idea that loneliness was a natural occurrence of ageing was raised. Narrators admitted that they had unpleasant feelings of loneliness following widowhood, although they were unsure who to approach. This uncertainty stemmed from the belief that loneliness was a consequence of ageing, and bereavement, and something that had to be endured.

Err I think my own expectation of myself changed, I’m not really sure if I recognised loneliness for what it was…When you’re older you kind of feel an expectation to get on with things. I can’t ever remember thinking I must tell someone I’m lonely because that was what or is expected after you lose your wife. I can’t say I was embarrassed, it wasn’t like that, it just felt very lonely but I couldn’t think who to talk to about it. I don’t remember talking to my children (Walter).

Sadly there is still a tendency within Western society to regard some individuals as homogeneous in need. This usually stems from assumptions based on a person’s chronological age. Ageism is evident, although less overt in modern day society. Ageism, in relation to old age, has been defined as “negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of ) elderly people on the basis of their chronological age or on the basis of a perception of them as being ‘old’ or ‘elderly” (Iversen, Laren & Solem, 2009, p.15). Participants felt particularly aggrieved when they had tried to access social activities to address loneliness, and encountered a restricted range. They believed certain agencies looked no further than a person’s age before they reached a conclusion about what a person would be interested in. Participants felt excluded from wider society because of their chronological age.

I want to do things that are normal and I was really taken aback about how people are viewed when they reach a certain age like 70…I feel like people look at my age now, not who I am. I am a Māori woman, my age doesn’t matter to me. I was really annoyed that I rang a Māori lady who put me onto a group for older people that I have no interest in, my only connection is my age (Heni).
Participants described a discreet societal pressure on older people to retire, downsize or to restrict activity based upon age rather than functional ability. This was even more apparent for widows and widowers. Participants talked about the well-meaning advice they had received to relocate from a rural property to a more age appropriate one, despite feeling relaxed in their surroundings.

You must realise you’re 83 and I get the message that I can’t keep on here forever…Although I feel quite relaxed here (Michael).

The stereotypical views of old age that persist within modern society were conveyed in a selection of participants’ stories. Some participants held the view that loneliness was to be expected and endured as part of old age, whilst other participants felt that as they aged they were viewed as a uniform pensioner with uniform likes and dislikes, rather than as an individual. The restricted views that shaped these ageing stereotypes perpetuated the experience of loneliness, as participants either accepted their situation unquestioningly or rejected intervention as it was seen as age specific.

Sympathetic stories of widowhood, ageing and loneliness

Participants developed an understanding of widowhood and loneliness through a process of social comparison. In the majority of stories narrators’ felt compassion for others who were widowed and lonely, which reinforced their gratitude for their own situation and acted as a protective factor against perceived loneliness.

By comparing themselves to others they perceived as worse off, participants’ appeared to feel appreciative of their own circumstances. Participants were able to put their experiences into perspective, through their sympathetic evaluation of other people’s situations.

I’m probably much less lonely because I’ve had a good life and I have my memories to keep me company…I visit a friend and we’ve been friends for, I love saying this, three quarters
of a century sounds better than 75 years (laughing). He and his wife are separated, she’s in
a rest home and he up until quite recently has been running his own house and now his
heart’s given out on him. They miss each other dreadfully. I often think about him and how
he feels lonely (Alan).

The thought that there would always be someone in a worse situation appeared
to help participants cope. Ill health and limited socialization may have led to
increased loneliness for some participants, yet they were able to moderate their
loneliness through sympathetic social comparison. Despite their own setbacks,
narrators felt that older people who were unable to remain in their homes would
be in a worse position. This increased their sense of achievement, and controlled
feelings of loneliness.

If you had asked me that [Do you feel you are more or less lonely than other people of your
age group?] a few months ago I would have probably said less, because I’ve always been so
active and busy…This heart business has knocked me sideways and it has stopped me doing
things. I am lonelier as to whether I am lonelier than others I’m not sure, I think I have
done pretty well staying at home (William).

Several participants’ considered themselves lucky, in comparison with others. The notion of luck implied that fate controlled the narrators’ destinies; however,
narrators retained an element of self-control. Narrators’ focused upon the positive
aspects of life, which suggested an underlying optimistic personality.

Well if I compare myself to people around here I think I am quite lucky. I have a good family
who I keep in touch with and I have friends who will come and take me out. For my age I
can still do a lot, which some of the poor folk in there [rest home] can’t do…I think I have
been very lucky through my life and I don’t think I am as lonely as some people my age
(Hugh).

The subject of luck was also referred to in relation to faith. Participants felt lucky
to have been given the gift of faith. Faith sustained them, in times of loneliness.
When they compared themselves with other older people who were not spiritually fulfilled, some narrators were convinced that loneliness was a consequence of impiety.

*I think I’m luckier than most people of my age because I was given a gift when I found the truth. I think there are plenty of people my age, man and woman, that have not been afforded that chance or if they have, have not been in a position to understand and accept it into their lives…They are getting older and they don’t feel valued by their families or friends and their faith can’t help them. Even younger people you’d be surprised and I think they are spiritually lonely, lost in a wilderness and you’ll never be alone once you know the truth. It’s my sustenance you see* (*Joe*).

Participants’ adopted a supportive role for friends they felt were not coping. This form of compassion appeared to strengthen narrators’ resolve as when they provided assistance, although tiring, it reinforced participants’ pride in their own abilities.

*Well I’ve got a friend she’s 95 as well and still lives on her own, but she gets very depressed and she usually rings me and (laughing) by the time you’ve hung up you’re feeling very worn out. She keeps saying well you’re better off you’ve got people around you and I haven’t. But I really haven’t got any more people around me than she has. And she really doesn’t welcome visitors, even if she has them anyway. So perhaps I’m not as lonely as other people aged 95 (laughing) (Eunice).*

Narrators’ appraised how they coped with loneliness through empathy, and proffered this advice to other widows who they felt were lonely. This in turn reinforced narrators’ self-belief, and confirmed that they had managed their own feelings of loneliness following widowhood.

*You see there’s a lady over at [East Christchurch] and she is an English person, we got on very well, good sense of humour. I asked her here but she never asked me back, now she would be lonely I’m sure…My friend phones me every week she is lonely…I know I work*
hard to stay involved. I make the effort so I suppose I’m less lonely than some of my friends (Elizabeth).

Narrators developed understanding and acceptance of their own experiences of widowhood, ageing, and loneliness through a process of sympathetic social comparison. Narrators’ stories described people, they perceived as worse off. These sympathetic comparisons compelled participants to appreciate their own lifestyles, and view them in a way which made loneliness tolerable.

Acquiescent stories of widowhood, ageing and loneliness

Some participants were less overt in their views on loneliness and widowhood. Widowhood and loneliness, were viewed with neither sympathy, indifference, nor condescension, but rather with acquiescence. They felt they were neither better nor worse than other people, as circumstances were viewed as subjective. Following the initial reading of the participants’ stories, their acceptance implied avoidance and an unwillingness to comment on other people’s business. On further analysis, however, their assenting attitude created a sense of collegiality as it placed participants amongst a group they perceived as the majority.

Participants talked about life circumstances. The idea that there would always be someone more or less lonely, helped the narrator to gain perspective upon feelings of loneliness and provided a balanced outlook by which to evaluate personal experiences.

I think some people may be lonelier than me and some not as lonely as me, because of circumstances (Lucy).

Some participants viewed widowhood as a common life experience, and this appeared to reduce the intensity of loneliness. Narrators used family members as a point of comparison. This helped them to rationalise their own social arrangements as family members behaved in a similar fashion.
I’m probably average [Do you feel you are more or less lonely than other people of your age group?] really. I don’t think I get particularly lonely but then again I don’t have a wide circle of friends. My brother J. was quite similar, my brother K. was much more austere, very private (Walter).

Narrators who viewed loneliness as a common experience appeared to foster a connection with other people, which helped them tolerate loneliness. Participants deduced that solitary people had a greater appreciation for social interaction, than those who were surrounded by company. Conversations with strangers were used as examples within the stories.

I’m probably the same [feelings of loneliness] as a lot of folk, I think, people on their own…I was out the other day trying to dig dandelions out of the garden…and an older lady walked past and she stopped and I don’t know how old she was but she said I like your garden, and then she said I was thinking about going [for] a walk in the gardens but it’s not much use on your own, and we were just talking until her bus came (Margaret).

In some instances participants’ compared themselves with other people, to highlight their own capabilities to their families. By placing themselves amongst a majority such as an age cohort, participants did not feel they were any more or less lonely.

Err I don’t think I’m that lonely. How lonely are people of my age? (laughing). I think health certainly changes as I’ve got older. My family probably think I’m lonely at times, they keep trying to get me to do things go to clubs (Colin).

The embarrassment associated with loneliness was a topic implied but not declared in many of the narratives. The reciprocal support between neighbours was a type of connection that appeared to make loneliness endurable. Participants appeared less embarrassed about loneliness when they talked about how they assisted neighbours that were lonely and isolated. They were able to identify with another person who appeared to experience similar feelings.
Oh you know probably the same [Do you feel you are more or less lonely than other people of your age group?]. I should imagine I’d be average, yes. I’m sure my neighbour is a bit lonely sometimes, and that’s why she visits me. We keep each other company and it keeps her busy, gives her a chore (laughing) (Arthur).

Participants’ emphasized the inimitable, and isolating nature of loneliness. By placing themselves within a wider context, however, they were able to restructure their thoughts and realised that they were not alone and that others probably felt the same way.

I don’t think I’m necessarily lonelier than people of my age, I think I’m probably average, but when it’s happening to you it always feels as though it’s the biggest problem ever. I don’t think I’m that bad, but it isn’t easy. It’s harder to make plans when you’re on your own (Peter).

The realization that loneliness is a normal part of human experience helped narrators adjust, and to reach out to others. Narrators spoke about acquaintances, of a similar age, that were prone to loneliness. The feelings were transitory and each of the people experienced different feelings on different days, which meant they were able to provide support to one another.

If I think about the girls I go to Housie with we are all similar ages, and I think we all help each other out. I don’t think I’m any more or less lonely than them, we are all different on different days. I help them when they need it and they help me when I need it (Huia).

Acceptance of themselves and other people allowed narrators to suspend judgement, and promoted greater understanding of loneliness and how to manage it. Some narrators believed they were no better or worse than others who had experienced widowhood, and that loneliness could occur throughout the lifespan, regardless of the person or their circumstances.

Oh I think I’m average [Do you feel you are more or less lonely than other people of your age group?] really. I think age comes to everyone who’s still breathing (laughing), and it’s
age that changes things really, so I’m sure I’m not alone in my experiences. I think people
deal with things differently and I am quite sensitive but I also make an effort to stop myself
when I feel lonely, I don’t wallow (Bob).

Participants described how they shared their experiences, to help others who
were recently bereaved. Narrators focused upon the practical side of adjusting to
widowhood. The onus was on normalising loneliness, by comparing the
experience with the many other people who have been widowed. By sharing
experiences, participants extended a connection to people who were recently
bereaved.

Oh you know I’m probably the same, anybody who has lost their wife or even husband
probably knows what is like to feel lonely, it’s part of life isn’t it? If you are married one of
you has to be the first to die, I’m not sure which is worst really. I know one or two people
that are going through what I went through and it’s hard, but it happens. I told a man I
know what happened to me and he’s just started at the club, he was the same he didn’t like
it, and he was thinking of stopping and I told him you just have to keep coming and you’ll
get used to it. I suppose some people won’t get the opportunity, if they don’t know about
places like this and then, they will stay the same or get worse with loneliness that would be
hard (Graham).

Stories that reflected an air of acquiescence depicted widowhood as an
inevitable experience that would eventually happen to one spouse within a
marriage. Participants perceived loneliness as an occurrence that could happen to
any individual, regardless of who they were or what their circumstances were. By
adopting the view that loneliness was not a personality defect or a shortfall, many
participants who adopted an acquiescent attitude described a connection to others
who may have been in a similar situation. This outlook appeared to make
loneliness tolerable for participants.
Stoical stories of widowhood, ageing and loneliness

Further along the spectrum were those participants whose opinions of widowhood and loneliness were less sympathetic or accepting, and more stoical. Through comparison with other people narrators seemed to have developed a degree of self-resilience, which enabled them to distance themselves from loneliness. Resilience in relation to old age has been defined as “the maintenance of normal development despite the presence of threats or risks (internal or external) and the recovery from trauma” (Staudinger, Marsiske & Baltes, 1993, p. 543). Participants were neither grateful that they were less lonely than some people, nor did they express a connection to lonely people. Participants’ adopted the attitude that life had to go on, despite the challenges that had presented.

A practical attitude to life and loneliness helped participants move on from widowhood. Narrators claimed to have acquired a sense of level-headedness, through age and experience. When comparing themselves to other people, narrators did not feel all people had learned such a skill. This acted as a defence against feelings of loneliness.

I’m probably less lonely, there aren’t any other people in my bowling group my age. I just get on with things, you have to it does no good sitting around worrying (Rita).

The notion of self-belief appeared to impact upon levels of loneliness. Those participants whose stories highlighted their capabilities, also conveyed a level of control and independence. A sense of independence removed self-doubt, and allowed narrators to formulate a plan should they ever succumb to loneliness.

I’m still able to do my own [look after oneself] so I’m going to. Well even if I was lonely I would go to someone who would listen and join something, go on little trips otherwise you get down you’d be useless (Joan).
Narrators took strength from specific life skills they had acquired throughout adulthood. These skills helped them view loneliness as another challenge they were able to meet. Prior knowledge helped them appreciate solitude, and adapt to change.

Less [lonely] I would think, because I’m used to moving to new places so I like my own company. Things change, but that’s life. I’m glad I am quite healthy for my age I’m 96. My hearing is bad and I get breathless, but I can still do things I think that matters (John).

Those participants who felt equipped to manage life in general, did not seem unduly worried by loneliness. Participants were buoyed by peoples’ reactions to their apparent strengths. This inner strength helped narrators to protect themselves from loneliness.

I think I’m probably less lonely because I mix with so many people of different ages that I don’t really class myself as being old. Well it’s funny because when I told my work mate how old I was she said I don’t believe it, you are not. And I think that is because of my attitude to life. I grasp it with both hands and give it a good old shake (laughing) (Alison).

Participants that had dealt with other people’s challenges had a higher tolerance for loneliness. Narrators found the preoccupation left little time to think about their own situation, and also reinforced their sense of resilience and practicality and reduced emotionality.

I should think I’m less lonely because I still have to do a lot for my family, because of my daughter’s health. I don’t have time to sit down and think poor me, because there isn’t any time to do that (Elsie).

Confidence played a part in the way narrators viewed loneliness. Participants fostered self-belief through their familial upbringing. Some narrators adopted the view that they would be able to deal with loneliness as ancestors had always been hardy, therefore they must have inherited those qualities.
Probably less [lonely]. I’m from a family of resilient women, so I think at 93 I probably manage pretty well thank you (Diana).

Some participants felt they developed resilience, as they adjusted to widowhood. Narrators compared themselves to other widows and widowers that were not as resilient. Narrators’ ability to adapt to bereavement, when others were unable, seemed to reinforce their stoicism.

*I mean some of the ladies had their husbands away [in hospital or in a rest home] and they seemed to be even lonelier than I was. I think as time goes on you kind of get used to a situation, almost a resilience (Ruth).

The ability to stave off loneliness through perceived self-resilience, and a stoic attitude, proved useful to multiple narrators. The stories were less empathetic and narrators demonstrated pride, rather than gratitude for their capability in dealing with both widowhood and loneliness. Practicality rather emotionality, was the key to moving forwards and adapting to life’s challenges.

*Stigmatic stories of widowhood, ageing and loneliness*

Finally, at the opposite end of the spectrum from participants who were sympathetic towards loneliness and widowhood, were those whose views were more judgemental. Narrators were not unkind, but their stories of lonely people were mildly condescending and implied a sense of stigma. On further analysis of these stories it appeared that narrators were embarrassed, confused, or anxious about loneliness, therefore it was much easier to be dismissive about lonely people.

Loneliness was viewed as self-inflicted, and the responsibility of the individual. Narrators concluded that it was ultimately poor organizational skills that led to loneliness, despite the individuality of each person.
Loneliness, well of course I’ve often thought of that and everyone is different, everyone’s made up differently and my advice would be if you’re lonely you must be very disorganised because I don’t get lonely…(Michael).

The misunderstanding surrounding the causes of loneliness was evident in some of the stories. Some participants conveyed quite judgemental opinions about acquaintances they knew, who had withdrawn from the social circle due to deteriorating health. Whilst not callous narrators were dismissive, as they viewed the social withdrawal as ridiculous because loneliness was self-inflicted.

…A friend who live down the road she’s one of those women that’s got something wrong with her bladder, or something, and it’s the biggest secret that ever there was…We were good friends and used to go out a lot, but not anymore because of her bladder and I think that’s silly because she is lonely (Alice).

Participants’ stories reduced loneliness to the simple matter of choices, whereby people opted to be lonely through lack of motivation. Lonely people were portrayed as ignorant of their condition, which was caused through not wanting to socialize.

I have got a really good family as I say they are very helpful cause there are some people on their own, perhaps, they might have one child living goodness knows where…I think there are a lot of lonely people who perhaps don’t realise that they are lonely but just don’t want to go anywhere (Lois).

The idea that loneliness was a consequence of choices was challenged by those narrators, who felt that loneliness was the result of old age and infirmity. Despite participants defending lonely older people that suffered from loneliness, there was still a sense of stigma. Older people were portrayed as involuntary victims. This instilled a need in some participants to verify their own competency, and distance themselves from such weak and helpless individuals. Participants’ stories suggested they themselves were normal in terms of loneliness, and did not need
rest home care. Interestingly this view reinforced the stigma surrounding rest homes, and the role they play in supporting older people.

_I think I’m average [loneliness]. I’m determined to stay in my own home. I am not going into a rest home. I want to stay independent. I do my own meals. I am not having meals on wheels I don’t want them. I prefer to do my own it keeps me busy. I like having what I want when I want it_ (Jean).

Loneliness and rest home care seemed to be synonymous, in the opinions of some narrators. Narrators felt they were less lonely because they were active. References were also made to friends in rest home care who were not active. The underlying implication from some participants was that older people who reside in their own homes are less lonely and more active than older people who reside in rest homes.

_I might be less lonely because I’m active, I always have been active. I have a friend who I used to go shooting with he’s in a rest home now just up the road, it’s almost walking distance. I go and see him regular_ (Tim).

Participants portrayed pity for infirm elderly people, who were unable to care for themselves and were prone to loneliness. There was, however, an unspoken belief that the narrator was distinct from the person they pitied.

_Next door the lady has memory loss and she pops in quite a lot. She gets lonely, so I think I’m probably quite independent for my age…she’ll be out at Senior citizens so she won’t call in and interrupt us. I never know when she is going to turn up, but she manages although, I do keep an eye on what she’s up to_ (Violet).

The stigma surrounding loneliness prevented some narrators from undertaking social comparison. Narrators claimed they were unable to determine whether their feelings of loneliness were normal or excessive, as the widowed people they encountered were reluctant to talk about loneliness. Stories such as
these indicate that loneliness remains an uncomfortable topic of conversation, for some people, which in turn restricts others from talking about it.

A lot of people don’t open up much, so it’s difficult to tell. Around here [neighbourhood], in the process, of walking I quite often stop and talk to someone in their garden or when they are walking their dogs or something like that. It’s surprising the number of widows there are around here (Eric).

**CONCLUSION**

The collective story began with the apperception of loneliness through context based life events, namely widowhood, and its associated memories and meanings. This current chapter covers the central component of the collective story. The main body of the story focused upon the actual experience of loneliness, and what it meant to the narrators. Narrators described circumstances that further influenced the intensity of loneliness, as they renegotiated their self-identity, following widowhood. The main factors, that influenced the experience of loneliness, were the personal impact of the ageing process and the perception of societal expectations of older people.

Five key areas emerged from participants stories in relation to the ageing process: sense of being a burden, changing health, driving (access to transport), outliving social networks, independence and choice (financial restriction). Participants used a micro perspective (Crothers, 2013), from which to deliver their stories of widowhood and ageing, as the stories were particular to their own personal experiences. For rural participants driving, or access to transport, was a pertinent factor that influenced the experience of widowhood, ageing and loneliness as it highlighted the importance of routine or the deviation from it.

