THE LIVED EXPERIENCES OF SOCIALLY-ISOLATED SENIOR WOMEN

by

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ABSTRACT

Social isolation has been linked with negative health effects in senior women. The purpose of this study was to understand the lived experiences of socially-isolated senior women. Local senior-serving organizations assisted with the recruitment of six socially-isolated senior women to participate in individual qualitative interviews. Three service providers were also interviewed. Seniors' interviews were analyzed using interpretive phenomenological analysis and service provider interviews were analyzed using thematic analysis. Three superordinate themes were derived from the senior interviews: social needs, self-perceptions of isolation and loneliness, and constraints to and facilitators of social engagement. Five superordinate themes were derived from the service provider interviews: definitions of social isolation, differences between social isolation and loneliness, gender differences in isolation and loneliness, identifying socially-isolated seniors, and essential components of initiatives aimed at reducing social isolation. The views of socially-isolated seniors are important to understand to develop programs and policies that promote healthy aging.

ACKNOWLEDGEMENTS

CHAPTER 1   INTRODUCTION

According to Health Canada (2002a) the proportion of seniors, defined as adults aged 65 and older, is growing faster than any other age group. In 2001, one in eight Canadians were seniors, and by 2026 that ratio will increase to one in five (Health Canada, 2002a). In Nova Scotia, the proportion of seniors will nearly double by 2026 (Seniors' Secretariat of Nova Scotia, 2005). Currently, Nova Scotia has the highest percentage of seniors at 16.6% of the population, compared to the national average of 14.8% (Statistics Canada, 2012). Although women make up about 51% of both the Canadian and Nova Scotian population, this number rises to about 56% both nationally and in Nova Scotia in the above 65 age group (Statistics Canada, 2012).

People experience a number of changes as they grow older; for example, they retire, their physical or mental health status may change, and they may experience changes to their social networks due to loss of friends or family members. Seniors can adjust to these changes either positively or negatively, depending on the resources they have available to them, such as social support networks (MacCourt, 2004). However, one of the negative effects of aging-related changes is *social isolation*, which is associated with poor health and well-being (MacCourt, 2004).

Nicholson (2009) synthesized the various definitions of social isolation in the literature and defined it as "a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling and quality relationships" (p.1346). Aspects of this definition also encompass aspects of *loneliness*, which is defined as a person's unfavourable evaluation of the number of social connections he or she has (De Jong Gierveld & Van

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Tilberg, 2006). While Nicholson's definition of social isolation does include the subjective experience of dissatisfaction with one's social contacts, other researchers focus only on the objective aspects of reduced social network size and limited frequency of social contact when defining social isolation (e.g., Steptoe, Shankar, Demakakos, & Wardle, 2012). Social isolation can have negative consequences at the individual (e.g., loneliness, decreased mental and physical health, reduced quality of life), environmental (e.g., neighbourhood deterioration, lack of social cohesion) and societal (e.g., ageism) levels (Ferrara, 2009; Hall, 2004).

The estimates of social isolation in seniors vary depending on the population and indicators used (Keefe, Andrew, Fancey & Hall, 2006). In Atlantic Canada, about eight percent of seniors indicated that they had no close friends, defined as friends they felt at ease with, could talk with openly, or call for help; these seniors were less likely to report being in very good or excellent health compared to seniors with at least one close friend (Turcotte & Schellenber, 2006). Only two percent of seniors indicated that they had no close friend or relative (Turcotte & Schellenber, 2006). The association between the presence of a close relative and self-reported health was not reported in this study. Nationally, about 17.5% of seniors were identified as being socially isolated, which was conceptualized as living alone and having few close friends and relatives (Cloutier-Fisher & Kobayashi, 2009). These isolated seniors were more likely to be female, to have a lower income, to report poorer health, and to experience significantly lower levels of social support than non-socially isolated seniors (Cloutier-Fisher & Kobayashi, 2009).