Participants went onto make sense of their experiences of widowhood, ageing, and loneliness through a process of social comparison. Social comparison was used as a means of understanding widowhood, ageing, and loneliness in the context of
the wider community; a macro perspective was adopted (Crothers, 2013). Participants’ perceptions of society’s expectations were presented through their stories of social comparison. The overall topic of social comparison was divided into five sub-topics to maintain authenticity to the stories. The five areas focused primarily on participant attitudes towards other people’s experiences of widowhood, ageing and loneliness. The areas were termed stereotypical, sympathetic, acquiescent, stoical and stigmatic stories of widowhood, ageing and loneliness. The stories reflected a spectrum of opinions, and acted as both a contributory factor towards and a protective factor against loneliness.
The collective story began with the apperception of loneliness through context based life events. For the purpose of this research the life event under discussion was widowhood. It was the meaning ascribed to widowhood, however, that determined loneliness, not the event itself. As the collective story progressed narrators described how they had renegotiated their sense of self identity following widowhood. The relationship between loneliness, ageing and societal expectations was explained. Each story was unique yet there were common denominators. Participants described their lives as they aged, and the way other people perceived them. They also explained the experience of loneliness, and how at times the presence of loneliness was an intrusion in their lives.

The final stage of the collective story is compiled from the narratives participants told about how they adjusted to widowhood, and the adaptive/maladaptive coping strategies they used to prevent or contain feelings of loneliness. Narrators’ opinions of the role of health services are also considered. Prompt questions were used to support the narrator and nurture the narrative. Participants were asked ‘How do you deal with loneliness?’ The prompt question elicited two main types of narrative. The first type of narrative proffered mechanisms for managing loneliness. Narrators were not ashamed to talk about their experiences of loneliness. The second type of response dealt with mechanisms for preventing loneliness. Participants denied feeling lonely and so talked about the strategies they used that stopped them from succumbing to loneliness, and what they thought they would do if they became lonely.
Interestingly, whether loneliness was approached from a preventative or curative direction, the coping mechanisms were similar. A further prompt question asked ‘If older people find lonely feelings distressing, how do you think health services could help them?’ The question was asked in a way which allowed all participants to continue their stories, even if they were not lonely. Narrators’ views of health services were conveyed and the management of loneliness, from a professional perspective, was considered. Stories are both introspective and extrospective in nature, as they describe how participants view loneliness and how they felt health professionals viewed loneliness. The stories provided even greater insight into participants’ experiences, and perception of loneliness.

The chapter is divided into two sections. The first section describes personal coping mechanisms. It is a collection of extracts from the stories narrators told about their individual ways of addressing loneliness. Personal coping mechanisms included: sense of independence, adaptability, meaningful activity/role, whanau/family (giving and receiving support), pets, friendship, social contact/collegiality, solitary activity (background noise/distraction), dual role of formal support. The second section considers participants’ views of health services, and the role they play in addressing loneliness. From a negative perspective narrators told of their uncertainty, fear, and shame in approaching a health professional about loneliness, along with their own perceptions of what were legitimate health concerns, and the impact of communication skills during health appointments. From a more positive perspective, participants talked about rapport and trust in facilitating open dialogue between patients and health professionals about loneliness.
PERSONAL COPING MECHANISMS

Sense of Independence

The notion of independence threaded itself through the collective story. Loss of independence was referred to in the central component of the story, in relation to ageing and loneliness. Conversely, a sense of independence encouraged participants and helped them stave off feelings of loneliness. Narrators who felt they had control of their lives perceived themselves as resilient and able to cope with solitude, although families and friends worried about them.

I’m very good at managing things like that [loneliness] I’m very direct, very disciplined sort of person. I am a very, very organised person and a very disciplined person…Erm I don’t need people from outside no I don’t need that I don’t get lonely because I’ve got so much to do here that and I’ve become very reclusive but that doesn’t worry me I think it worries my friends because I don’t have anyone here (Michael).

Narrators took charge of a situation and directed the outcome, rather than allowing the situation to shape their feelings. Resilience was viewed as a learned skill passed down through families.

No never [lonely], too busy…If you have a property then you always have a job for sure…..I’m not a lonely person. I’m resilient. I get on with things I think that’s it. It applies to all my family, you know, you learn resilience it comes down through the family…I think loneliness is a family thing, I remember all my aunts just being so capable that I thought that’s how you had to be, yes, get on with it do something (Diana).

Solitude was tolerated secondary to the demands of employment, and loneliness was dismissed as a waste of time. There was a forceful element to some of the stories about independence, as though loneliness was a sign of weakness.

No, no never have done [felt lonely], I’m used to being alone what with working in the back country, I talk to myself. With the job I used to have a hut, used to go out there and camp
a couple of days, work out there and not see people not anybody for days, so I manage quite well. I don’t think I ever will [get lonely], I haven’t got the time, I’d rather be doing something than wasting my time being lonely (Jack).

Some female narrators were of the opinion that widowers were less independent than widows due to the gender roles within a marriage. Although saddened by their loss, some of the women were relieved that they only had themselves to look after and valued their independence.

Women cope much better than men, I think men as I say men my age only want you to cook and look after them. So you keep away from them (laughing), you don’t even look their way… I don’t really get lonely I do my own thing. If you’ve been married for 53 years, it’s some good thing pleasing yourself (Isobel).

The ability to self-care and undertake daily chores was significant and provided narrators with a routine that kept them occupied.

I look after myself with meals and I enjoy meals. I do everything I suppose that’s what helps to fill your day in keeping busy. I think that’s probably what helps keep you sane…I’m the oldest member of the bowling club, so I try to get out more and be with people not staying inside for hours (Rita).

The collection of stories suggested that perceived independence generated feelings of control, resilience and a sense of survival. Loneliness was viewed, as a waste of time and resources. Narrators appeared to have developed this demeanour throughout their lifetime, as a result of their upbringing or the roles they had been exposed to. A sense of independence appeared to have a negative undertone, however; stories appeared to promote resilience at all costs, and to succumb to loneliness was to fail.
Adaptability

With such a life changing event as widowhood, adaptability was seen as a mechanism for either easing loneliness or evading it altogether. With time, narrators were able to normalize their experiences of bereavement. This process of acceptance meant some narrators were not consumed or defined by the event, and were able to move on with their lives. Preparation for and acceptance of life’s randomness, rather than avoidance or denial, helped participants with the adaptation to widowhood and management of loneliness.

*You have to be prepared, prepared to face changes, otherwise I think that’s when the loneliness creeps up on you* (Lucy).

The fluctuating nature of life, and the processes people go through when they lose someone significant, was mentioned in the stories. Some narrators reached the conclusion that death was a random part of life.

*I mean many of these things [bereavement] just happen and you’ve got to adapt, life goes on I think and you’ve got to adapt. I can’t think how long it took to get back to normal, it just did* (Rita).

Participants’ ability to adapt to change appeared to impact upon their levels of loneliness. Narrators who had faced multiple changes, throughout their lives, appeared to be mentally equipped to manage loneliness.

*I don’t think I’m that different, although, plenty has changed in my life that’s for sure. I don’t think so [got lonelier as got older] I manage well I accept what comes my way* (Jack).

Personality was also given as a reason why some people were able to adapt to widowhood more successfully than others.

*I think I’ve adapted pretty well, but it wasn’t easy, and I think a lot of it is down to personality or rather how you cope throughout your life not just getting older* (Walter).
Finally, the idea of starting each new day afresh was proffered as a way of adapting to widowhood and containing loneliness.

I just walk away from things, move on, don’t sit and dwell cause if you sit and dwell you’re in trouble I feel that’s just me. You’ve got to be self-motivated it’s very, very, difficult. I don’t know I try and get out and do something, don’t sit around dwelling (David).

Adaptability narratives possessed similar characteristics to the stories about independence, but adaptability was a softer coping mechanism. Stories reflected a gradual process which mitigated the impact of bereavement over time, rather than a forced outlook as suggested by the stories that referred to independence.

**Meaningful Activity/Role**

Narrators had a variety of activities and pastimes that either helped to prevent loneliness or alleviate feelings of loneliness. The common denominator for the majority of these pastimes was that participants had a specific interest or felt valued in the role they occupied. The activities were peculiar to their taste, and were the result of personal choice. Cultural affiliation was important and reinforced a sense of connection, which in turn reduced feelings of social isolation.

Since I’ve been going to the Marae on Tuesdays and Wednesdays it’s been really good, I love it...It’s laughter that does it, we are all laughing, we have a ball we do. There is aroha, a lot of love going around, and it’s wonderful it is...The girls that look after us, they are wonderful...They spoilt us they really did, absolutely marvellous...I love going and it’s good fun and you know the people are good company (Huia).

The effective reduction of loneliness was influenced by certain activities. The meaning attached to an activity determined the value of the activity, and how effective the activity was in controlling loneliness.

If it wasn’t for my friend telling me about the Marae (Communal sacred place) and going on visits and learning about the Kawa (Marae procedure), I would never have got in with
this group and it’s so important it’s let me meet other people…Being Māori you’re always aware that you could step on somebody’s toes at their Marae, now by going and being part of a group that goes to the Marae allows me to learn all about their Kawa. It builds respect and confidence because now I know I can go to that Marae and not offend people, you see how important this is. I don’t need bowls and bloody bridge what good is that to me…Older Māori people who are alone would thrive from going to the Kaumātua (respected tribal elders) group, even if they are not from that Marae. If people don’t know about things, if they are not told about things, how can they change what is wrong? We Māori women need someone with the knowledge to help us get out, if we are lonely, encourage us (Heni).

Participants who had life-long interests and still felt connected to them used this to moderate loneliness. Long standing membership of groups or societies allowed participants to remain linked to a community.

I’m still interested in horticulture and I read about the different societies, so that keeps me busy…I mean try and stay involved if you can. I’m a life member of the Horticultural Society…I go to a few of the other societies when I can, I try to keep active, I think that’s important (Max).

Narrators talked about feeling useful and although a majority of roles were voluntary, participants did not miss being paid as the feeling of being involved outweighed monetary recompense.

I go in once a week to help out at the golf club and when the green keeper’s away. I cut the green whilst he’s away three or four times a week, keeps me out of mischief for an hour or two (David).

Conversely, narrators found imposed activity meaningless and far more damaging than loneliness, especially when families, friends, or agencies assumed an older person would enjoy an activity by virtue of their age alone.

We are all different aren’t we? Yes I mean what I do to keep myself occupied may not appeal to other people, and some can’t do as much for themselves…I mean I like to play cards but
I know a man who can’t do that anymore because he can’t pick things up, he has arthritis. I may watch telly and look at some of the films, but if your eyesight is no good then what use would that be. I think you really have to know the person before you offer advice, otherwise you could make things worse (Arthur).

There was an underlying contrariness to some of the narrators’ stories. Whilst participants wanted to be recognized for their individuality and rejected homogeneity, they conveyed a reluctance to be placed with people they had nothing in common with and preferred to forgo a new group rather than attend.

There’s a Probus group, which is a similar sort of thing but some people don’t want to go. I can identify with that, you might not have the same interests... (Lois).

Similarly, arranged companionship was a delicate topic for some narrators, who perceived it as offensive and infantile.

My family mentioned getting some help but I would hate it, I would hate it. I think they thought it would be someone to keep me company, but I told them in no uncertain terms, I would rather choose my own friends thank you very much (Alan).

For activities to be deemed an effective coping mechanism in managing loneliness, it was essential that participants’ individual tastes were taken into account. Assumed interest by virtue of age perpetuated a stereotype of homogeneity in old age which was as damaging to self-esteem as loneliness.

Whanau/Family (giving and receiving support)

Family and Whanau were used as a primary coping mechanism for loneliness and widowhood. They performed a dual role, in that participants talked about receiving support from and giving support to their families and whanau. This reciprocal support helped them in the process of adjustment, following bereavement and as they aged. Giving support to families and whanau strengthened the perception of meaningful roles, as participants felt their position
in the family group was valued and needed. In turn face to face, phone or internet contact with family provided a form of support as it reinforced a sense of connection for participants. Interestingly, there was a delicate balance between family contacting participants in a supportive manner, versus the contact being perceived as intrusive.

**Giving support**

Participants provided support to adult children, and to grandchildren within a family unit. Childcare was a particularly important role, as it allowed adult children to return to work. It also provided an opportunity for customs to be passed onto the next generation, and strengthened family bonds as it allowed participants to have a significant presence in the lives of their grandchildren.

*I’ve got my whanau here still, my mokopuna (grandchild). I had him from when he was about a week old, so you could say we have a bond and to this day I tell him off in Māori because it’s more gentle and he responds better...if I speak Māori he is fascinated and stops whatever he is doing, and he sits and looks at me and he tells me he is sorry... They are my rock [Whanau], they are there for me and that isn’t just about location, they are here in my heart which is vital (Heni).*

Child minding was also offered at weekends, and gave adult children a break. Again this reinforced the valuable roles participants played within the family, and reduced feelings of loneliness.

*They [grandchildren] come at weekends. They are coming this weekend for two hours. My youngest grandson is funny...Yes he’s a joy...I am lucky... And my grandson lives [nearby] and his partner is lovely. I’m very lucky, I’m very involved with my family, I do what I can. I do get involved with people, because I like people. I’ve always been a people person (Elizabeth).*

Some narrators had to take a more active role in their adult children’s life due to ill health.
I have to do a lot for my daughter though, because of her health she needs a lot of support. I’m not sure how she would manage without me, that’s a worry…She’s needed more help over the last 18 months, she was still not managing so I’ve had to step in. I have to help her out as best I can (financially), but I really can’t afford much. I take her out places (Walter).

Secondary to the pressure of caring for an adult child, some narrators had to take on a full time parenting role for grandchildren. Whilst this was offered as a means of coping with loneliness as participants felt they did not have the time to feel lonely, the input had a dual effect. Although it distracted participants, the pressure of solo parenting intensified the deceased spouse’s absence. It was not necessarily a positive coping mechanism as narrators replaced loneliness with stress.

My daughter is here, but my daughter has always had bad mental problems (sigh). I do feel sorry for her, she has had bad, bad times and it’s not her fault that’s why [granddaughter] came to stay with me. There’s not a lot of happiness in my daughter’s life, but it’s just terribly difficult. I still have to keep an eye on her because she is alright for a while and then things take a turn for the worse (Elsie).

Phone and Internet contact (receiving support)

Phone and internet contact with family helped narrators manage feelings of loneliness. Phone contact allowed narrators to close the gap created by geographical distance, and kept them actively involved in their relatives’ lives despite the distance.

I think keeping your thoughts on track [helps a person cope with loneliness] that’s what my son says. I speak to my family a lot on the phone, they are all dotted about the North and South Island and further afield. Someone is always phoning me or I’m phoning them (Colin).

More modern means of communication were also valued, as narrators not only got to communicate but also had to learn a new skill.
My grandson gave me a computer and I’ve been to senior net for a couple of courses. I haven’t entirely got the hang of it. I’ve learned to email. I email my grandson, I’ve got a granddaughter I email her (Patrick).

Ultimately participants’ stories highlighted the importance of regular phone contact, and how it should not be underestimated in managing loneliness.

Most of my children are handy so that helps, the eldest daughter phones me every day. She’s already phoned twice and she lives in town…And we are all pretty close still, mainly by phone, my son comes in most nights and my other son visits when he can (William).

Face to face visits (receiving support)

Face to face visits were an effective strategy for addressing feelings of loneliness, although some participants felt they were placing extra pressure upon their families.

My daughter she comes in most days after work and my son and his wife come at weekends, when they can… (Margaret)

Where families were able to visit, participants found it provided structure to their day and gave them something to look forward to.

My daughter rings me nearly every day. Oh my son comes in every Sunday morning and my daughter comes in every Saturday or Sunday, she works. I go to my daughter’s on a Sunday night for tea and my other daughter has just arrived back [from living overseas] (Patrick).

It was obvious from the expressions, and the manner in which they conveyed their stories, that familial visits provided not only social stimulation but reassured participants that they still mattered to their families.

My daughter is great and she calls in to see me almost every day and my other daughter is just up the road, by the school (Graham).
Balance between supportive and intrusive contact

Despite familial support being a significant coping mechanism for loneliness, there was a subtle line between what participants perceived as supportive versus intrusive.

_We speak a lot on the phone. They look after me like a bloody baby…_ (Laughing). _They are a good family, they do look after me and check up on me_ (Tim).

When relatives visited too frequently, some participants felt as though they were on a curfew and that the parent/child roles had been reversed.

_I have one son…He and his wife ring me every day. It’s very kind of them, but I keep telling them hey I may want to go out…And they still ring, so I have to be home in time… I don’t want smothering with unnecessary concern_ (Alan).

Similarly, excess contact led some narrators to question whether family were genuine in their actions, or felt duty bound.

_They [family] all visit me a lot, all the time. I sometimes feel as though they are checking up on me, like I did when they were young. They don’t intrude though_ (Joe).

Family support, both giving and receiving, were presented as significant methods for coping with or preventing loneliness. The format and level of support took many different forms. Care was needed to preserve a balance between helpful and harmful support, as giving support had the potential for increased stress, and receiving support had the potential for intrusion and parent/child role reversal.

Pets

For some narrators pets played a pivotal role in helping them cope with loneliness. Pets were given human characteristics, and assumed the status of a housemate. Narrators became animated and smiled frequently as they relayed their story.
I think if you love animals, have an animal [coping with loneliness]…I love my dog… He comes out and I talk to him, and he knows his head moves from side to side, and his ears go so I think he talks to me. He keeps me busy, I have to get up in the morning because he likes his porridge (Isobel).

Both cats and dogs received much attention, and provided participants with a meaningful role. The animals were conversed with and even though conversation was one sided, narrators felt listened to and to a degree understood.

(Laughing)…Look at miss cat she’s made herself at home, she’s thoroughly spoilt. I never feel alone when she’s [cat] here. She sleeps with me; she comes in and out of the window. She creeps in and I find her sleeping on my stomach in the morning. When she first came here I talked to her [cat], I have a friend who was here [visiting] every other day and she said that cat’s far too thin, I’m going to feed her and I said no don’t because she’ll think that this is her home. I went away for a few days and my friend went and bought food and fed her, so I think she’s adopted me now I don’t have a choice (Lucy).

Dogs offered an opportunity for social interaction, particularly if the narrator was able to take their dog out walking.

She’s a great companion, she’d never run away from me, and it’s amazing you know we go for a walk in the park and the number of people who will stop and chat about dogs. Everything you talk about is the dog and she knows. I don’t know what I talked about, before I got her. It’s like sharing the house with another little person. She’s nice to have around the place I feel safe, she probably wouldn’t do anything if anyone did break in but, I think the barking would put them off (Elsie).

Narrators felt more comfortable striking up a conversation with a dog owner, even if they did not own a dog. These brief informal encounters with other people helped narrators feel less lonely.

Keep busy, if you feel an attack of loneliness coming on change step, get up and do something, even if it’s only to beat the daylights out of your garden (laughing), or go out
for a walk or find somebody that you can talk to. The dogs are a good starting point and I just about know all the dogs [in the neighbourhood], and they know me (Eric).

Pets provided convenient interaction, and a focus for conversation within the home. Animals were accorded human attributes, which reduced the sense of social isolation. Pets facilitated opportunities for exercise. They also increased social interaction with other people out walking, as they provided narrators with a topic of conversation even if they did not have a pet of their own.

Friendship

Friendship was used as a coping mechanism for loneliness. Interaction with friends provided participants with a different form of support than was provided by families. Friendship provided companionship, and reduced the sense of isolation. Narrators appeared to value the mutuality that friendships delivered, and did not feel infantile or a burden.

Well I spend most Saturday evenings with a friend for tea and we got going [friendship], what would it be 10 years ago, after going to a golf tournament together in a mixed tournament. She, err, I said to her very cheekily oh we could go out on more occasions and, err, she agreed. First time we went out she said well I do not want to get married, she’d only lost her husband about six months ago, and so it suits me fine. It’s been going for 10 years, we play bowls together and golf. She’s got her family, I’ve got my family and occasionally we sort of have a family thing, but not together she has her side of them and I have my side of it you know (David).

Shared interests were a positive aspect of friendship, which participants felt helped them to cope with widowhood.

I’ve got a friend who lives near B [local suburb]. I usually meet him and play snooker twice a week and I go round and see him every now and again (Walter).
Participants acknowledged the effort required in maintaining friendships. As referred to in the introductory component of the collective story, following bereavement it was difficult for some narrators to socialize or to entertain the idea of ever socializing again.

So you see, I’m not lonely. I have a lot of friends and people complain that they don’t have friends, but you know you’ve got to work to keep your friends, you can’t expect them just to be there you have to invite them… You must invite other people. I usually invite them to lunch, we all have a pact now not to make any fuss [when preparing lunch] (Elizabeth).

Participants emphasised the importance of staying in contact with friends, even when they didn’t feel like it, as it stopped loneliness from getting worse.

I am alone now, or rather I live alone, but I’m not lonely because I have so many friends and family around me who like visiting and coming to see me. That’s why when I feel a bit growly, or don’t feel like seeing people, or life just feels too busy, I think to myself just stop and think what it could be like. I mean I can still get out, not much but I get out if I want to, as some folk can’t… I think they are so important [friends and family] because I don’t get lonely, I have people to see and things to do (Alison).

Friendship was used as a coping mechanism by narrators, to manage or prevent loneliness. The role of friendship was different to that of families. Friendship was based upon mutuality and shared interests, and helped narrators distract themselves from thoughts of loneliness. Narrators felt that friendship required dedication and effort, and although it was difficult to contemplate after widowhood, maintenance of friendship was essential to help alleviate or reduce loneliness.

Social Contact/Collegiality

When narrators talked about friendship as a coping mechanism for loneliness, they focused upon specific significant relationships within their network. Social contact was also employed as a means of dealing with loneliness, but referred to
the narrators’ wider social network and concerned casual acquaintances or neighbourhood support rather than intimate contacts. Group gatherings were a particularly effective form of support for some of the narrators, who found being amongst their peers provided them with collegiality, which reduced their sense of isolation. Probus and Senior Citizens meetings provided a welcoming place for people to catch up with others.

*I do go to different things here and I’ve made quite a few friends... I go to the Probus club here and that’s a good place to meet up with people* (*Violet*).

Other groups were formed around the sharing of food, and helped to reduce loneliness. Mealtimes can be a particularly lonely time for widowed individuals, as it is a specific reminder of being alone. Coming together as a group to share a meal on a monthly basis restored an element of enjoyment for a group of widows/widowers in North Canterbury.

*It was one of the ladies who was widowed and living by herself. She thought...I have noticed that quite a lot of people are living on their own, and a lot of people say oh we never cook ourselves a meal. You can have these meals now brought in, but it’s never quite the same really. And so I think that’s possibly how it may have started [luncheon club]. On average about 40 or 50 people go, but it covers a big country area, those people sort of come to here for something doing... We were there yesterday, once a month is good and I thought oh (relief) I don’t have to cook a meal tonight* (*Lois*).

Social group gatherings did not appeal to everyone. The effectiveness of social contact as a coping mechanism for loneliness was not always obvious at first especially when the contact was with strangers. For many older married couples, their primary source of social contact is one another. When one spouse dies the thought of replacing their company with that of a social group can seem quite unpleasant. Usually it is families or a formal agency that suggests a social group as an alternative means of social contact, and as already identified this can be
insulting for some. Interestingly, some narrators who acquiesced to family suggestions found, after several visits to the group they started to adapt and were able to tolerate it.

I go to a club now you see, it’s nothing fancy but it serves a purpose, and I’ve been going for about a year or two now. I started six months after my wife died, so yes it will be over two years. I didn’t want to go and my family said try it, and I wouldn’t go and then I thought oh I’ll shut them up I’ll go along. But I didn’t like it at the start, nobody talked and it seemed like nobody wanted to know me, they were all sort of cornered up in their own little groups. It took me three or four visits before I started to settle in. We play games and that sort of thing, it takes you mind off things. I’m usually about second or third all the time (laughing) I just get beaten, never mind. You win a cake of chocolate and people always share it, so I don’t miss out. I’m around different people and that’s what matters, I suppose. It’s not something I ever thought I would do. But we go for trips out as well, and they are good (Graham).

Social contact occurred in many different forms. The neighbourhood was used to minimise loneliness by several participants. Narrators described chatting to people as they passed by their gardens, as it broke up the monotony of the day and kept them entertained. For older generations the notion of greeting or talking to a passer-by may not be as strange as it may seem to younger generations. Face to face interaction appeared to be of significance to this group of older people, and even casual comments to people walking by helped to reduce loneliness.

I make myself talk to people on the road there, as they pass, and you know it breaks up the day. I suppose I’m socialising with people I’ve never met before in my life, and sometimes they talk to me first and sometimes I talk to them. But, err, you should go out where there are people, even if they just sat in the chairs and watched people I’m sure that would help. And remember it will pass, loneliness passes, I think it’s a normal part of life. They are nothing days, but you have to have something days as well (Margaret).
Neighbours proved to be a significant source of social contact. Neighbours were not classed as close friends, but their regular visits did help narrators to manage loneliness by breaking up the day, even if it was to complete something as informal as a crossword.

*I do crosswords most of the time. And my neighbour next door she's similar age to me, and she is on her own, and she comes into see me and we do the crossword together (laughing)*

*I tell her I’m only helping her because she gets stuck on the difficult ones* *(Arthur).*

Not all forms of social contact used by narrators to cope with loneliness were healthy coping mechanisms. Despite the known risks associated with gambling, playing the pokies was suggested as a way for managing loneliness. Access to company outweighed the potential for addiction and money loss.

*I shouldn’t, but I do go in and play the pokies because I’ve got people to talk to. I think I know they’ve got a big thing about people gambling and everything, but a lot of those people I talk to are lonely ladies. One lady who goes is a dear little lady and she always talks and it’s like having your own little family, not good losing money. I have $20 but it doesn’t last long, but it’s not the gambling so much as the company and I’m finding that a lot of people do it for exactly that reason* *(Judy).*

Social contact/collegiality was employed as a means of dealing with loneliness. Narrators referred to their wider social network; group gatherings, casual acquaintances, neighbourhood support, rather than intimate contacts. These resources reduced feelings of isolation, as narrators described an increased sense of contact and collegiality. Not all resources were considered healthy, such as casual acquaintances met whilst gambling, and perhaps reflected the desperation some of the narrators harboured as a result of their loneliness or isolation.
Many participants looked to solitary activities as a way of managing their loneliness. Solitary activities were less physically demanding for participants, and were something they could do independently of others.

*I have the radio going, I like listening to things on that talk back although something’s on [the radio] annoy me. I join in with the conversation, when I don’t agree with it… I usually put on the programme [TV] in the morning, the morning show, that’s interesting I like the people they have on speaking and some of them cooking. no but I think it’s a company thing really* (Rita).

Some activities such as the radio filled silent rooms with much missed voices, and acted as a source of company.

*I either get up and get a book, or turn the radio on, or the television on, or try and keep busy you know do something and it gradually goes off [loneliness]. It didn’t at first but it will now but erm…Oh yes it’s a voice, someone speaking…I listen to National at the weekends and when I’m going to sleep. I like listening to the wee bit of news that goes on, because I don’t read the paper very well. I keep…I quite like the radio; I’m not that fond of television, unless there’s something I really want to watch you know* (Rose).

Other narrators used television as a passive distraction, and kept it on in the background, as it stopped them from ruminating. This reinforced the concept of silence being one of the most challenging aspects of widowhood, and a primary cause of loneliness.

*...If you have too much time on your hands you start to think, and that’s not always a good thing. I remember everything that has happened to me but I don’t let myself think about it too much, because it would get me down, so I keep busy with whatever I can do like TV. Sometimes I don’t even like the look of the programme, but it stops me thinking* (Elsie).
Reading was another solitary pastime that participants engaged in. Reading a book required active concentration and helped to distract narrators, as it kept their thoughts away from loneliness.

_Ha, you’d be surprised err a little [feel lonely] occasionally, but I make myself throw it aside it is not a feeling that I welcome. Err I'll get a book and make sure I concentrate on it until that feeling goes away, or I’ll find something else to do… (Alistair)_

Library membership increased the opportunity for social interaction, as it brought narrators into contact with people when they chose or returned books. Most libraries have cafes nearby or their own cafes onsite, which also facilitates interaction.

_I love reading, it keeps me occupied and I’m happy...I enjoy going to the library for my books. I don’t think I will [get lonely]. (Jean)._

Finally less generic hobbies were employed by narrators to keep themselves occupied. These included such interests as crafts.

_I think if you really get down or lonely, there’s always something to do. I always get out the spinning wheel and I quite like listening to music, when I’m spinning. It’s lovely spinning to music, you sort of get a rhythm you know, and it’s very relaxing. And if there’s anything interesting on the television you can have it on in the background, but there’s nothing very much on, it’s pretty awful some nights there’s hardly anything on. So I get a nice tape or something and play some music (Lois)._

Not all individual pastimes were constructive, despite helping narrators cope with their feelings of loneliness. Going to bed early was a tactic used by some of the widows, so that narrators did not have to think about being alone. Although going to bed early was viewed as a coping mechanism for loneliness, it was also a method of avoidance to reduce the time they spent alone.
I think it's better at night when you think you're going to bed and you don't have to think about everything. You know perhaps I don't know whether I look at it like that or not, it may seem to be like that (Rose).

Solitary activities were used as a means of managing loneliness as they were activities that could be engaged in independently of others, were usually less physically demanding for participants, and were an effective source of distraction. Participants also described spending time in bed to avoid being alone. Going to bed when tired is a natural thing to do; however, going to bed early or getting up later when alert can be a threat to good sleep hygiene. Such practices may lead to insomnia or the use of medication to encourage sleep, which can be a precursor to depression.

**Formal Support**

Multiple narrators referred to formal support as a coping mechanism. Formal support delivered by care agencies not only provided physical support such as cleaning, shopping and other domestic or personal hygiene chores, it also provided social support for many participants. Participants described the value they placed upon the daily, or weekly, interactions with carers. Most carers were there to perform a paid domestic or personal hygiene chore, but the conversation that accompanied these visits was of far greater significance. For some participants the relationship between themselves and their formal carer had lasted for years.

I chat away with her [homehelp], she's a lovely girl from [care agency], yes and erm we chat away then we're quiet. She's very, very nice. I think we got her when my husband was ill and he would have been ill for about four years, maybe one more I don't know... Oh I love her, she's a beautiful woman, but she's been away now for it'll be er three weeks or four weeks. She comes on a Monday. So I've been a long time without her. I miss her course, she's funny, she makes me laugh too and she'll take you shopping, pay your bills or do
anything you like, you know, she’s really lovely…She only comes once a week for two hours, but it does make a difference cause she makes you laugh (Rose).

Over an extended time period, this regular source of informal conversation helped some narrators reduce loneliness. Formal carers were described with genuine affection. Relationships had even greater value for participants when the carer had started to visit prior to widowhood, and through the subsequent period of adjustment.

I have a home help, comes in every Thursday. She’s been coming here about eight years. She’s very nice. She came when my wife was very ill, and when I had two hip replacements she carried on. She talks with me a lot when she comes in, she’s very friendly. She’s a very nice lady and I know her husband, she comes for two hours a week we get on very well together. We have coffee together part way through, when she visits (Patrick).

As a result of a possible underlying vulnerability, the professional relationship between carer and narrator appeared to blur in the majority of stories. Narrators who received formal support were limited in functioning. To be eligible for formal support in New Zealand, an individual has to be assessed and deemed as unable to carry out activities of daily living as a result of declining health. Such restriction limited narrators social networks, and increased the value they placed upon the contacts that they did have available to them.

I have a lady coming in and she is very nice, in fact she is absolutely lovely...I feel we have become such good friends that I would miss her if she left. She comes once a week for a couple of hours and I love her visiting, she cleans my house and my soul (laughing). I still get lonely a wee bit, but not as much as I used (Huia).

Carers who were respectful of narrators’ needs and idiosyncrasies were elevated from formal status to informal status in the narrators’ lives. As support workers were viewed as more than just employees, it highlighted the need for clear professional boundaries to protect both worker and service users. The role of
formal support can be of great importance to an older person in managing loneliness. It would be regressive to revert back to task orientation rather than establishing professional boundaries that acknowledge the importance of communication.

*My carer is good. I get help with personal cares and they come from the Marae and you know they are Māori and they understand. I’m not being racist I mean she understands my customs, what I do in my home and respects them (Heni).*

Narrators described rituals they went through preparing for the carer’s visit, or routines they had during the visit. The rituals were established during marriage, and following widowhood the opportunity to follow the rituals decreased. The weekly support visits preserved the link to the past, as they allowed narrators to engage in a familiar and comforting custom.

*I have one and a half to two hours per week on a regular basis home help, which reminds me I always put on a cup of tea for her, I’ll make us one now…There you go home baked scones and muffins… I like to get the china cups out and the saucers, bit of an airing…People here don’t bother as much with baking anymore, but I like it…She’s [home help] quite a caring person. She’s a grandma and has lots of little anecdotes to tell you know that’s wonderful. She did these photos for me; they are pictures of the gorge. It’s very nice isn’t it…we like talking about photos (Eric).*

Interestingly, many older male participants saw this form of social support as acceptable, as the carer was being paid for a domestic purpose.

*I get a lady comes in for two hours, but I just got a letter from the hospital telling me they are going to look into it. Maybe cut it back, which I’d be real sad about if I’m honest she’s a nice girl and we have a laugh whilst she cleans and then we have a cup of tea before she goes (Arthur).*

Alternatively if the carer was being employed in a befriending role, the support may not have been so readily accepted, perhaps as a result of shame.
I have a carer that comes in once a week and when she does we have a coffee and we talk. I said to her it’s important to talk to people and get their view of what’s happening around the place, instead of getting the bloody cleaning done. People are important, not dust. The conversation is the most important part, when she visits, the most important (Alistair).

Finally, the fear of losing the formal support highlighted the importance narrators placed upon the visits as a means of managing loneliness.

I have a lovely lady come in and do the cleaning as well and she’s a real breath of fresh air. We have a quick cup of tea when she’s finished and we have a chat. She always makes me laugh and sometimes she may be the only person I see throughout the week, in my house. I’m a bit worried though because they have just reviewed my case, and they said they are cutting her time down, well I won’t be able to do the bedding or the shower I’ll fall. I do enjoy talking to her as well and it takes my mind off things (Bob).

The primary role of formal support was to meet the physical and functional health needs of the narrators. However, the stories revealed the social value narrators placed upon the visits. Carer visits moderated some of the negative aspects associated with widowhood and loneliness, and were frequently used as a coping mechanism. The stories highlighted a need for professional boundaries to protect both worker and service users, as with time the relationship changed from formal to informal due to the intimate conversations that took place during the visits.

This concludes the first section of this chapter, on personal coping mechanisms. Narrators described how they adjusted to widowhood, and came to an understanding of how to prevent or contain feelings of loneliness. Narrators viewed loneliness from a preventative, or curative perspective. Narrators who were comfortable admitting to feelings of loneliness, described their process of understanding and how they learned to live with loneliness. Narrators who denied ever feeling lonely or reported the experience as fleeting, talked about how they
prevented themselves from succumbing to loneliness. Interestingly, the coping mechanisms were similar and the actual coping mechanism is not the key issue, rather the relevance of the coping mechanism for the individual and how effective the individual perceives it to be.

**ROLE OF HEALTH SERVICES**

Narrators’ views of health professionals and their role in addressing loneliness not only revealed the complexity and misunderstanding that still surrounds loneliness, but also the importance of effective communication. Uncertainty featured in the stories, in relation to talking to a health professional about loneliness and bereavement. Although some participants stated they would raise the topics with a GP or a nurse, it was said with uncertainty which suggested potential incongruence between words and actions.

*Uncertainty*

Participants described an element of uncertainty surrounding the role of health services in the management of loneliness. Although most narrators stated that they may raise the topic of loneliness with their GP or practice nurse, this was accompanied by an underlying hesitation. The issue of time was a common topic amongst the narratives. Narrators felt that loneliness was not an issue that could be dealt with in short time frames and as generally health professionals were pressured for time, it was unlikely that they would be able to address loneliness.

*I don’t know whether there’s much they can do really [about loneliness], unless they can take on more staff, they’d have to take on more staff* (Rose).

Participants refrained from speaking with their GPs about loneliness due to its subjectivity, as they felt that within time they would adjust to widowhood. Some narrators believed the management of loneliness was up to the individual, despite helpful attempts from health professionals.
I didn’t actually tell him [GP] I was feeling lonely, because I’m not sure what he could have done for me. It’s just time isn’t it and adjusting to your new life, but I’m sure if I had have told him he would have listened. I think it depends on how you feel and who you are with, as to what you think and how you respond to it. So health services would be dealing with all different personalities. I mean I’m basically a cheerful person and I don’t think you can make a person become cheerful if they are not, I mean if it’s not in their nature (Walter).

Pressured time, plus confusion about what could be done to manage loneliness, led some narrators to feel uncertain about raising the topic of loneliness at all. The suggestion was made that management may be more successful if health professionals raised the topic first.

They [health professional] are busy enough as it is, I know that from all the appointments that I took the wife to. I suppose they could talk to people more and ask them if they were lonely, because otherwise it’s not necessarily a subject that people would bring into a conversation. And I suppose they could share information about how to cope with being lonely, you know especially after losing someone close. I mean I could have done with that in the early days, I mean now I try to snap myself out of it (Bob).

On the whole the stories suggested an element of doubt regarding the health professionals’ role in the management of loneliness. Participants were unclear about loneliness and how it could be resolved. Such ambiguity decreased their confidence in raising the topic, despite having a seemingly good relationship with their primary health professionals.

Fear

According to several narrators, the uncertainty some older people feel about loneliness may stem from fear and stigma. Health services make significant life changing decisions with regard to aged people and permanent care. There was a misconception, amongst some narrators, that a disclosure of loneliness may have negative consequences.
I don’t know that they [health professionals help people to manage loneliness] can really. People don’t always want help and I don’t think people should be forced into things, that wouldn’t help them that will just cause more worry (Rita).

Enforced rest home placement was seen as a major deterrent, as to why older people may not feel comfortable talking to a health professional about loneliness. Reassuring older people that talking about loneliness does not lead to incarceration was suggested as a way of improving communication about loneliness.

I think older people are frightened of being put into a home if they admit they are not coping. I think doctors and nurses need to take that fear away, people would then feel more secure they would feel happier because the happiness comes from the security (Lucy).

Participants highlighted the fine line between concern which was helpful, and interrogation which was unhelpful and increased suspicion and worry. The stories emphasised the need for basic interpersonal communication skills amongst health professionals.

Well I like talking to my doctor, she’s very approachable and always happy to listen, but she doesn’t pry. I think If she did [pry] I wouldn’t tell her as much, because I’d worry why she was asking me. That’s what worries me with the hospital, I think why do you want to know these things, do you think I’m not coping. That’s my biggest worry having to move into a rest home, I would hate that. I think it depends on the person, I would probably be suspicious if somebody wanted to know if I was lonely and I didn’t know them. I don’t think I would tell them [health professionals]. I like to do my own [coping], but other people may like somebody showing concern. I’m not sure, I think that is definitely down to the person, so you would have to be careful of who you were asking and how you asked them [about loneliness] (Elsie).

Participants were more inclined to disclose loneliness to health professionals if the therapeutic relationship was balanced and not one of pity. The need for confidentiality was also essential, particularly in rural communities.
They [GP surgery] probably would tell my family and they would want me to join a club (laughing). I wouldn’t thank them if they interfered and sent me to a club I didn’t want to go to. I wouldn’t mind talking in general like I do with the nurses, but we just chat I don’t think she feels sorry for me I couldn’t be doing with that (Colin).

Fear of the consequences of talking to a health professional about loneliness brought attention to the need for skilled interpersonal communication. Interestingly three of the four narrators who referred to fear in their narratives were women from the older age group 85 plus, which could suggest a relationship between gender and age and fear of the consequences of talking about loneliness. Understanding skills such as reassurance, and education about loneliness, are important if older people are to feel comfortable raising this topic with clinicians. Alternatively the topic of loneliness may need to be introduced into conversation by health professionals. An emphasis needs to be placed on legitimatizing the topic of loneliness, not medicalizing it. A proactive rather than reactive approach is required if the topic of loneliness is to be raised in a health conversation.

Legitimate Topics of Health and Well Being

Participants’ perception of illness, and the role of health professionals, influenced how they felt about discussing loneliness. Narrators’ expressed their views of illness, and what they deemed legitimate symptoms to bring to the attention of a health professional. Most narrators portrayed health professionals as the epitome of wisdom and virtue, who should not be troubled with something as insignificant as loneliness. This behaviour revealed a lack of awareness about the impact of loneliness, and the role of a health professional.

Loneliness was viewed as a marginal matter as it did not appear to fit easily into the medical model of health and illness.

They [health professionals] can’t do anything about it. They have much more to deal with than minor things like that [loneliness]. They are absolutely brilliant. I think you have to
push your own barrow [stay independent] and that’s that. I’m not sure who I would talk to (Jean).

Interestingly, when the term health professional was mentioned in the prompt question, multiple narrators instinctively thought of doctors. The role of the doctor was intrinsically linked to the treatment of illness, not loneliness.

I’ve got a good doctor here and I was having trouble getting up in the morning [low mood], and that sort of thing, and so I went to see him…I’m not sure… I always think of illness not loneliness… (Jack).

Despite it being a source of distress, loneliness was viewed a natural occurrence and therefore not a topic to bring to the attention of a doctor.

I don’t think I would talk to my doctor about loneliness. They have too much on, I feel loneliness is part of life and people at some point through their life will have to manage it (Alan).

For some narrators the focus of a doctor patient interaction was very much physical health related.

I don’t think I even visited the GP for a while not unless there was something wrong with me. I mean I do go, to get my blood pressure and waterworks checked, but I only focus upon what I’ve gone to get seen to [physical health]. I’ve never thought to talk to him about how I’m feeling [loneliness] (Walter).

At times, health professionals focused upon a medical diagnosis and confused loneliness for depression.

He’s [GP] already done some tests with me in the past. He said oh I think you’re a bit depressed, gave me a questionnaire and put it in an envelope and sealed it down with a clip and gave it to me and I answered all these questions and took it back to him and he said you’re alright, just… They [GP] don’t have the time to spend on those things [loneliness] I’m sure of that (Eric).
There was an element of awe to the stories and the manner in which narrators described the health professional and their role, the focus of which was the hard working nature of busy health professionals. According to some participants, health professionals’ time should not be wasted with complaints of loneliness.

*Probably not, [tell GP lonely].* Well I just feel he is in a different category, he’s my GP. I wouldn’t talk to my GP about that [loneliness]. Another reason is that my GP is so good; a respected doctor. He is so busy you really have to wait. You rarely get in before half an hour late…But anyway about loneliness, I wouldn’t speak to my GP *(Elizabeth).*

The belief that only certain illnesses should be discussed with a health professional may be a generational trait with no specific cause. Alternatively the way professionals interact with older people may reinforce the notion of pressured time and limit the conversation.

*Oh yeah I expect I would [tell GP about loneliness].* I don’t think it’s going to get on top of me [loneliness], so I don’t feel I need to say anything to him now. Oh you know if I was depressed or I couldn’t get out of bed and do my own. doctors are busy people aren’t they? I’m not sure I would appreciate it if all my patients turned up and told me they were lonely, it would be a waste of my time. Well there are some things you have to do for yourself and I don’t think it is wise to waste a doctor’s time with talking about loneliness. Usually we talk about my heart problems and I think he has enough dealing with serious issues…I think health services are busy enough. If I felt things were getting on top of me I’d speak to my GP, but otherwise I think they have enough to cope with *(William).*

The interaction between health professional and patient, is more than the superficial exchange of information. As the extracts from the stories have demonstrated, both patients and professionals perceive illness and roles differently. The manner in which narrators described health professionals suggested they viewed the health professional as being in charge of the situation. The onus therefore is on the professional to move disclosure from the superficial
to the intimate, which may be achieved by reviewing interpersonal relationship skills such as availability.

*Communication skills*

The impact of a health professional’s interpersonal communication skills was clear throughout the stories. The manner in which a health professional communicated was important, as the way it was perceived influenced whether a narrator felt comfortable or uncomfortable divulging feelings of loneliness. Narrators commented upon eye contact, or the lack of it, and how this gave the impression of disinterest.

*The doctor here…Err very arm’s length. I ask him questions, even today, and he never gives me a proper answer. He’s always looking at the screen, very evasive people* (Michael).

Although on the whole the care received was efficient, on some occasions narrators felt as though they were reduced to a body part rather than being treated as a person.

*No, I would deal with it [loneliness] myself. I never talk much to the GP, I don’t need to……When I was in hospital they were great, but they were focused on the part that was playing up. It didn’t seem like the rest of me was considered, not dissimilar to the way you’d look at a machine. I think it would have improved my experience to no end, if they had had more time to talk……I’m a great one for talking things through* (Alistair).

Professional consultations were clinically focused, and based upon the collection of medical data. Decisions based upon surface observations, such as the presence of a family, may actually be assumptions.

*Well I went to the doctor with my daughter, and we went to talk about my weight because I’d been losing weight, and we got onto talking about meals on wheels. And before you know it he was asking me about how I was feeling, and I said I was lonely and then that’s how [Hospital] became involved…Oh he’s not a bad doctor, he does quite a bit for me,*
although my daughter thinks he could do a bit more. She thought he took too long to pick up on the loneliness. She thinks because my doctor knew there was family around, he assumed I was ok when I wasn’t (Graham).

A clinical approach to assessment was not welcomed by all participants. Narrators found the lack of empathy culturally unsafe. They felt they were not always listened to and this in turn impacted upon respect, and influenced negatively their willingness to disclose feelings of loneliness.

I don’t have time for the health services, everything is done the Pākehā [white New Zealander] way, there’s no feeling just processes and I don’t feel comfortable being a part of that…I wouldn’t talk to my GP [about loneliness], because I don’t think they understand truly how we [Māori] live. They don’t have the time to understand, our standards are different that’s all it is. That really gets to me, it’s just the whole attitude...It’s not difficult, just listen and learn. Take time to listen to people, earn their respect and their trust, learn what values are important to them and then people will trust you and accept help easier. No one is going to tell a doctor or a nurse they are lonely if they think that person won’t listen, or isn’t respectful or interested, would you I wouldn’t there is no point (Heni).

Interpersonal communication forms the foundation of a therapeutic relationship. Extracts from narrators stories highlighted the negative impact poor communication skills had upon the disclosure of loneliness.

**Rapport and Trust**

The importance of rapport and trust was highlighted in several narratives. Participants referred to communication skills such as patience, listening, and being non-judgemental. Rapport was established through non-verbal communication, which indicated interest and promoted validation. This could prove useful for a sensitive subject such as loneliness.

*I would [tell health professional about loneliness] when we had a very good GP, a little while ago. He was actually a very, very good doctor, an understanding doctor,
unfortunately he left and I wasn’t the only one who was sad to see him go. He was the sort of person that if you said I’ve got something bothering me somewhere, he didn’t look at you as if to say oh no what else have you got. You know, what are you imagining now…I have a very nice lady doctor now…I’ve no complaints with her at all, she’s really very nice but she just doesn’t seem to grasp what he did [previous GP]. He [GP] would see things and he was very good when my husband died. It’s hard to say really, everyone’s different and it depends on the doctor, some of them you wouldn’t bother to tell them anything really... (Lois).

Participants talked about health professionals who demonstrated sensitivity, and were aware of an underlying concern that had not been expressed. This helped to form a therapeutic connection.

I think a good doctor should have intuition and that would have a good deal to do with picking out the lonely people. Anyway, any doctor should have it [intuition] to a degree and if they haven’t they should learn to develop it, because if they haven’t they may miss people who are too proud or nervous to admit it [loneliness] (Lucy).

Feeling understood, with regard to loneliness, was a major issue for some participants. Some narrators highlighted the effectiveness of support which was based upon their individual needs, as it demonstrated an understanding nature on behalf of their doctor.

Oh my doctor’s good, when I was feeling a bit down she sat down with me and we went through a list of things I could do...She’s a little cracker, I’ve been going to her for about 25 years now. We talk about all sorts of things. I’ve said to her you are not allowed to retire…I think if you feel completely alone, that’s when you should let your doctor or the health people know (Margaret).

Rapport increased the confidence that narrators had in their health professionals. Confidence broadened the range of topics narrators felt comfortable talking about.
I absolutely love my doctor. It’s a lady doctor and her husband is also a doctor and he was my husband’s doctor, and sometimes if my doctor isn’t there they [receptionists] always ask if I want to see her husband and I don’t hesitate. I say, oh yes that’s fine and they are both marvellous to me...Yes I’d tell my doctor [about loneliness], I would and I think I would tell her husband as well, because they would listen and I’m sure they would help me (Huia).

The issue of availability and feeling listened to was again brought up as a way of establishing rapport, which in turn was essential for discussion of loneliness.

My doctor’s good he takes time and he doesn’t rush... If I felt that it was really getting me down [loneliness] I may tell him... but I’m not sure big places like rest homes or hospitals have the chance to do that. Just taking the time to talk about something a person is interested in helps, it’s not that complicated but not everyone is intellectual and they have other jobs to do (Max).

For the therapeutic relationship to move beyond superficiality and into the realms of professional intimacy, trust was required. Participants who had developed trust in their health professionals, were able to talk about their feelings more easily.

A couple of years ago it was winter and my son had been home and he had gone away, and erm it was a bleak sort of winter... so I went to my doctor and said look I wonder if I’m losing the plot...I needed to tell someone and she was good, I thought I was going doolally...I talk to the nurses at the surgery as well, one in particular is very good very patient and kind. I think that [patience and kindness] is so important because that would make you really worse if they were a bit dismissive, I think yeah (Ruth).

Participants revealed that being able to trust a health professional enough to share the torment of loneliness, was the first step in managing loneliness.

Oh yes I have a wonderful GP and she has been marvellous to me and she knows all the problems I have had. She has been good all the way through, because I have had quite a lot
of other problems in my life you know and she has been just great. She insists I go to see her every three months and if ever I can’t get in she’ll say I’ll come and see you, you know. I’ve been going to see her for, oh it must be about 10 years I think… I’ve been able to talk to my GP, which was amazing really because it [loneliness] was quite terrible whilst it was happening. I didn’t have anyone to talk to. I’m quite a private person and I wouldn’t feel comfortable telling my friends (Elsie).

Measures such as levelling the power imbalance and raising the topic of loneliness in conversation, were mentioned as ways in which health professionals had helped narrators develop trust and cope with loneliness.

I have a good doctor and she looks after me well, she’s good. It’s all first name terms at the surgery, no surnames. I’ve been going there for over 10 years… I think I could tell her [about loneliness], there would be nothing stopping me if I felt I was getting lonely and needed help with something …My doctor is really good, I could talk to her about anything…A doctor can only do so much, but maybe if they introduced the topic [loneliness] more people would talk about it (Joe).

Objectivity was crucial as it encouraged trust, and enabled the narrator to feel as though the health professional could help them to manage their loneliness.

Oh I think he [GP] knows [about loneliness], because they put me on some tablets for my mood at one stage. It [medication] does [help], I think I’m still on it. That [loneliness] was one of the main things that I talked to him about and he said these tablets would help. I don’t have any problems with the way he is with me, no none at all. Things happened and I thought well it will pass, but it didn’t and when I did tell him [about loneliness], he didn’t seem shocked or embarrassed, I was a little (Peter).

Positive reinforcement, through successful interactions, meant that narrators found themselves open to the idea of discussing loneliness as they trusted the health professional.
He’s a good doctor, he’s been our family doctor for a long time. I think I could tell him I was lonely if it got so bad, actually I think I already have, I think I told him one other day…I found my doctor was very helpful. I don’t know if other people would feel the same, but when you do go to the doctor you do share quite a bit of private information with them so I don’t see why talking about loneliness would be any different. I suppose some people may feel embarrassed, because it may look like no one wants to spend any time with you therefore you must be a pretty miserable old person. My doctor did ask me, if I was lonely, especially after my wife moved into the rest home and I think I did tell him how I felt, talking about it did help (Hugh).

Rapport and trust played a key role in facilitating the therapeutic relationship between narrators and health professionals. Rapport helped to establish the relationship, and trust helped to move it from a superficial level to one of professional intimacy. A degree of professional intimacy was required for narrators to feel comfortable disclosing loneliness.

CONCLUSION

The final part of the collective story consisted of narrators’ personal coping mechanisms, extracted from the stories they told of their adjustment to widowhood and understanding of loneliness. The personal coping mechanisms prevented, or contained, feelings of loneliness. Some narrators were comfortable talking about their experiences, and how they dealt with loneliness. Other participants denied feeling lonely, and so talked about the strategies they used that stopped them from succumbing to loneliness and what they thought they would do if they became lonely. Interestingly, whether loneliness was approached from a preventative or curative direction, the coping mechanisms were similar. Both gender and age appeared to impact upon the way in which participants viewed loneliness and widowhood. Some female and male participants claimed that in general women adapted to widowhood and dealt with loneliness, better than men, as a result of life experiences and gender roles. The younger group of men aged 70-
84 appeared to view loneliness as a personal challenge that they would not succumb to; stories from older male participants did not demonstrate the same level of provocation.

Narrators also shared their views on the role of health services in the management of loneliness. The stories revealed an underlying sense of awe, fear and uncertainty pertaining to the role of a health professional. Narrators had a medical based view of legitimate topics that a patient could approach a health professional about. The importance of health professionals’ communication skills was a key discovery in the final component of the collective story, as was the issue of who should raise the topic of loneliness in an interaction between patient and health professional.
CHAPTER SEVEN DISCUSSION

Loneliness is a complex phenomenon that generates much discussion about its causes, consequences, and methods for managing it (Havens et al. 2004, Pettigrew & Roberts 2008). An international response to improving health care for older people, calls for further research into precursors leading to poor health. Loneliness features frequently in the list of precursors for many physical, mental and social health issues that may threaten quality of life and independence in old age (Hawkley & Cacioppo, 2010; Luo et al., 2012; Sabir et al., 2009; Theeke, 2009).

RESEARCH AIMS

The aims of this research were to explore, i) individuals’ subjective experience of loneliness, ii) the impact of ageing and lifestyle upon loneliness, and iii) what informal and formal coping mechanisms are used by individuals to manage loneliness. Whilst loneliness is more prominent as a research topic, the subjectivity surrounding loneliness remains unclear (Tiikkainen et al., 2008). The current study, focuses upon stories that describe the unique nature of contextual influences and their relationship to loneliness.

CENTRAL ARGUMENTS

The contents of this chapter will follow the trajectory of a collective story of loneliness, which was drawn from the perspective of the 40 widows and widowers who shared their individual stories. The story began with an event or a change in lifestyle, which was ascribed meaning by the individual. The context of meaning ascribed to the event/change influenced the intensity of the emotional response, specifically loneliness. This study explored the relationship between loneliness and the life event of widowhood. The apperception of loneliness represented the first part of the collective story. The plot continued with participants’ accounts of the
process of renegotiating their self-identity following bereavement. Loneliness was influenced further by the subjective experience of physiological change, namely ageing and the impact of societal expectations. Loneliness and the renegotiation of self-identity shaped the mid-section of the collective story. The final stage of the collective story was an amalgamation of participants’ coping responses to loneliness. Coping mechanisms ranged from adaptive to maladaptive, formal to informal, and revealed a continuum of integration and adjustment to loneliness. Cultural influences shaped personal coping strategies and the perception of formal support.

The subjective nature of loneliness in relation to individual circumstances and life history, and the significance interpersonal communication plays in identifying and addressing loneliness, are the central arguments that shape the findings of this research. The findings from this research suggest a need to reconsider existing understanding of loneliness. The understanding of loneliness that emerged from the narratives of the participants in this study could be described as follows:

“Loneliness is an unsolicited condition that can arise when an individual experiences, sudden or gradual, change to an established lifestyle. An emotional parasite, loneliness is usually linked to loss or grief. Its trajectory and duration are subjective and prolonged by the perception of successive loss and compromised adaptation. At its worst loneliness is all-consuming and tolerated, because of shame and or misunderstanding. The process of managing loneliness begins with recognition and acknowledgement from both the individual and external supporting agencies” (Davies-Kelly, 2014).

This definition was drawn from participants’ descriptions of loneliness and incorporates the fundamental components of the collective story. The sense of connection, choice, or control, which was seemingly lacking when the participants described or recalled times of loneliness, is included in the definition. It is also
acknowledged that loneliness arose when individuals experienced a, seemingly irreversible deviation from their familiar routine.

**THE COLLECTIVE STORY - THE APPERCEPTION OF LONELINESS THROUGH CONTEXT BASED LIFE EVENTS.**

First and foremost, the findings from this study emphasise the importance of recognizing the subjective nature of loneliness. The collective story acknowledged the shared meaning of loneliness, but also the subtle differences that each individual story contributed. The collective story was developed from narrative fragments taken from participants’ stories, and followed a trajectory that began with narrators’ recollections of the onset of loneliness.

Participants underwent a process of apperception, in relation to loneliness. Apperception refers to the process of understanding, in relation to past knowledge or experience (Collins, 2011). Most people within Western society have developed an understanding of loneliness by adulthood. Understanding, however, may not necessarily be the result of first-hand experience. Understanding can be derived from a shared meaning, conveyed through a particular cultural or societal perspective. The assimilation of existing knowledge with new knowledge, borne through a life event such as widowhood, can move understanding into a more meaningful realm. Suffice it to say, the manner in which participants responded or ascribed meaning to widowhood was determined by their previous life experiences and ways of coping.

Widowhood is a key event in life, and featured in many of the narrators’ accounts of the onset of loneliness. For some participants loneliness was embedded in the process of grieving, which appeared to legitimize its presence. Loneliness can be viewed as an expected consequence of losing a significant person, and whilst such an outlook may enable people to proceed with the grieving process, it
can also carry with it the expectation of forbearance which may not be possible for some individuals, depending upon their coping skills and life experiences.

The literature relating to a key life event such as widowhood, suggests a symbiosis between loneliness and the event. Widowhood is purported to be a common cause of feelings of loneliness in old age, and bereavement in general is a significant source of loneliness (Adams et al., 2004; Drennan et al., 2008; Dykstra et al., 2005; Golden et al., 2009; Greenfield & Russell, 2011; Heikkinen & Kauppinen, 2011; Savikko, 2008; Scharf & Bartlam, 2006; Theeke, 2009). Researchers acknowledge the protective elements of a long-standing relationship, such as marriage (Luanaigh & Lawlor, 2008; Rasulo et al., 2005; Shiovitz-Ezra & Leitsch, 2010; Victor & Yang, 2012). Historically, the presence of a partner/spouse is viewed as a significant uniting design of society, and a protective factor against loneliness. Alternatively, this societal belief may reinforce the notion that widowhood leads to loneliness (Chalise et al., 2007; De Jong Gierveld et al., 2006).

Widowhood is associated, specifically with emotional rather than social loneliness (Weiss, 1975). A person who is emotionally lonely may have contact from friends and family. However, they may lack a definite attachment figure, hence the presence of emotional loneliness (Adams et al., 2004; Giles et al., 2005; Townsend, 1973; Weiss, 1975). Social loneliness can be caused through lack of friendship and is rarely alleviated by familial relationships (Drennan et al., 2008; Tiikkainen et al., 2008). The relationship between widowhood and loneliness can be prolonged with some people only demonstrating improvement following remarriage, or the formation of a similar relationship (Townsend, 1973).

The findings from the current study elaborate on Weiss’s theory and add to the meaning of emotional loneliness. Emotional loneliness is not only the absence of a key figure following a life event such as widowhood. It is more than that and equates to what the key figure represented. The presence of a confidante, usually a spouse, who may or may not have engaged in conversation, but provided back
ground noise, is significantly noticeable when absent. The simplicity of presence is deceiving, and it is only with absence that its significance becomes clear. Stories revealed an unmet desire for lost spontaneity, and the convenient familiar connection some participants had with their late spouse. Loneliness was a longing for a spouse who had previously provided protection from isolation. The intensity of loneliness was influenced by the void of meaning left, when a spouse passed away.

The impact of marital/cohabiting status upon loneliness in old age remains a matter for debate. Widows who did not consider the role of a spouse or partner as intrinsic to well-being were found to be less lonely (De Jong Gierveld et al., 2006; Vikstrom et al., 2011). Seminal research suggests that fewer spinsters/bachelors experienced loneliness than widow/widowers (Townsend, 1973). Individuals who had been widowed for five years or less reported higher loneliness levels than individuals who had been widowed between 10 or 20 years (Savikko et al., 2005). These studies suggest that whilst marriage may protect against loneliness, widowhood can increase the risk for loneliness. However, loneliness lessens during widowhood the more time passes.

The findings from the current study do not support the finding that loneliness, secondary to widowhood, lessens as time passes. Whilst some individuals appear to adjust to widowhood with fleeting episodes of loneliness, for others loneliness remains intense irrespective of time. These findings reinforce the significance of subjectivity. Health professionals, in particular, should not assume that an individual has adjusted to widowhood because a prolonged period of time has passed. Narrators told vivid and moving stories of widowhood. Some experiences were many years ago, yet narrators conveyed a present sense of disbelief and loneliness, at the suddenness and finality of the situation.

Research suggests the intensity of loneliness or distress can be related to the perceived closeness of the relationship (Li et al., 2005; Reid-Keene & Prokos, 2008).
The findings from the present study indicate that it is not only perceived closeness, it can also be the length of time an individual has performed a certain role that can lead to loneliness. This finding forms part of the central argument, which relates to the heterogeneous nature of loneliness and the need for individual consideration of the experience. The majority of narratives from the 85 plus age groups implied that the longer a person had been embedded into a particular role, the more difficult it was to adjust. The relationship between roles and loneliness was likely to be the result of being frequently reminded that the significant other was missing. Reminders manifested themselves through deviation from familiar daily chores such as finance and cooking, and encompassed wider issues such as gender role divisions.

Stories from the present study also touched upon the age of participants at the time of bereavement. On reflection participants felt they had more or less time to adjust to widowhood, depending upon how old they were when their spouse passed away. Loneliness appeared to be related to the individual’s perception of this. Participants from the current study, in particular female participants, felt they had wider choices available to them, the younger they were at the time of bereavement. The female participants’ stories suggested that their range of choices narrowed as they aged, which appeared to impact on loneliness.

In this study participants’ stories were shaped by personal meaning, rather than a temporal recollection of a life event. On analysis, a past event was ascribed meaning by the narrator and linked to loneliness. Loneliness did not arrive unaccompanied. The narrators’ experience or emotional response to the event was the focus of the story, not the timing of the event. Hollway and Jefferson (2013) interpreted the sequence of stories from a psychosocial perspective. The emotional sequencing of narrative was particularly pertinent to this research, as when narrators began to tell their stories the emotion resurfaced, and for some it appeared that time had been suspended. The experience was still memorable as a
result of the emotional meaning, despite the passing of time and many other events having occurred. As some narrators appeared more comfortable to talk about other people’s experiences of loneliness, both first hand experiences of loneliness and the experiences of other people were conveyed in the stories.

Whilst widowhood is acknowledged as a significant risk factor of loneliness, a high proportion of research studies are quantitative, and focus upon the key event as the link to loneliness (Chalise et al., 2007; Li et al., 2005; Reid-Keene & Prokos, 2008; Subramanian et al., 2008). Participants’ stories from the present study suggested, widowhood was an event that all participants had experienced at different points in their lives. Widowhood did not, however, predetermine loneliness; it was the meaning ascribed to the event that determined the emotional response that was loneliness. For some of the participants, widowhood was a very lonely time whilst for others it was the time leading up to widowhood that was lonely.

Loneliness for some people can be the emotional response to a deviation from a familiar routine. What represents a familiar established routine for one person is invariably different for another. The value attached to a routine may also be significant. This may explain why some individuals experience more intense loneliness following spousal bereavement. It may also clarify why individuals feel lonely despite the presence of others, as it is a routine or specific company that is missed, not company per se. Participants’ narratives about spousal illness suggested that loneliness at times arose when personal routines deviated from the familiar.

Narrators felt loneliness was less noticeable during the period leading up to their spouse’s death. The gradual withdrawal from socialization or activity, as a result of a spousal illness, and the demands of the caring role were acknowledged retrospectively as a time of loneliness. The marital relationship is significant as it can actually contribute to loneliness, particularly if one partner has to adopt a
caregiver role (Leung et al., 2008; Shiovitz-Ezra & Leitsch, 2010; Wenger & Burholt, 2004). The uncertainty and misunderstanding in acknowledging loneliness, or having loneliness acknowledged by others, resulted in a paradoxical situation whereby loneliness fostered loneliness. Spousal carers described a sense of helplessness and the isolating effects this caused. The feeling that no one truly understood what they were experiencing increased their sense of loneliness.

Though a fundamental part of many older individuals’ lives, marriage forms only one component of social networks. Social network consists of formal and informal support, acquaintances, family and friendship. This results in different relationships and fulfillment of different needs at various points throughout life (Tomaka et al., 2006; Valadez et al., 2006; Wang et al., 2011; Weiss, 1975; Wiles et al., 2009). The socio-emotional theory identifies bereavement as a risk factor for loneliness (Carstensen, 1995). Carstensen (1995) believes older people nurture and cherish existing social emotional relationships. Whilst these condensed relationships may reduce the need for multiple social contacts, they can negatively influence the ability to form new relationships. Once the familiar contacts are lost through bereavement, lifestyles may change dramatically and result in loneliness (Townsend, 1973).

The opportunity to establish new trusting relationships is not as readily available as people age (Aebischer, 2008; Arve et al., 2009). Findings from this study support the socio-emotional theory. Narrators identified a decreased social circle as a source and meaning of loneliness and a deviation from the familiar. A decreased social circle equated to a decline in opportunities for social interaction and was the result of death, retirement and financial restriction. Narrators’ stories about the passing of friends differed from their stories of spousal bereavement. Bereavement stories described the multiple losses associated with a decreasing social network, which in turn perpetuated feelings of loneliness. Multiple losses reinforced a sense of mortality. The impact of a diminishing social network
challenged participants’ sense of control over their lives. Participants felt that enforced isolation increased loneliness, as their perceived range of choices decreased. The loss of consistency and control of access to other people increased narrators’ sense of restriction and dependence.

In terms of networks it appears that friends provide the greatest protection against loneliness after a partner or a spouse. This is usually protection against ‘social’ loneliness (Steed et al., 2007; Van Tilburg et al., 2004; Weiss, 1975). A majority of older widows/widowers depend upon the family for social support. Family support can help lessen feelings of loneliness particularly with regards to filial obligation (Drennan et al., 2008; Heylen, 2010; Li et al., 2005; Pettigrew & Roberts, 2008; Victor et al., 2005). It is interesting to note, however, that the social loneliness caused through lack of friendship is rarely alleviated by familial relationships (Drennan et al., 2008; Tiikkainen et al., 2008). A shared chronological point of reference may account for this occurrence, something which a child parent relationship may not provide (Bekhet & Zauszniewski, 2012; Valadez et al., 2006).

Again the narratives from the collective story both support and add to existing research. Participants from the current study described feeling lonely despite being surrounded by other people, including their families. Participants determined what made them feel lonely. This created a sense of conflict for some narrators who recognized the need for interaction, yet did not always find a reprieve from loneliness even though they were in the company of others. The presence of adult children does not always alleviate loneliness, and gives credence to previous research that suggests older people who are childless are no more at risk of loneliness than those older people who have children (Vikstrom et al., 2011; Wenger & Burholt, 2004). Furthermore, older individuals who rely solely upon their families for social contact can actually place themselves at greater risk of loneliness as, their familial relationships may be limited (De Jong Gierveld et al., 2006). Bereavement is not the only source of loneliness. Industrialisation has
caused families to disband and removed a potential source of company that may have moderated the isolation of widowhood.

To understand and acknowledge loneliness, is to understand and acknowledge the individual. Change in established lifestyle through bereavement or functional decline, or a combination of these events, may highlight a sense of dependency and a discrepancy between need and availability (Dennis, 2005; Havens et al., 2004; Jylha, 2004; Palkeinen, 2005). Outliving social networks can intensify perceived loneliness (Dykstra et al., 2005). Despite the impact of such change, the relationship between social networks and loneliness is afforded less consideration than widowhood in the literature. Recent research calls for greater consideration of networks and loneliness, specifically in the area of formal support service development (Ekwall et al., 2005; Tiikkainen et al., 2008). In particular, the relationship between networks and quality of life in people aged 85 plus remains ambiguous, as the inclusion of this age group in the research studies is limited (Hellstrom et al., 2004). The participants aged 85 plus within this study commented upon the difficulties associated with changes to an established lifestyle. The adjustment to widowhood, combined with taking on a new skill or recommencing an activity as a single person, was so overwhelming for some participants that they avoided it. Ultimately avoidance led to loneliness.

Respondents’ narratives revealed a possible link between the onset of loneliness and an event or a change in lifestyle. However, it was the individual meaning ascribed to the event or change that precipitated loneliness, not the event itself. Loneliness, therefore should not be dismissed as routine following bereavement, nor should it be viewed as an abnormal grief reaction when prolonged over many years. Loneliness is an emotional response an individual can experience when they encounter a deviation from the familiarity of a routine, meaningful to them.
Loneliness can affect all older people in varying degrees (Perlman, 2004; Van Tilburg et al., 2004; Victor et al., 2012). As people age they are exposed to change; the structure of familial and social networks may alter, which in turn can increase the risk of loneliness (Cavallero et al., 2007; Rius-Ottenheim et al., 2012). Greater awareness and preparation for change may encourage adaptation, promote the importance of maintaining physical well-being, and help to decrease loneliness (Dykstra et al., 2005; Golden et al., 2009; Ruxton, 2006; Tomaka et al., 2006; Wenger & Burholt, 2004).

Health and social service provision should include education about role change and adaptation following bereavement. The experience of widowhood and bereavement is a traumatic but inevitable part of ageing, which should not be ignored (Adams et al., 2004; Dykstra et al., 2005). Education is required to encourage service use if the issue of loneliness is to be addressed. However, more subjective awareness is required to establish greater understanding of the meanings older people attach to relationships and support (Hellstrom et al., 2004; Sabir et al., 2009; Shiovitz-Ezra & Leitsch, 2010; Tiikkainen et al., 2008).

LONELINESS AND THE RENEGOTIATION OF SELF (THROUGH INDIVIDUAL AGEING, WIDOWHOOD AND SOCIETAL EXPECTATIONS).

Narrators ascribed personal meaning to loneliness by way of external context based life events, through a process of apperception which was described in the first part of the collective story. As the collective story progressed the narrators’ focus switched from them giving personal meaning to an external event, to the way that external forces shaped their personal thought processes. Findings from this study suggest that following widowhood, participants went through a fundamental time of reappraisal. The process was one of self-evaluation; participants considered life from the perspective of an individual, rather than a married couple. Stories focused on the seemingly ordinary events associated with ageing. For widowed narrators, however, events took on a different meaning when
faced alone rather than as part of an established partnership, and experiences that had previously seemed familiar were suddenly strange. The absence of a confidante, combined with physical and functional changes, had the potential to exacerbate loneliness. Narrators emphasized the perception of loneliness, in relation to their experiences of ageing, rather than the physical state of isolation. The process of renegotiating an identity was also related to the contextual world/society in which participants lived and influenced the way narrators experienced and expressed loneliness.

McDonald (2012, p.5) defines perception as “a personal manifestation of how one views the world that is colored by many sociocultural elements”. With regard to loneliness in old age, perception is a fundamental concept. The relationship between loneliness and perception is highly significant as a person’s perception is their reality, and therefore plays a considerable part in determining both the way a situation is viewed, and the degree of loneliness felt. Most definitions of loneliness refer to a perceived discrepancy between desire and availability of relationships. The greater the perceived discrepancy between desire and availability of relationships, the higher the risk of loneliness (Dykstra et al., 2005). Cognitive theorists emphasize the subjective nature of loneliness (Ayalon & Shiovitz-Ezra, 2011). Individual personality traits, along with cultural differences, can shape the way individuals experience loneliness (Dykstra, 2009; Luanaigh & Lawlor, 2008; Ni Mhaolain et al., 2012; Rius-Ottenheim et al., 2012). A person can perceive the state of being alone as peaceful solitude or unwelcome isolation, depending upon whether they have extrovert or introvert personality characteristics (Barg et al., 2006). There is a positive correlation between low self-esteem and feelings of inadequacy and higher levels of loneliness, suggesting that individuals who perceive themselves as socially inadequate succumb to loneliness (Heinrich & Gullone, 2006).
Events such as bereavement and ageing can disrupt both the way people interact, and the manner in which they construct reality. Research suggests social networks diminish with age. Whether this leads to an exacerbation of loneliness, however, is debatable (Adams et al., 2004; Winterstein & Eisikovits, 2005). Physical and functional decline, secondary to ageing, contribute to smaller social networks (Tikkainen et al., 2008). Decline can result in limited opportunities to form new contacts, or engage in social activity. As these are considered important to well-being in later life this may increase feelings of loneliness (Heylen, 2010; La Grow et al., 2012; Murray et al., 2006; Pettigrew & Roberts, 2008; Savikko, 2008; Tiikkainen et al., 2008; Victor & Yang, 2012; Wenger & Burholt, 2004). Conversely socio-emotional theory (Carstensen, 1995; Hutnik, Smith, & Koch, 2012) and Continuity theory (Atchley, 1989) maintain that a reduction in relationships is a natural adaptation to ageing, and does not impact negatively on well-being. As noted throughout this thesis consideration needs to be given to the subjective nature of ageing. Theories of ageing may run the risk of presenting an oversimplified view that could perpetuate homogeneity and stereotype. In terms of the perceived benefits of support network relationships, the quality of social contact rather than the quantity is purported to be of greater significance (Dykstra, 2009; Savikko, 2008; Shiovitz-Ezra & Leitsch, 2010; Tiikkainen et al., 2008; Yang & Victor, 2008).

Being seen and understood by others are important factors for sense of self and existence, the lack of which can result in loneliness (Steeves & Kahn, 2005). Drennan et al. (2008) researched the emotional and social loneliness experiences of older people in Ireland. A quantitative telephone survey was undertaken with 683 older adults. Findings suggested that loneliness is influenced by the level of expectation an individual has for a relationship. Drennan et al. (2008) did acknowledge the limitations associated with a participant sample that was mainly white Irish female, a population group that is more likely to be part of a social
network. The link between loneliness and perceived discrepancy between expectation and reality is well documented (Heravi-Karimooi et al., 2012; Heylen, 2010). A study by Rius-Ottenheim et al. (2012) surveyed 416 men aged 75 plus, and found a propensity towards positive expectations resulted in lower levels of subjective loneliness. As this was a male only study findings cannot be generalized to women. The collective story from the current study took the concept of being seen and understood by others a step further. The collective story reflected the narrators’ views of their own existence, along with the comparisons they made between themselves and other people in society. Societal expectation and comparison helped to mediate loneliness. An understanding of loneliness was developed through a context based life event specifically, widowhood. Comprehension of loneliness was also achieved by way of comparison with other people that had experienced a similar situation. This resulted in both positive and negative views of loneliness, depending upon the individual’s perception of loneliness as a stigma or a natural occurrence of life.

Older people spend more time alone than younger people; however, loneliness is reported less (Adams et al., 2004). Loneliness is not necessarily defined by the number of contacts an older individual receives (Gilmour, 2012; Shiovitz-Ezra & Leitsch, 2010). Tiikkainen et al. (2008) maintain that individual perception can place a positive or negative value upon social interactions. It is this that is the crucial determinant in the experience of loneliness and not, as frequently believed, the objective state of being alone. Individuals who have always led a solitary existence will not, as they age, automatically become lonely. It is the perceived change in lifestyles that contributes to feelings of loneliness (Schnittker, 2007; Tiikkainen et al., 2008; Townsend, 1973). Individuals who perceive their age, health and interpersonal circumstances in a positive way may foster resilience and are less likely to experience loneliness, regardless of the actual situation (Steed et al., 2007; Wiles et al., 2009). The findings from this study support these conclusions,
but also develop them further. The collective story once again reinforced the subjective nature of loneliness. The collective story identified that it was not the physical or functional changes themselves that predetermined loneliness, but the meaning or value ascribed to the activity that was lost as a result of the physical or functional change.

For the purpose of eliciting individual meaning and understanding perception Barg et al. (2006) argues that, a qualitative research approach is more appropriate, as it is guided by a participants understanding and language rather than the applied terminology in surveys or questionnaires. Barg et al. (2006) opted for a mixed method approach and interviewed 102 older people about their views of depression and the non-uptake of treatment. They used a semi-structured interview, combined with a depression scale and grounded analysis. Results from their study indicated that loneliness is a precursor to depression. Participants described depression in their own words and frequent references were made to loneliness. The topic of depression was opened up to a broader range of interpretation, by allowing participants to use their own words. Had a questionnaire been used the participants may have been more restricted to the choices listed. Interviewer bias, along with the impact a depressive illness may have upon the severity of the loneliness feelings, were cited as limitations of the study (Barg et al., 2006).

The connection between the perception of relationships and loneliness is well documented (Savikko, 2008). The way an individual views other aspects of their life, can also influence levels of loneliness. Perception of health is another example; people may feel lonelier if they view their well-being in a negative light (Gilmour, 2012; Havens et al., 2004; Savikko et al., 2005; Theeke, 2009; Van Tilburg et al., 2004; Victor et al., 2005; Wilson et al., 2007). Negatively perceived health is linked to increased loneliness, irrespective of actual health status (Heylen, 2010; Steed et al., 2007). According to Blazer (2008), who undertook a literature review of self-
perceptions of older adults and the impact on health and well-being, people who feel connected and supported to remain independent have better health outcomes and lower levels of loneliness. The protective factors of perceived social support were highlighted in a quantitative study that researched the impact of spousal bereavement on mental health (Onrust et al., 2007). Depressive symptoms and other psychological distress including loneliness can be predicted by age, duration of widowhood and perceived non supportiveness. Hellstrom et al. (2004) researched the quality of life for people aged 75+. A postal questionnaire was sent out to a number of participants receiving formal support at home and a number who did not. Those participants that received assistance and who felt restricted and dependent on others, experienced loneliness and reported a lower quality of life despite having more contacts. The researchers cited one major limitation of using a postal questionnaire. It was unclear if respondents’ questionnaire answers were given independently, or with assistance, which may have distorted the results.

The results from the study emphasized the relationship between a person’s understanding and their level of loneliness. An observational study undertaken by Van Der Geest (2004) supports Hellstrom et al.’s findings; 35 elderly Ghanaians took part in the study and their conversations were analysed. The results from the study suggested that loneliness occurs even when people have social contacts. This implies that perception plays a major role in determining the value of a contact. A limitation flagged by Van Der Geest (2004) was the potential loss of meaning in translation. A Dutch loneliness scale provided the basis of measurement and all respondents were Ghanaian. A strength of the current research study design was that interviews took place in the participants’ homes which meant the interviewer and interviewee were face to face. The interviewer had the opportunity during the interview to clarify any potential misunderstandings and misinterpretation, thus enhancing authenticity.
Perception illuminates the fluctuating nature of loneliness. The experience of loneliness is not static, and can even change in intensity depending upon time of day, or time of year (Grenade & Boldy, 2008; Hauge & Kirkevold, 2012). Perception is the filter which separates the subjective attributes of loneliness. Perception may lead to an ageist view of loneliness, as perception influences the way a younger person may view an older person and what is acceptable in terms of loneliness. Two pervasive themes within some Western societies are those of ageism and stereotyping. The relationship between loneliness, ageism and stereotypes is multidimensional, and incorporates such issues as overly positive or negative imagery. This may lead to complacency, denial and refusal of services (Howse et al., 2004; Murray et al., 2006; Sabir et al., 2009). Historically, industrialized countries paint a pessimistic and misleading picture of old age (Dykstra, 2009; Dykstra et al., 2005; Townsend, 1973).

A popular misconception is that all older people are lonely, which can result in complacency and acceptance of loneliness as a normal part of ageing (Koc, 2012). Such is the degree of stigma attached to the term loneliness, some older people and researchers avoid using it for fear of negative outcomes (De Jong Gierveld et al., 2006; Heravi-Karimooi et al., 2012; Palkeinen, 2005; Rosedale, 2007; Victor et al., 2005; Wilson et al., 2011; Yang & Victor, 2011). Contrary to stereotypes, not all older people are isolated from their families or wish to participate in community life (Findlay, 2003). Research has shown that whilst loneliness can increase with age, it is usually a consequence of being or becoming institutionalized (Dykstra et al., 2005; Ekwall et al., 2005; Lester et al., 2012). The issue of ageing and health succumbs to stereotypes of a burgeoning ageing population, who will drain health resources (Zodgekar, 2005). The desire to be perceived as a useful member of society, rather than a burden, is documented in the loneliness literature (Hauge & Kirkevold, 2012; Lund & Engelsrud, 2008).
The view that elderly people are typically lonely, isolated and abandoned has been challenged, although negative imagery within the media exists (Adams et al., 2004; Davey & Wilton, 2005; Statistics New Zealand, 2004). Supporters of disengagement theory assert that voluntary social withdrawal is an integral part of ageing (Cumming, 2000). This may have been appropriate for the cohort that was studied during the 1960s when the theory was developed (Cumming et al., 1960). In today’s society, however, the theory may not be as relevant as some people are living longer, and remain active into old age (Dykstra et al., 2005). Certainly the older participants who took part in the current study were actively engaged in society, although a major limitation of the study is the purposive sample. One of the recruitment criteria of the study was that participants had to live alone in their own homes, which denotes a degree of independence.

Perception is particularly important. The power of suggestion has self-fulfilling prophetic type qualities that can be both positive and negative (Alma et al., 2011; Fagerstrom et al., 2011; Hawkley & Caccioppo, 2010; Luo et al., 2012; Rius-Ottenheim et al., 2012; Wenger & Burholt, 2004). The way a person views their world, and the way society views a person, can impact upon the types of health promotion and interventions that are offered and accepted (Rosedale, 2007). Health professionals may increase the chances of identifying loneliness, by understanding the way individuals perceive their world. This approach could facilitate more appropriate service input at an earlier stage of intervention. Perception reinforces the subjective nature of loneliness, in terms of unique experience (Heinrich & Gullone, 2006). The collective story, within the current study, revealed what narrators thought society expected of them, and the impact this had upon their sense of ageing, and their perception of loneliness. Evidence of stigma and stereotypes were found in the collective story. Narrators demonstrated both dismissive and pitying attitudes towards lonely people. Common to both of these
attitudes was the tendency of the narrator to distance themselves from the lonely person they were describing.

Individuality and heterogeneity need to be recognized, if positive changes are to be made to the way that older people are perceived in society (Palkeinen, 2005). The ageing experience is unique for each individual. The danger of homogeneity lies not just in the perpetuation of ageism from the way a young person views old age, it also increases the risk of denial within an aged cohort, help avoidance behavior, and reluctance to talk about loneliness because of the associated stigma (Howse et al., 2004; Rokach, 2012; Theeke, 2009; Theeke et al, 2012). Older people may choose not to adopt a social identity as an older person, due to stigma associated with old age in that given society (Williamson, 2011). Refusal of social services such as day care may arise from the archival image of infantilisation and infirmity attached to such institutions (Wenger & Burholt, 2004). Infantilisation refers to “the tendency in western culture to treat older people, and particularly those with some degree of age related dependency, as if they are children” (Hepworth, 1996, p.424). For example the use of pet phrases such as ‘good girl’ or ‘naughty boy’ towards older adults who far removed childhood or infantile pastimes that could be perceived as demeaning. The complexity of loneliness and ageism, may cause repercussions that could impact upon the wider political, social, and professional context. Negative associations may result in poor service uptake, which may impact upon annual budgets, and in turn perpetuate loneliness, and lead to physical and mental health issues. Ageist attitudes within health care may result in inappropriate care packages, limited autonomy, and premature admission to rest home care, which serves only to sustain dependency and loneliness.

LONELINESS – ADAPTIVE/MALADAPTIVE COPING STRATEGIES – A CONTINUUM OF INTEGRATION AND ADJUSTMENT.

The final component of the collective story of loneliness, reflected the shared and individual meaning of loneliness in terms of recognising, understanding and
communicating its presence. The coping strategies that narrators employed, to address loneliness were both adaptive and maladaptive, and revealed a continuum of integration and adjustment. Recognizing and acknowledging loneliness was a process specific to the individual. The manner in which participants adjusted to loneliness was subjective and followed a trajectory that was determined by them. A helpful role of external supporting agencies, be they family, friends or more formal organisations, was to facilitate open communication as this provided the person with an opportunity to examine what loneliness meant to them, and to identify what strategies may help to modify the experience.

Loneliness in old age is a heterogeneous experience, yet even the fundamental differences between the way men and women face and cope with loneliness are unclear. Disagreement arises in the literature with regard to gender and risk of loneliness. Buys and Miller (2004) mark deteriorating physical health plus being unmarried and male as potential high risk factors. Adams et al. (2004) and Savikko (2008) maintain bereavement and being female places an individual at greater risk. A third argument states environment, age and marital status have more influence over loneliness than gender (Golden et al., 2009; Havens et al., 2004; Victor et al., 2005). The findings from this study both agree and disagree with the arguments put forth by the previous research studies in the sense that the collective story highlighted the individual as the key determinant of risk.

For women, longer life expectancy increases exposure to change, widowhood, health deterioration and ultimately loneliness (Savikko et al., 2005; Valadez et al., 2006). On average mortality rates are lower for older women than for older men (Boneham & Sixsmith, 2006; Davey, 2004b; Townsend, 1973). Ip et al. (2007) found that older female Chinese immigrants were more vulnerable to loneliness than their male counterparts, not only because of a language barrier, but because their access to transport and finances was limited. The results from surveys suggest that women report loneliness more after the age of 55, while men report loneliness more
after the age of 75. As men’s life expectancy is lower than women’s, this may explain why women appear to be lonelier than men (Victor & Yang, 2012; Wang et al., 2011).

As women experience widowhood more than their male counterparts, it has been suggested that this increases the risk of emotional loneliness (Adams et al., 2004; Fokkema et al., 2012). Rasulo et al. (2005) disagree with the notion that bereavement is harder for women. They maintain that women have a means of distraction in the form of social networks, even though this is not a specific attachment figure. Women may however place greater value upon social networks; if change does occur within a network the impact may be greater for older women than men (Buys & Miller, 2004; Rasulo et al., 2005). The female participants within the current study remained active and made an effort to stay socially connected.

In terms of familial relationships men tend to rely upon women to organize family contact with adult children and grandchildren (Dykstra & De Jong Gierveld, 2004; Ruxton, 2006). Men may experience the brunt of bereavement as their social ties are usually concentrated into a few intimate relationships (Drennan et al., 2008; Rasulo et al., 2005). Interestingly, the findings from this research indicated that men who still provided support (emotional/financial) for adult children were less socially lonely, but increasingly emotionally lonely. The meaning the participants’ ascribed to the loss of a key attachment figure (spouse) and the routine that they represented loneliness manifested itself as loneliness. Contact with adult children who required financial or emotional support further reminded the male narrators of their spouses’ absence, particularly with regards to decision making. This was similar for female narrators but their stories appeared to focus more upon the psychological presence of their husband whose very presence gave them a moral boost, rather than relying upon them to make practical decisions.

Gender may influence the way loneliness is perceived as within society males and females may be raised to socialize in different ways. This may also impact on
the way that loneliness is reported (De Jong Gierveld et al., 2006). Men in general rely upon a spouse or a partner to meet social and emotional needs via uncomplicated relationships and are more reluctant to answer direct questions about loneliness or psychosocial distress (Cavallero et al., 2007; De Jong Gierveld et al., 2006; Murray et al., 2006; Williamson, 2011). The rural male/female 85 plus groups from the current study support this. When asked to describe their lifestyle in the health questionnaire the male participants considered themselves to be less active both socially and functionally, than the female participants.

Women in general have more inclusive social and emotional needs, wider social networks yet often report higher levels of loneliness (De Jong Gierveld et al., 2006; Mezuk & Rebok, 2008). Older women may be more at ease with emotional expression, therefore the detection of loneliness would be less complicated (Tiikkainen et al., 2004). Data collection and the format in which a measurement scale is worded can deliver different results depending upon a person’s gender (Steed et al., 2007). Steed et al. (2007) argues that depending upon a person’s gender, the use of the term loneliness in an assessment tool can influence whether a person admits to the experience. Avoidance of the word loneliness is a way of addressing gender differences. However, avoidance also runs the risk of perpetuating the stigma associated with loneliness.

Within the current study, participants were invited to talk about loneliness in other people. Experience centred narratives empowered participants to talk about loneliness from the perspective of another person they may have encountered (Squire et al., 2008). In some interviews the trajectory of the story was redirected to personal experience as the narrator became more comfortable relaying their story. The recruitment stage of this research was particularly successful and may be the result of adopting this approach. The recruitment literature advised that participants did not have to be lonely to take part in the study. Both male and female participants were willing to take part. Male participants in particular have
been difficult to recruit in previous studies (Li et al., 2005; Pettigrew & Roberts, 2008; Tikkainen et al., 2008).

The social needs of older men are largely overlooked in comparison with older women (Ruxton, 2006). Ruxton (2006) maintains that there is a growing body of older males who are bachelors, divorced or widowed, who are less likely to have access to social networks, and for whom loneliness will potentially present as a significant problem. The same can be said within other cultures such as Ghanaian culture where it is not usual for older men to be divorced or separated (Van der Geest, 2004). In a Turkish study by Koc (2012) which considered the determinants of loneliness in people (aged 60 plus), loneliness was noted to be greater amongst men than women. Study flaws include limited generalizability due to the sample being from a rural location in only one area of Turkey.

The importance of social and functional activity was highlighted by the rural and urban male participants aged 70-84. Interestingly, whilst both groups considered themselves to be moderately active they described their mood as mildly depressed. The male participants from this age group reported difficulty renegotiating self-identity following widowhood, which provided a rationale for the incongruence between moderate activity and low mood. The collective story also emphasized adaptability as a coping strategy following widowhood. Both male and female participants felt that women were generally more adaptable to widowhood.

The stories told by male participants within this study placed experience of loneliness and widowhood at two ends of a continuum. For some of the men the experience was particularly poignant as they had relinquished other responsibility and pastimes so that they could devote themselves to their spouse and the caring role. Following bereavement the void that was left was filled by loneliness. At the other end of the continuum were those male participants who described both widowhood and loneliness in a fatalistic fashion; both event and experience were
something to be endured, dealt with but not necessarily vocalized. Alternatively female participants’ stories, whilst generally more open than male participants, were regulated. The extreme responses to loneliness, as relayed by male participants, were less apparent in female participants’ stories. Loneliness was acknowledged for what it was by female narrators; an unsolicited longing.

With regard to networks, older men are likely to have more female friends, rely more upon marriage relationships than on networks as a protective factor against loneliness, and are less likely to be widowed yet more likely to remarry (Dykstra & De Jong Gierveld, 2004). A study by Li et al. (2005) into the effects of gender and pre bereavement support on adjustment to widowhood found no gender differences. Li et al. (2005) argues that a majority of older Chinese men remarry. This, combined with providing support to families and friends, acts as a protective factor against loneliness. Interestingly, the mean age of the sample was 66 years and those who dropped out were older, less educated, in poorer health and male, which may have led to an underestimation of the impact of widowhood on men.

The male participants’ stories from the current research study talked about female companionship, but only one of the 20 male participants had remarried and experienced widowhood a second time. The remainder of participants had been married and widowed on one occasion. The mean age of male participants was 86.2 years and the majority had been widowed for less than 10 years. Findings from the current research suggests that the age of participants reflected how embedded certain routines were in their lives. The comfort of married routine was deeply missed and featured frequently in the stories. Female companionship acted as a source of secondary comfort and was usually through mutual friendships, and through formal support relationships such as carer or cleaner. For the male participants in particular, the formal female relationships appeared to act as a surrogate routine that reconnected them with the familiarity of a previous routine displaced by widowhood.
Older men living alone are more likely to receive support from extended family than those living with other people (Statistics New Zealand, 2004). As all statistical information can be exposed to manipulation, researchers need to be mindful of individuality. An older person may exaggerate the number of contacts to reduce the risk of stigma or offence. The difference between the way men and women perceive support can also be significant in terms of loneliness. A Nepalese study that considered the relationship between providing and receiving support and loneliness found that receiving support from cohabiting adult children helped reduce loneliness in elderly women (Chalise et al., 2007). For elderly Nepalese men loneliness was reduced by providing support to a spouse, child, friend or neighbor. Chalise et al. (2007) believes the findings are related to gender roles within Nepalese society. It is more acceptable for women to receive assistance from adult children, whereas men are seen as protectors who are served by their spouse as a measure of respect and provide support to others. Functional decline may necessitate the need for assistance from adult children. The need for assistance could compromise social standing for elderly Nepalese men, although the researchers highlight the cross sectional design of the study and call for further investigation into causal factors. The transferability of these findings may be limited as only one societal cast was researched (Chalise et al., 2007).

The current study supports the results of Chalise et al. (2007) with regard to formal and informal support and the attitudes of older men. The majority of the stories from the male participants gave the impression that whilst some level of support was welcome, there was a fine line between what was perceived as an acceptable level of support and what was perceived as nannying behavior, and this was different for each individual. This reinforces the central argument of this thesis, namely the subjectivity of loneliness. This finding should be observed by both families and health professionals who want to assist, as in some instances too much help can be as detrimental as too little, particularly to a person’s self-esteem.
Lack of empathy can lead an individual to feeling misunderstood, emotionally isolated and ultimately lonely.

In the same way that support from adult children can act as a protective measure against loneliness for older women, the reverse situation can expose them to increased loneliness. In a survey of Indian Elders aged 65 plus Bhatia et al. (2007) found that loneliness was significantly higher in female participants who were widowed and felt their families neglected them. Furthermore results from the US National Social Life, Health and Ageing Project found that older single women who lived with adult children were actually more vulnerable to feelings of loneliness. This may be the result of cultural backgrounds; however, researchers did not differentiate between types of single status (such as divorced, widowed, never married) which may impact upon the findings (Greenfield & Russell, 2011).

Loneliness can change in intensity depending upon circumstances, therefore intervention may need to be long term and require adaptation over time (McCarthy & Thomas, 2004). The type of intervention is also important as inappropriate intervention can be as damaging for an individual’s self-esteem as no intervention (Chalise et al., 2007; Manthorpe et al., 2007; Routasalo et al., 2009). Overall there is limited empirical evidence to justify the efficacy of interventions designed to address loneliness (Cattan et al., 2005; De Jong Gierveld et al., 2006; Tiikkainen et al., 2008). Consideration of income, leisure, gender and culture is crucial to successful intervention (Cattan et al., 2005; Howse et al., 2004; Tiikkainen et al., 2008; Valadez et al., 2005). Leisure activities are vital to well-being in old age as long as they are meaningful. Non-meaningful activities may reduce isolation but do little to minimize loneliness levels, particularly if an individual has limited interest in a day center or group (Minardi & Blanchard, 2004; Savikko et al., 2005). Loneliness may well be a common denominator between older people but it will not necessarily forge friendship (Hawkley & Cacioppo, 2010; Pettigrew & Roberts, 2008; Ruxton, 2006).
Little contemplation is given to pre-morbid personality and the potential impact upon intervention; enforced support can magnify a sense of failure or threaten independence (Steeves & Kahn, 2005). The success or failure of a loneliness intervention can be influenced by subjectivity and the way a loneliness intervention is perceived (Adams et al., 2004; Barg et al., 2006; Chalise et al., 2007; Dwyer & Hardill, 2011; Grenade & Boldy, 2008; Ruxton, 2006; Wenger & Burholt, 2004; Williamson, 2011). Group intervention may not be appropriate for an individual who is used to socializing with a small number of people (Barg et al., 2006; Cattan et al., 2005). Gender specific intervention may also promote engagement with services; for example, male volunteers or support staff to encourage older men (Ruxton, 2006). Traditionally support services have been female focused which may account for the limited number of male attendees (Ruxton, 2006). If loneliness is to be addressed health services need to develop realistic interventions based upon age and health status (Bekhet et al., 2008).

Research suggests social network maintenance is significant in the battle against loneliness in old age (Cattan et al., 2005). Many studies call for the nursing role to include health promotion and education about loneliness, as this may improve quality of life for older people (Chew-Graham, 2010; Ekwall et al., 2005; Fagerstrom et al., 2011; Fried et al., 2005; Harris et al., 2006; Heravi-Karimooi et al., 2012; Murray et al., 2006; Theeke, 2009; Wilson et al, 2011). There is a need, however, to normalize feelings of loneliness and work within a person’s comfort zone before gradually introducing new strategies (De Jong Gierveld et al., 2006; Ruxton, 2006; Savikko 2008).

Driving or access to transport played a key role in narrators’ ability to function, and connect to the outside world, this was particularly evident in the stories from rural participants. Stories highlighted the deviation from routine, in a rural area a car was featured heavily in a number of daily routines. Declining health and functioning, secondary to ageing, compromised participants’ ability to continue
driving. When faced with cessation, the significance of the driving role appeared to increase. Narrators’ stories described the impact of driving cessation, and were not dissimilar to the stories told about grieving and losing a significant other. Loneliness was associated with the loss of convenient access to transport and spontaneity. Policymakers and service providers need to acknowledge the demographic changes in society that may increase susceptibility to loneliness (Buys & Miller, 2004; Howse et al., 2004). A report by Statistics New Zealand (2004) into older New Zealanders recognizes the impact of lifestyle change and the need for awareness and health promotion to reduce social isolation and improve well-being in old age. Strategies include national, regional and local initiatives to investigate retirement experiences (Statistics New Zealand, 2004). Age Concern New Zealand (2007) calls for the ongoing evaluation of such interventions and policies to safeguard quality and encourage adaptation to newly identified needs.

Transport, accommodation and reliable services with suitably selected, trained staff and easy access are all measures that could help to reduce if not prevent loneliness in old age (Davey, 2007). Loneliness and depression may be reduced by addressing issues such as falls and isolation (Harris et al., 2006; Van’t Veer-Tazelaar et al., 2008). Consultation is required with potential service users and evaluation with existing service users, as to their individual and collective needs, as this may help to provide meaningful activities and supports that are more than token gestures (Arve et al., 2009; Cattan et al., 2005; De Jong Gierveld et al., 2006; Grenade & Boldy, 2008; Luanaigh & Lawlor, 2008; Pettigrew & Roberts, 2008; Wang et al. 2011). The notion of independence threaded itself through the collective story. Loss of independence was referred to in the central component of the story, in relation to ageing and loneliness. Conversely, a sense of independence encouraged participants and helped them stave off feelings of loneliness. The notion of resilience also featured within stories. Resilience in relation to old age has been defined as “the maintenance of normal development despite the presence of
threats or risks (internal or external) and the recovery from trauma” (Staudinger et al., 1993, p. 543). Whilst for older people maintaining independence and developing resilience can be perceived in a positive light there was also a sense within some of the stories that the participants felt the pressure to remain resilient and independent at all costs. Consultation and health promotion may foster and preserve a healthy sense of independence and what it means to be resilient in old age.

A variety of interventions have been suggested for addressing loneliness. These include meaningful activity, useful role, life style education that encourages elderly people to maintain or establish social relationships and utilize adaptive coping skills, friendship groups, telephone support, pet therapy, psychosocial intervention, home visiting, computer technology, volunteering, gardening, walking, reading, and watching television (Adams et al., 2004; Alma et al., 2011; Bekhet & Zausniewski, 2012; Blazun et al, 2012; Cattan et al., 2005; Cattan et al., 2011; Dwyer & Hardill, 2011; Gunnarsson, 2009; Hawkley & Cacioppo, 2010; Krause-Parello, 2008; Lester et al., 2012; Pettigrew & Roberts, 2008; Pitkala et al., 2009; Prieto-Flores et al., 2011; Rijken & Van Beek, 2011; Routasalo et al., 2009; Savikko, 2008; Schnittker, 2007; Verstraten et al., 2005). Clearly a majority of these pastimes depend upon a certain level of health and functioning; this highlights the need for maintaining optimal health and functioning in old age (Harris et al., 2006; Koc, 2012; Theeke, 2009; Wilson et al., 2011). The negative ageing and mental health stereotypes associated with some of these options may limit efficacy and is an area that needs further investigation (Dwyer & Hardill, 2011; Lund & Engelsrud, 2008; Williamson, 2011).

In an Australian study by Pettigrew and Roberts (2008) 19 older subjects were interviewed about loneliness and pastimes which may help moderate such feelings. Findings suggested that meaningfulness is a key element. Social contact through rituals such as food and drink were especially important, although this
could not necessarily be replicated in environments such as day care centers. Solitary pastimes such as reading, gardening and television were also identified as means of dealing with loneliness through the constructive use of time. Although a small sample the quality of the data obtained from the semi structured interviews help paint an astute picture of the meaning of loneliness in old age.

The findings from the current study supported and added to the findings from the Australian study. The collective story highlighted the importance of meaningful activity and revealed that there remains a degree of stigma associated with old age support services. Some informants from the current research were offended that they could be viewed as needing such support. A complete review of the terminology surrounding old age support services is required as even the name ‘day care’ can be interpreted as infantile and demeaning. Multiple studies suggest that families need education and encouragement to maintain contact with their elderly relatives; this in turn may improve intergenerational communication and reduce loneliness (Adams et al., 2004; Hauge & Kirkevold, 2012; Pettigrew & Roberts, 2008). As discussed, familial relationships are diverse and whilst for some this may prove successful, care needs to be exercised as it may place pressure upon families and result in resentment and increased loneliness (Dong et al., 2007; Heravi-Karimooi et al., 2012; Ip et al., 2007; Kaneko et al., 2007; Murray et al., 2006; Winterton & Warburton, 2011).

Support that is deemed a necessity because of ill health or functional decline can be a cause of loneliness, particularly if the individual believes themselves to be a burden or it is detrimental to their social position within a specific culture (Chalise et al., 2007; Hellstrom et al., 2004; Ruxton, 2006; Winterton & Warburton, 2011). Another area of concern is non-uptake of formal services in preference of family support or because of the stigma attached to welfare services (Dwyer & Hardill, 2011; Howse et al., 2004). As discussed, the chances of families being available to care for older relatives are lower than in previous generations due to
the developing industrialized society and changing composition of families through divorce, remarriage and childlessness (Fokkema et al., 2012; Howse et al., 2004; Hunter, 2012; Koc, 2012; Leung et al., 2008; Perlman, 2004; Shen et al., 2012).

Similarly, family relationships may not always be conducive to well-being, particularly in cohabiting situations where adult children are working full time and older parents are isolated or neglected (Dong et al., 2007; Heravi-Karimooi et al., 2012; Ip et al., 2007; Kaneko et al., 2007; Murray et al., 2006; Winterton & Warburton, 2011). Lack of appropriate formal support services can increase the reliance upon families and friends and ultimately impact upon psychological and physical health of an individual if a need is not met and loneliness persists (Howse et al., 2004; Tomaka et al., 2006; Wang et al., 2011). If social assessments remain needs based and network continues to be measured by number of contacts rather than quality, it may serve only to increase feelings of loneliness and dependency and render support packages ineffective (Statistics New Zealand, 2004). Meaningful relationships (formal or informal) act as a buffer against loneliness and reinforce feelings of usefulness and caring rather than a sense of being incompetent or a burden (Alma et al., 2011; Boneham & Sixsmith, 2006; De Jong Gierveld et al., 2009; Fokkema et al., 2012; Heravi-Karimooi et al., 2012; Hinck, 2004; Lester et al., 2012; Moyle et al., 2011; Pettigrew & Roberts, 2008; Schnittker, 2007; Wang et al., 2011).

Potential interventions for addressing loneliness appear to be gaining popularity amongst academic and research circles, yet the degree to which these resolutions are reaching the agencies that have access to older people remains unclear. GPs in particular feel inexpert with regard to the issue of lonely people (Van Ravesteijn et al., 2008). The relationship between loneliness and culture remains unclear, along with intervention uptake and accessibility to strategies for addressing loneliness (Ferguson, 2011; Ip et al., 2007; Sabir et al., 2009). The findings from this study highlight the significance of subjectivity and the manner
in which the topic of loneliness is communicated. Multiple research findings suggest that health services could play a greater role in identifying the risk factors and symptoms for loneliness (Elsadr et al., 2009; Hauge & Kirkevold, 2012).

The collective story confirmed the significant socialization role played by formal carers, which sadly for some participants had been cutback secondary to budgetary restrictions. Further research is required into this area of unrecognized support as the collective story suggests that cutting a reasonably inexpensive form of support may be false economy if loneliness and social isolation increase in the older population secondary to the reduction of services.

Findings from this research study also highlighted the subtlety of support relationships. Health workers should not assume because they have rapport with an individual that an individual will feel comfortable acknowledging loneliness or introducing the topic into conversation. The onus is upon health workers to improve their interpersonal skills so that loneliness is destigmatized and does not become medicalised. The Kaumātua involved in this study felt that the interventions they had with some health workers were often medically based rather than person centered. They described feeling as though they were a mere symptom or a uniform pensioner, rather than a person with life experience and characteristics. One interpretation of this, is that a clinical rather than person centered approach did not foster respect, encourage open communication or instill trust. This was echoed throughout the collective story. Similarly, the perceived availability of a health professional was important. Narrators commented in their stories that they were less inclined to disclose personal information if the health professional did not appear to have the time to listen.

On a positive note there are services available within New Zealand that seek to address loneliness in old age. Accredited visiting services (Age Concern), Enliven befriending service (Presbyterian support services), and caring caller telephone service (St John) are to name but a few (Age Concern, 2014; Enliven, 2014; St John,
2014). Organizations such as these provide an invaluable source of support for older people. The findings from this research suggests, however, effective use of such services, is dependent upon the perception of the service. Services need to be person centred and focus upon the individual and not adopt the view that all older people have the same characteristics, needs and attributes.

LIMITATIONS

For the purpose of this study a narrative methodology was deemed the most appropriate process of accessing the inherent meaning of loneliness due to the sensitivity surrounding the topic. A purposive sampling method was adopted to recruit participants with the aim of presenting a broader spectrum of views from distinct groups within the population in terms of age, gender, and geographical location. There are, however, several limitations related to this study and its design. The study is cross sectional by design, which means that the findings are observational and the causal relationships have not been established.

The sample was purposive, therefore the inferences that can be made in relation to the wider population are restricted because of its non-probability status. Recruitment information was sent through to all GP surgeries within a 50km radius of Christchurch CBD. Recruitment was determined by age, gender, and geographical location, identification of suitable participants sat with the participating surgeries and was outside the control of the researcher. Once the required number of participants were recruited for a specific group the surgeries were contacted to advise that recruitment had ceased, and thanked for their help.

The size of the participant sample is also a source of criticism due to its impact upon generalizability. As noted earlier a narrative methodology was used in response to the requirements of the research topic. A larger sample than is usually associated with this methodology, was recruited in an attempt to present a broader range of views and level the criticism regarding generalizability. The larger sample
did allow the stories from underrepresented groups to be heard. These groups include people aged 85 plus, male participants and those who lived in a rural locality. Areas that were not considered, however, and may influence loneliness include educational background, financial status and quality of marital relationship. The sample from this study was primarily white from a westernized nation. Migrants were included in the sample but the majority had come to New Zealand from a westernized nation which limits transferability.

As a qualitative methodology was adopted for the current study the limitations levelled at Barg et al. (2006) could also be directed at the current study. Consideration was given to possible researcher bias, in the planning stages of the research project. The decision was made to use a single interviewer for all 40 interviews to reduce researcher bias. The use of seven prompt questions, although semi-directive, was mitigated by allowing the narrators’ stories to guide the order in which the questions were asked.

Conclusion

The collective story of loneliness followed a trajectory that began with an event or a change in lifestyle which was ascribed meaning by the individual. The event/change precipitated an emotional response, specifically loneliness. For the purpose of this research study participants gave meaning to loneliness through the life event of widowhood. Participants explained through their stories the process of renegotiating their self-identity following bereavement. Loneliness was influenced further by the subjective experience of physiological change, namely ageing, and the impact of societal expectations. The final stage of the collective story revealed a continuum of integration and adjustment to loneliness through adaptive and maladaptive coping responses to loneliness, both informal and formal. Cultural influences shaped personal coping strategies and the perception of formal support.
The central argument of this research relates to the subjective nature of loneliness and the significance interpersonal communication plays in identifying and addressing loneliness. A key conclusion from this work is that the contextual story behind loneliness, rather than the symptoms a person displays, can be pivotal to successful intervention. The management of loneliness is a continuum of adaptation and adjustment, which begins with seeing the individual and listening to their story.
CHAPTER EIGHT CONCLUSION

OVERVIEW

In conclusion the current research study was a response to the World Health Organization’s call for greater understanding of the causes of depression in old age, one of which is said to be loneliness (World Health Organization, 2004). Globally, countries are looking to sustain quality of life, whilst also attempting to manage the financial demands associated with the treatment of mental and physical illness in the ageing population. (Moyle et al., 2011; Schnittker, 2007; World Health Organization, 2011).

Although quality of life and health in old age are highlighted as primary topics of investigation, the costs associated with funding the health and social needs of older people are sometimes portrayed as a drain on society, which runs the risk of perpetuating a stereotypical image of dependence (Bhatia et al., 2007; Cattan et al., 2011; Drennan et al., 2008; Hellstrom et al., 2004; Hunter, 2012; Savikko, 2008; Yang & Victor, 2008). The current research study attempted to address the negative imagery associated with old age by investigating loneliness, from the perspective of older widows and widowers. It is imperative that a balanced approach to old age is adopted. Homogeneity in old age is all too easily assumed through associations such as poor health and dependency (Chalise et al., 2007; Townsend, 2006). Similarly, loneliness and social isolation are often presented as complaints of the elderly (Yang & Victor, 2008).

Following a rigorous review of New Zealand and international Gerontological research literature it was apparent that the prevalence of loneliness, in old age, is a matter for debate. Differences in data collection methods may account for divergence in opinion. Subjective participant experience may also contribute, as it
would appear that life experiences and not ageing per se impact upon loneliness (Rius-Ottenheim et al., 2012; Smith, 2012). The findings from the literature review guided the choice of research method. As loneliness is such a complex phenomenon and prone to misunderstanding, the current study adopted a qualitative research design. Narrative research suited the topic of loneliness as it captured meaning through the interpretations of loneliness revealed in participants’ stories. Narratives are “well suited to studies of subjectivity and identity” (Riessman 1993, p.5). The review highlighted the potential for using qualitative research as a means of investigating loneliness. There were a limited number of qualitative research studies relating to the subjective meaning of loneliness from the perspective of old age. The opinions and narratives of older people need to be given greater attention if successful interventions are to be developed (Heylen, 2010).

RESEARCH AIMS

The aims of the research question were to explore i) individuals subjective experience of loneliness ii) the impact of ageing and lifestyle upon loneliness and iii) what informal and formal coping mechanisms are used by individuals to manage loneliness.

The study was designed specifically to accommodate the subjective nature of loneliness. The research topic of loneliness guided the choice of methodological design. There was a natural order to the progression of this study, from my professional interests in Gerontological nursing, to the development of the research problem, to the design used to investigate the problem.

The Subjective Experience of Loneliness

In terms of achieving the first aim of the research which was to explore individual subjective experiences of loneliness, the narrative methodological design of the study allowed the participants to relay personal stories of loneliness.
from the perspective of old age. The purposive sampling design meant that attention could be given to recruiting participants from underrepresented groups, as highlighted in the literature review (Arve et al., 2009; Ferguson, 2011; Golden et al., 2009; Krause-Parello, 2008; Luanaigh & Lawlor, 2008).

The recruitment and interviewing phase of the study was particularly successful. The complete process from liaising with GP surgeries and explaining the purpose of the study to surgery staff, to identifying potential participants to obtaining consent and visiting individuals to complete the interviews, took approximately six months. The dropout rate was low, only two individuals did not complete the interview following an expression of interest. Reasons for the first person withdrawing are unclear as two appointments were made for the interview, but on both occasions the person had gone out. It was decided after the second attempt to refrain from making further contact, as the person may have felt pressured. The second individual experienced a family bereavement the day before the interview and was involved with Tangi preparations. It did not feel respectful to continue with the research, and the participant was thanked for their initial interest but offered the opportunity to withdraw, which they understandably accepted.

At one point during the study the recruitment process was reconsidered, as there were no Māori participants recruited through GP surgeries. As it was important to me to ensure that Māori as the indigenous people were represented in the project, attempts were made to incorporate Māori values (Pere & Barnes, 2009). Contact was made with a local Marae that holds a monthly luncheon for ‘Kaumātua’ (respected elder or elders). I was invited to the Marae to share kai (food) and to talk with Kaumātua. It was an honour to be offered this opportunity. Three women volunteered and the researcher was invited to their homes to carry out the interview, only two of the interviews took place due to one of the volunteers experiencing a family bereavement. Pere and Barnes (2009) describe the
process as Kanohi te Kanohi (face to face), and maintain that Māori people prefer to see and meet a researcher before giving consent, so that trust and an understanding of the motives that drive the research can be established. The researcher gave koha (a gift) as a token of respect for the time and knowledge the Kaumātua were willing to share. The koha was a small posy of native New Zealand flowers. Participants were unaware of the koha prior to the interview taking place so as to prevent the gesture being misinterpreted as inducement (Sporle & Koea, 2004).

I believe the recruitment and interview phase of the study was successful as I utilized both my emerging skills as a researcher and my professional experience as a nurse. The skills I use within clinical practice include genuine interest, active listening, and a warm and open, respectful, manner. These particular communication skills are highlighted as key components for fostering therapeutic alliance (Byrne & Neville 2010). All interviews took place in the participants’ homes, which provides a possible explanation for the high consent rate and low dropout rate. Participants were offered the choice of being interviewed at the GP surgery or in their own homes. All participants chose to be interviewed in their own homes. I believe the convenience of me travelling to see the participants, combined with the comfort of a familiar environment, may explain why the dropout rate was so low. A familiar environment may also have prompted the participants’ stories as they had personal photographs and objects surrounding them. Had the interviews been undertaken in a neutral setting such as practice surgery rooms the environment may not have been as conducive. The environment and the research design may have helped to elicit stories from the participants about loneliness.

All 40 narrative interviews were transcribed, the narrative fragments were identified and extracted and then reread and interpretation accomplished through a process of narrative analysis (Murray, 2000; Squire, 2008). The main reasons for
adopting Murray’s framework within this study, were to consider the wider impact of society, culture, and history upon loneliness narratives both from the perspective of the participants and from my own perspective, as I am responsible for retelling the collective story (Tetley et al., 2009). The four levels of narrative analysis described by Murray (2000) ensured that I retained as much as possible of the true meaning of loneliness, ageing and widowhood as described by the participant, whilst developing the collective story that could be retold within this thesis.

**Contribution**

The participants’ stories helped to answer the first part of the research question ‘How do older widows/widowers describe experiences of loneliness?’ The collective story of loneliness was presented from the perspective of older widows and widowers. It followed a trajectory that began with an event or a change in lifestyle which was ascribed meaning by the individual. The event/change precipitated an emotional response, specifically loneliness. For the purpose of this research study, participants gave meaning to loneliness through the life event of widowhood. The decision to concentrate upon older widowed individuals, and the impact of widowhood on lifestyle and loneliness, stems from Davidson (2001) and Victor et al. (2005). The experience of widowhood encompasses both physical and psychological changes (Demichele, 2009). Murray’s first level of narrative analysis referred to as the personal level was essential to this aspect of the research as it allowed the examination of the individual narratives about loneliness and widowhood and the manner in which the stories were presented. This level of analysis allowed the nuances and the individuality of each story to be preserved and portrayed in the collective story.

Participants did not have to be lonely to take part in the study. The stigma associated with loneliness may have prevented individuals from coming forward. Some individuals may prefer to talk about someone they have known who has
been lonely, rather than admitting that they have been or are lonely (Victor et al., 2002). As a result of the impact of potential stigma, I wanted to open the research up to experience centred narratives that included broader experiences of loneliness, as opposed to event centred narratives which concentrate on actual past events encountered by an individual (Squire et al., 2008). Narrative fragments were gathered from the individual stories. The second level of analysis considered the interpersonal relationship between me, in my role as listener, and each narrator. The effects of interpersonal interaction were evident in the way in which each of the interviews progressed in terms of the pace and direction. As noted each interview was guided by a set of prompt questions, yet the necessity for the prompts and the order in which they were delivered changed with each collaboration. Levels of comfort and ease with which narrators delivered their stories fluctuated between each interview.

The apperception of loneliness, through context based life events, emerged as the introductory component of the collective story. Further analysis revealed that stories consisted of memories of personal experiences of loneliness, and also observations of other people’s experiences. The collective story suggested that for this group of participants, events themselves such as widowhood, did not predetermine loneliness. The degree of meaning ascribed to the event by an individual shaped a new understanding of loneliness. This supports the argument for promoting heterogeneity in old age (Palkeinen, 2005).

The Impact of Ageing and Lifestyle upon Loneliness

The collective story facilitated an exploration of the impact of ageing and lifestyle upon loneliness, which was the second aim of this study. Participants explained the process of renegotiating their self-identity following bereavement, through their stories. This helped to answer the second part of the research question ‘How does the experience of loneliness change over time with age and
lifestyle for older widows/widowers? Loneliness was influenced further by the subjective experience of physiological change, namely ageing and the impact of societal expectations. The research design of narrative analysis was a dual process and well suited to the topic of ageing and loneliness. The first aspect of the narrative analysis process was identifying narratives and themes within the interview transcripts. This was a rigorous and practical method that was kept transparent to enhance the trustworthiness of the research. Once the narratives and themes were identified the process of analysis began so that the collective story could be developed and retold. Murray’s positional and societal level of analysis proved particularly pertinent for this aspect of the collective story. The influence of my social position and that of each of the participants upon the formation of the narratives was considered. The impact of New Zealand society and the individual cultures in which the narratives were shared were also examined. Both positional and societal analysis of the narratives revealed some interesting insights and shaped the collective story in terms of the renegotiation of self-identity and the coping strategies described.

As mentioned earlier, the research topic focused upon experience centred narratives so participants did not have to be lonely to take part in the study. This allowed for a broader consideration of loneliness and meant that the study was open to a wider spectrum of views (Fraser, 2004, Ryan & Bernard, 2003). Attention was paid to canonical narratives and their possible presence within the transcripts (Bruner, 1991). Bruner (1991) argues that the researcher needs to be aware of canonical narrative and personal narrative, during the process of narrative analysis. Canonical narratives refer to narratives that are constructed in line with the stipulations imposed by a culture or a society. By way of contrast, personal narratives represent an individual and candid view, which may clash with canonical narrative and lead to stigma and ostracism. It is for these very reasons that individuals may acquiesce and present a canonical narrative in a research
environment. Murray’s framework allowed for consideration of this phenomenon (Murray, 2000).

During the interview and the analysis stages I was mindful that I clarified discrepancies, and that my interpretation was based on both the spoken word and participants’ actions. Incongruity between language and body language helped to identify the difference between a personal narrative, and a canonical performance. The performative analysis of narrative provides an insight into how the narrative is delivered, and for what reasons (Phoenix et al., 2010; Riessman, 2008). Fraser (2004) presents another dimension to Bruner’s argument as she maintains that narrators do not always perform the narratives that society or a specific culture expects from them; a role of analysis therefore would be to consider why.

As the research topic of loneliness has previously been associated with stigma I was interested in the canonical narratives, if any, that arose from a discussion on loneliness. One of the reasons for focusing upon these types of narrative was to determine the range of views of loneliness within the contemporary New Zealand society in which the study was set. I followed the format suggested by Riessman (1993) for locating canonical narratives and highlighted any conflicting narratives within a transcript. Such contradictions may indicate the presence of both personal and canonical narratives which are not necessarily compatible. Consideration was given to the manner in which narratives were expressed. Participants’ choice of words and the intonation of their speech along with the non-verbal aspects of communication were also reviewed.

Murray’s framework (figure 4.) proved useful in the analysis of the loneliness narratives. Murray (2000) believes that all four levels require attention to achieve holistic analysis of narrative. The collective story developed from a collaboration between the narrator and listener. Murray’s framework allowed the existing knowledge and culture that participants’ brought to the interview in the form of
stories and that I as a researcher brought to the interview and subsequent analysis to be acknowledged.

Contribution

The collective story, within the current study, revealed what narrators thought society expected of them, and the impact this had upon their sense of ageing, and their perception of loneliness. Evidence of stigma and stereotypes were found in the collective story. Some narrators demonstrated both dismissive and pitying attitudes towards lonely people. Common to both of these attitudes was the tendency of the narrator to distance themselves from the lonely person they were describing. This finding is particularly pertinent for the planning stages of service development. Even something as basic as the name of a service influenced the way it was perceived by older people, for example the term day care.

Informal and formal coping mechanisms used to manage loneliness.

The aim, to explore what informal and formal coping mechanisms were used by individuals to manage loneliness, was successfully achieved. Although, it is acknowledged that the collective story in this study is a compilation of only 40 individual stories. Transferability of the findings may be compromised due to the smaller number of participants. It is imperative to note that the actual coping mechanisms described in the stories are not necessarily the answer to loneliness. The subjective relevance of the coping mechanism for the individual, and how effective the individual perceived it to be, helped to modify loneliness levels.

The final stage of the collective story revealed a continuum of integration and adjustment to loneliness through adaptive and maladaptive coping responses to loneliness, both informal and formal. Cultural influences shaped personal coping strategies and the perception of formal support, such as attitudes towards health services. This helped to answer the final part of the research question, ‘What
strategies are used by older widows/widowers to manage the negative features of loneliness? What role do health services play?’

The story emerged from the narratives participants told about adjustment to widowhood, and the adaptive/maladaptive coping strategies used to prevent or contain feelings of loneliness. The story also touched upon the role of health services. Prompt questions were used to support the narrator, and nurture the narrative. Participants were asked ‘How do you deal with loneliness?’ The prompt question elicited two main types of narrative. The first type of narrative proffered mechanisms for managing loneliness. Narrators were not ashamed to talk about their experiences of loneliness. The second type of narrative dealt with mechanisms for preventing loneliness. Participants denied feeling lonely and so talked about the strategies they used that stopped them from succumbing to loneliness, and what they thought they would do if they became lonely. The idea of using experience centred narratives proved useful during this part of the interview, as it meant that participants could still contribute to strategies for managing loneliness even if they were not lonely. Interestingly, whether loneliness was approached from a preventative or curative direction, the coping mechanisms were similar.

Narrators’ views of health services were conveyed and the management of loneliness, from a professional perspective, was considered. Experience centred narratives enabled all participants to continue their stories even if they were not lonely. Stories were both introspective and extrospective in nature, as they described how participants viewed loneliness and how they felt health professionals viewed loneliness. The stories provided even greater insight into participants’ experiences and perception of loneliness as there was a definite presence of canonical narratives.

The stories revealed an underlying sense of awe, fear, and uncertainty pertaining to the role of a health professional. Narrators had a medical based view
of legitimate topics that a patient could approach a health professional about. The importance of health professionals’ communication skills was a key discovery as there was a definite issue of who should raise the topic of loneliness in an interaction between patient and health professional. The majority of participants’ stories revealed that they would not bring up the topic of loneliness with a health professional, even if it was a problem and even if they felt they had a good rapport with the health professional. Reasons for not raising the topic of loneliness included time wasting and embarrassment.

**Contribution**

The findings from this group of widows and widowers suggested that the contextual story behind loneliness, rather than the symptoms a person displayed was pivotal to successful intervention. The behavior of health professionals in terms of presence and availability was highlighted, by the participants in relation to disclosure of loneliness. The impact of consultation time on the disclosure of psychosocial information has been researched by Gude, Vaglum, Anvik, Brheim and Grimstad (2013). The findings from the current study support the argument for increased emphasis on the importance of communication skills for health professionals. The management of loneliness was a continuum of adaptation and adjustment, which began with seeing the individual and listening to their story.

**IMPLICATIONS FOR POLICY AND PRACTICE**

The collective story is the foundation upon which the central argument of this research is based, namely the subjective nature of loneliness. The collective story featured the main protagonists’ loneliness, ageing and widowhood yet its kaleidoscopic nature meant that each time an individual retold their own story, even though the content included the same topics, each story’s composition was unique. The stories told by the older widow and widowers who took part in this study have helped to contribute new knowledge to the field of gerontology in
the areas of loneliness, ageing and widowhood. The findings from this study serve as a reminder that whilst there are so many theories surrounding loneliness, ongoing disagreement about what defines it or how to measure loneliness in old age, we run the risk of obscuring meaning and overlooking the very views of the population we aim to research.

It is hoped that the findings from this study will aid greater understanding of loneliness by guiding health professionals to actively seek out what this phenomenon means to individual older people. The study was cross sectional by design. It is acknowledged that the findings therefore, were observational and the causal relationships not established. This does not detract, however, from the central argument which relates to the subjectivity of loneliness. The collective story emphasised the need to acknowledge heterogeneity in old age.

The development of age and gender appropriate health and support services for older people, both in New Zealand and internationally, is a recommendation of this study. A majority of services are weighted towards female attendees and may be one of the reasons why men are reluctant to engage (Dwyer & Hardill., 2011). The notion that all women enjoy knitting or housie and all men enjoy bowls or DIY is an extreme example of stereotypical gender pastimes that are sometimes offered at elderly ‘day care’ facilities and can be perceived as demeaning by individuals (Dwyer & Hardill., 2011). Engagement with a meaningful service or activity with both male and female support workers can be far more beneficial for an individual than endorsing a banal, homogeneous activity based on gender alone (Ruxton, 2006).

The sample from this study was primarily white from a westernized nation. Indigenous people of New Zealand were included in the study but this was limited to two female Kaumātua. Migrants were also included in the sample but the majority of migrants were white and had moved to New Zealand from a
westernized nation. The over representation of white westernized participants may limit transferability of the findings to other ethnic cultures. The findings from this particular participant group, however, revealed the importance of communication skills in a health professionals role. This knowledge may assist in the endeavour to sustain quality of life in old age and help address the global concern of escalating physical and mental health costs (Harris et al., 2006; Stek et al., 2005; World Health Organization, 2011). Taking time to get to know a patient and develop a rapport may initially seem costly but could prove cost effective in the long term if loneliness is addressed. The progression from loneliness to depression could be halted through the timely intervention of a health professional.

A review of the educational material that is used for older people’s health promotion is required. Generic health promotion literature needs to make reference to loneliness, to reduce stigma and embarrassment. Encouragement is needed so that people understand loneliness and realise that it does not need to be a medical condition before it can be classed as a legitimate health topic to raise with a GP. Improving awareness of health professionals and ensuring that the topic of loneliness is routinely raised during a health consultation is a further recommendation.

FURTHER RESEARCH

The opportunities to research loneliness stories are varied and numerous. This thesis has considered the perspectives of loneliness from the narratives of 20 male and 20 female elderly widowed people. The participants were relatively independent and lived in their own homes. They were also widowed. This study did not consider loneliness narratives from the perspective of older people whose spouses had, because of ill health, moved into long term care, nor were the views of older carers considered. As the collective story revealed in the apperception of
loneliness, some participants highlighted the period of caring for their spouse as a particularly lonely time. The higher prevalence of dementia within this cohort can generate potentially isolating effects. Both the person diagnosed with dementia and carers, particularly older spouses, may be exposed to factors such as reduced social contacts which may lead to loneliness.

The collective story confirmed the significant socialization role played by formal carers, which sadly for some participants had been cutback secondary to budgetary restrictions. Further research is required into this area of unrecognized support as the collective story suggested that cutting a reasonably inexpensive form of support may be false economy if loneliness and social isolation increase in the older population secondary to the reduction of services.

With regard to loneliness and other coping strategies older people may use, there is a heightened need for further investigation into maladaptive coping strategies such as excess alcohol and benzodiazepine use. Increased alcohol or benzodiazepines are sometimes used as a means of coping with loneliness or depression, by older people, and is an area of concern that health professionals are encouraged to consider during assessment (Khan et al., 2006; Van den Berg et al., 2014). As noted in the introduction to this thesis, the World Health Organization has classified depression as one of the most frequently diagnosed mental illnesses in older people. There is a call for greater understanding of causes of depression, one of which is deemed to be loneliness (World Health Organization, 2004). Alcohol, benzodiazepine use, and loneliness can be sensitive topics for people to discuss and some methods of data collection can obscure self-report bias and lead to possible under reporting (Kaplan et al., 2008). A narrative research study that considers people’s choices for employing maladaptive coping strategies, may elicit stories from participants that could provide insight into this area of concern.
Finally an alternative area of loneliness research that warrants further investigation is Health Professionals perspectives of loneliness. GP’s in particular feel inexpert with regard to the issue of lonely people (Van Ravesteijn et al., 2008). Narrative research could play a role in obtaining the stories of health professionals, particularly those professionals who come into regular contact with older people. This could provide a holistic view of loneliness that covers both ends of the health spectrum, namely patient and professional. The findings from this study suggested that health professionals should consider mentioning loneliness, as a routine part of their consultation with older patients, as older patients are less likely to talk about loneliness. A logical development from this study would be to research the narratives of the health professionals and find out their stories and perspectives of loneliness.

The final words of this thesis will reiterate the central argument of this research, which relates to the subjective nature of loneliness and the significance interpersonal communication plays in identifying and addressing loneliness. A key conclusion from this work is that the contextual story behind loneliness, rather than the symptoms a person displayed was pivotal to successful intervention.

The management of loneliness is a continuum of adaptation and adjustment, which begins with seeing the individual and listening to their story.


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Version: 1


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APPENDICES

APPENDIX A

CONSENT FORM, INFORMATION SHEET, RECRUITMENT FLYER
Views and experiences of loneliness in widows and widowers aged 70 and over.

CONSENT FORM

- I have read and I understand the information sheet dated April 2009 for volunteers taking part in the study designed to explore the views of widows and widowers aged 70 and over.

- I have had the opportunity to discuss this study and I am satisfied with the answers I have been given.
- I have had the opportunity to use whanau support or a friend to help me ask questions and understand the study.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time and this will in no way affect my future health care.
- I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.
- I have had time to consider whether to take part.
- I know who to contact if I have any questions about the study.
- I wish to receive a copy of the transcription of audio-tapes. YES/NO
- I wish to receive a copy of the results. YES/NO

I ___________________ (full name) hereby consent to take part in this study.

Date: ...................................... Signature: ....................................................

Researcher: Nicola Davies-Kelly RN, B.Sc, M.A, PhD candidate.

Project explained by............................................................... Project role..............................

Signature .................................................................................Date..............................

Principal Investigator: Nicola Davies-Kelly

Views and Experiences of loneliness in widows and widowers aged 70 and over
Centre for Postgraduate Nursing Studies – University of Otago, Christchurch
P O Box 4345, Christchurch 8140, New Zealand
Tel 64 3 364 3850 • Fax 64 3 364 3855 • Email nursingstudies.uoc@otago.ac.nz
www.uoc.otago.ac.nz
You are invited to take part in the study looking at loneliness and what it means to you. You do not have to take part in this study, it is your choice. Please read these pages to find out more about the study before you make up your mind. Please take your time to think about whether you would like to take part. You may like to talk it over with someone close to you. Feel free to ask any questions.

About the study
The aim of the study is to find out what older people think about loneliness and what would be helpful to recognise and manage this.

- The study is open to people aged 70 and over who are able to take part in an interview. In particular I would like to meet with people who are widowed and continue to live alone. As this is a sensitive topic, I would like to talk with people who have been widowed for 2 years or more.
- I will be interviewing 40 people in total. I will be conducting the interviews during 2010. If you would like to take part in the study, I can arrange to meet with you at your GP surgery or in your own home, if this is more convenient.
- The interview will take between 60 and 90 minutes. I will ask you about loneliness and any experiences you can recall.
- Should the interview highlight concerns about your mood or safety your GP will be informed.
- If it is all right with you, I will tape-record the interview. This helps me make sure I don’t miss anything you say.

Benefits and risks of the study
You will have the opportunity to provide feedback about your experiences. This will help me look at how loneliness is viewed and how it can be identified and managed. I do not foresee any risks involved in the study.

Participation
You do not have to take part in this study. It is your choice.

- You can change your mind at any time and stop the interview, or withdraw your comments. Just let me know. You do not have to give a reason.
- You do not have to answer any question that you do not want to.
Declining to take part in the study or withdrawing from the study will not affect your future health care.

You are more than welcome to invite a support person along for the interview. An interpreter can be arranged if you want one.

Confidentiality

I want you to feel comfortable telling me what you really think...

A typist will type a written version of what you have said. The written version of the interview will not include your name, or any details that might identify you. The typist will also sign a confidentiality statement which will be held with the ethics committee.

No material which could personally identify you will be used in any reports on this study.

You are welcome to see or edit the written version of your interview. Just ask me for a copy.

The tape of your interview will be deleted once the study is finished.

The written information will be stored in a locked cabinet in the researcher’s office for 10 years. This is in case I need to go back to the information to check anything.

Results

This study forms part of a student research project. It will be carried out by a PhD candidate to fulfil the requirements for the degree of Doctor of Philosophy in gerontology at the University of Otago. The information from this study will be used to help educate health professionals about loneliness in people aged 65 and over. The results will also be used in written papers and in talks so that it can help staff in other services.

I would be happy to send you a summary of the results on completion. I will ask you whether you would like to receive this summary.

General

If you have any questions please feel free to contact me. My name is Nicola Davies-Kelly. You can contact me via the Postgraduate Nursing Centre on 03 364 3850. This study has received ethical approval from the Upper South Ethics Committee.

If you have any queries or concerns regarding your rights as a participant in the study you can contact an independent Health and Disability advocate. This is a free service provided under the Health and Disability Commissioner Act. Telephone (NZ wide) 0800 555 050. Free Fax (NZ wide) 0800 2787 7678 (08002support) Email (NZ wide) advocacy@hdc.org.nz.

13th May 2009

Views and Experiences of loneliness in widows and widowers aged 70 and over. Perspectives on Loneliness: An analysis of elderly widowed people. Centre for Postgraduate Nursing Studies – University of Otago, Christchurch P O Box 4345, Christchurch 8140, New Zealand

Tel 64 3 364 3850 • Fax 64 3 364 3855 • Email nursingstudies.uoc@otago.ac.nz • www.uoc.otago.ac.nz
Recruitment flyer
Views and experiences of loneliness in widows and widowers aged 70 and over.

An Invitation
You are invited to take part in a study looking at older peoples’ views. I would like to hear what you think. Loneliness can be a problem for some people. Changes in lifestyle due to growing older may or may not increase feelings of loneliness.

I would like to find out what older people think about loneliness and how to manage it.
In particular I am looking for both men and women who have been through the life changing experience of losing a husband or a wife.
As this is such a sensitive experience I would like to speak with people who have been a widow or a widower for two or more years and live alone.

What would be involved?
If you would like to help, a practice nurse can pass on your details (name, address, age, gender, ethnicity, length of time since spouse died) and I will contact you. Or you can contact me and I can arrange to meet with you. I will answer any questions you have and you can find out more about the study.

If you agree it will take between 60-90 minutes of your time.

This research will help me to identify what loneliness means to older widows and widowers. It may help me identify ways in which services can be improved. This information will be useful in educating health professionals. I will also share the results in written papers and in talks so that it can help staff in other services.

To contact me,
If you have any questions please feel free to contact the principal investigator.
My name is Nicola Davies-Kelly. I can be contacted via the Centre for Postgraduate Nursing studies on 03 364 3850.
22nd April 2009.
APPENDIX B: RECRUITMENT FAX
Fax Template for recruitment purposes

F A C S I M I L E

TO: Dr ………………………..Health Centre
FROM: Nicky Davies-Kelly
DATE: 17th June 2010
SUBJECT: PhD Study into Loneliness in People aged 70 plus.

Dear Dr.………..,

I am currently undertaking research through the University of Otago. The research is part of a PhD and focuses on Loneliness in Older People. The study has ethical approval from the Upper South Ethics committee. The aim is to interview 40 older people and gain insight into their views and experiences of loneliness. The following groups have been identified to attempt to cover a broad range of experiences and environments.

5 female volunteers aged between 70 and 84 living in a rural area.
5 female volunteers aged 85 plus living in a rural area.
5 male volunteers aged between 70 and 84 living a rural area.
5 male volunteers aged 85 plus living in a rural area.

The second grouping focuses on urban Christchurch.
5 female volunteers aged between 70 and 84 living in an urban area.
5 female volunteers aged 85 plus living in an urban area.
5 male volunteers aged between 70 and 84 living in an urban area.
5 male volunteers aged 85 plus living in an urban area.

To date I have been successful in recruiting 34 volunteers from GP practices. I am having difficulties locating volunteers for the male rural groups and would appreciate any help from the practice. I am still looking for 2 male volunteers aged 85 plus and 1 male volunteer aged between 70 and 84.

What I have asked of the practices that have taken part is that they consider their practice lists and identify people who meet the criteria. Further criteria I have in place is that volunteers have been widowed for 2 years plus and that they live alone. I have also stated that people with dementia are not put forward as I do not want to take advantage of any person.
If you are able to identify any gentlemen can you ask whether you can pass their phone details on to me. I will then ring them and discuss such things as consent and anonymity. Any person can change their mind at any time there is no pressure to take part. I have included a flyer with some further details of the study. I can be contacted on 027…………

Kindest Regards

Nicky Davies-Kelly

B.Sc, M.A., PhD Candidate. PDN.
Thank you for taking the time to consider this. I am a mental health nurse based in Christchurch. I am currently undertaking research through the University of Otago. The research is part of a PhD and focuses on Loneliness in Older People. The study has ethical approval from the Upper South Ethics committee. The aim is to interview 40 older people and gain insight into their views and experiences of loneliness. The following groups have been identified to attempt to cover a broad range of experiences and environments.

5 female volunteers aged between 70 and 84 living in a rural area.
5 female volunteers aged 85 plus living in a rural area.
5 male volunteers aged between 70 and 84 living a rural area.
5 male volunteers aged 85 plus living in a rural area.

The second grouping focuses on urban Christchurch.

5 female volunteers aged between 70 and 84 living in an urban area.
5 female volunteers aged 85 plus living in an urban area.
5 male volunteers aged between 70 and 84 living in an urban area.
5 male volunteers aged 85 plus living in an urban area.

I have been recruiting volunteers through GP practices. Currently I have interviewed 23 people. The majority of the volunteers have been from urban/rural areas. To date I have no Māori participants and I am unsure as to the reason why. I have taken the opportunity to meet with............Māori Health Worker CDHB. I am very keen that my research is open to Tangata Whenua and that the process I am using is respectful to all participants. ......Māori Health worker has kindly agreed to act as a contact for any future questions I have.

I have included the information sheet I have been distributing. Criteria I have in place is that volunteers have been widowed for 2 years plus and that they live alone. I have also asked that people with dementia are not put forward as I do not want to take advantage of any person. I can be contacted on 027...............
APPENDIX C: INTERVIEW PROMPTS
INTERVIEW OUTLINE

1. Describe a typical day?
2. What does loneliness mean to you?
3. Can you describe times in your life where you have felt lonely?
4. How do you deal with loneliness?
5. Has your experience of loneliness changed at all with age?
6. Do you feel you are more or less lonely than other people of your age group? How does the area you live in impact upon levels of loneliness?
7. If older people find lonely feelings distressing, how do you think health services could help them?

The interviewer used general prompts, paraphrasing and following up topics as appropriate.

Thank you for taking part and agreeing to meet with me. My name is Nicky. I work as a nurse at PMH. I work with older people and enjoy the life stories and the experiences they recall. I am interested in using this knowledge and life experience to help improve services for older people. I’d like to start by talking about what a typical day involves for you. Is it ok for you to begin telling me what you do throughout the week and at the weekend.

A. Identifying what a routine day/week is like for the person.

Broad prompt - Who do you see? What do you do? Can you explain how you feel about your level of activity and contacts?
Follow up / explore Activities / Contacts

B. Views on loneliness (positive/negative)

What does loneliness mean to you?
Can you recall times in your life where you have felt lonely?
Follow up / clarify meanings

C. Identification of coping mechanisms/interventions

How did you deal with loneliness?
Identify positive action and explore the benefits. Clarify meanings. Broad prompt -Can you explain what was helpful or useful about this.
Identify negative aspects. Clarify meanings. Broad prompt-Can you explain what was unhelpful at this time.

D. Comparing past views/experiences with present views and peer group.

With regards to your thoughts on loneliness what aspects if any have changed with age? Do you think you are more or less lonely than other people of your age group?
Explore environment. Prompt: How does the area you live in impact upon levels of loneliness?

E. Identification of issues and improvement

If older people find lonely feelings distressing, how do you think health services could help them?
Suppose you were talking to someone who was going through what you have been through, what would you say to them?
What do you think about existing services?

F. Transition

Thank the participant for information and for taking part.
Check if they would like to add anything else
Is there anything else you’d like to tell me about what we have discussed?

QUESTIONS TO CONSIDER DURING INTERVIEWING.
MISHLER (1991, P. 96) RESEARCH INTERVIEWING, CONTEXT AND NARRATIVE.

• What is the role of the interviewer in how a respondent’s story is told, how it is constructed and developed and what it means?

• How do an interviewer’s questions, assessments, silences and responses enter into a story’s production?

• How do stories told in interviews differ from those told in other contexts such as naturally occurring conversations?

• Do different types of interview and question formats produce different types of stories?

• How can the presence and influence of an interviewer be taken into account in the analysis and interpretation of a respondent’s story
APPENDIX D EXTRACTS FROM CODING TABLE
<table>
<thead>
<tr>
<th>CODE TERM</th>
<th>CODE DEFINITION</th>
<th>SUPPORTING QUOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>NARRATIVE .2 89</td>
<td>URBAN FEMALE 85 PLUS</td>
<td>Pause I go every week cause we’re a bunch of girls and we all meet for coffee afterwards and have a jolly good laugh. And I’m standing back and hearing how ill all their husbands are.....what they’ve got and I thought jeepers they’re going through what I went through a long time ago.</td>
</tr>
<tr>
<td>REMEMBERING A TIME WHEN LONELY. COPING WITH LONELINESS</td>
<td>RESILIENCE EMPATHY FRIENDSHIP SURVIVAL</td>
<td></td>
</tr>
<tr>
<td>COPING WITH LONELINESS</td>
<td>ACCEPTANCE/ABILITY TO ADJUST/CHANGE IN RELATIONSHIP CHANGE IN ROUTINE</td>
<td>I can adjust to anything but all I mean is not just him....it’s a quiet life...everybody’s out of the house...pause...it is what it is.</td>
</tr>
<tr>
<td>COPING WITH LONELINESS</td>
<td>ADAPTING TO NEW SITUATIONS/LEARNING NEW SKILLS/FEAR OF LEARNING ROLE OF FAMILY.</td>
<td>Well I’ve never used public transport, I wouldn’t know where to even catch a bus or what to do and I’d stand up and probably fall down the step when I got there or something. I’m not prepared to start it now at 89.....laughing. No, no. To join things new I’ve got to go out. I’ve got to drive down to whatever you take on and erm....No I mean I’ve got friends who go out to bridge all day and I couldn’t stand that. That would be a waste of time as far as I’m concerned. I’m not interested in sitting on my backside all afternoon and all evening. It’s a fever with them. And they get cracking but I wouldn’t do that. I go to 1 or 2 films with my grand-daughter now</td>
</tr>
<tr>
<td>COPING WITH LONELINESS ENVIRONMENT/COMMUNITY</td>
<td>USING ACTIVITY AND ROUTINE SENSE OF BELONGING</td>
<td>Pause I don’t know having something to do I suppose. That’s why I go to bed early I think. I go to bed at 7 o’clock at night. I keep my garden. Yes I’ve enjoyed doing it to. It was nothing like this when I came here. In fact they had a chuck run out there with netting over there. I got that down pretty quickly. But I had a husband around for a while so he helped me get straight. I don’t think there is anything much to help it except good neighbourhood. I think it’s a great help. Most important yes.....mmm......and we’ve got it here. I’ve got very good neighbours.</td>
</tr>
</tbody>
</table>