Researchers have identified a number of individual, environmental, and societal risk factors for social isolation (Ferrara, 2009; Hall, 2004). Examples of risk factors at

these levels include living alone, lack of access to transportation, and negative perceptions of aging (Ferrara, 2009; Hall, 2004). Gender is also identified as a risk factor for becoming isolated, but the specific influences of gender are not yet clearly established. Some research indicates that men are more likely to be isolated (World Health Organization, 2007). However, senior women are more likely to live alone and to lose a spouse than senior men, placing them at greater risk for becoming socially isolated than men (Hall & Havens, 1999; Hall, 2004). Conversely, some research shows that the loss of a spouse leads to an immediate increase in some types of social participation (Ferraro, 1984).

Thus, the ways that gender acts as a risk factor for social isolation are not clear. Given that social support networks have powerful protective effects on senior women's health (e.g., Fry & Debats, 2010a) and that social isolation has been linked with negative health effects in senior women (Cloutier-Fisher & Kobayashi, 2009; Hall & Havens, 1999; Nicholson, 2012), an understanding of what socially isolated senior women experience is needed to develop effective health promotion interventions that reduce social isolation and encourage social participation. Moreover, given the complex, multiple influences that can either promote or discourage social participation, this thesis is focused on the impact of individual, interpersonal, and broader environmental influences on the experiences of social isolation of senior women.

1.1   People in their Environment

Social ecological models posit that behaviour and health outcomes are influenced by social, physical, and cultural aspects of the environment, as well as individual attributes such as disposition (Stokols, 1996). In health promotion, one of the most cited

social ecological models is a model by McLeroy, Bibeau, Steckler and Glanz (1988) that contains five levels of influence on people's health behaviours. These levels include intrapersonal factors (e.g., physical and mental health status), interpersonal factors (e.g., social networks), institutional factors (e.g., workplaces), community factors (e.g., neighbourhoods), and public policy. These factors can either contribute to or reduce risks for social isolation.

At the individual level, there are a number of intrapersonal factors that have protective effects on seniors' health. For example, a quest for personal meaning and personal growth is associated with resilience in later life (Fry & Debats, 2010b). An individual's likelihood of engaging in health-protective behaviours is influenced by a sense of perceived control, self-efficacy, and personality resources such as hardiness (Fry & Debats, 2010b). Individuals' perceptions of their own aging also have important effects on health. Researchers have found that older adults with positive perceptions of their own aging lived over seven years longer than those with negative aging self-perceptions, even after controlling for demographic variables, loneliness, and functional health (Levy, Slade, Kunkel & Kasl, 2002).

Although these internal resources are predictive of health outcomes, social engagement has one of the most powerful protective effects (Flatt & Hughes, 2013; Fry & Debats, 2010a; Gilmour, 2012; Tomaka, Thompson, & Palacios, 2006). At the interpersonal level, social support networks enhance well-being by providing emotional (having a close friend to confide in), instrumental (help with an activity), appraisal (help with decision making), and informational (provision of information or advice) support (Andrew, 2010). The effects of these social connections can be quite large. For example,

in a study of resilience in older widows, Fry and Debats (2010a) found that 70% of widows who scored high on a measure of social engagement survived 6.5 years after baseline compared to 38% of widows who scored low on this measure.

At the policy level, national and provincial initiatives have been developed to promote healthy aging and social engagement in seniors. Provincially, for example, Nova Scotia's Positive Aging Strategy (2005) identifies several goals for governments, communities, and organizations to aim toward to promote positive aging. The Strategy conceptualizes positive aging in terms of challenging the view that aging reflects withdrawal from society, and instead emphasizes that positive attitudes toward aging can promote the ongoing community participation of older adults. It promotes individual responsibility for positive aging, such as making healthy lifestyle choices, while addressing the role of environmental factors in supporting positive aging. Encompassed within the Positive Aging Strategy is the need to reduce social isolation and encourage seniors' participation in the community. However, evidence and best practice models to guide how this can occur in community settings is limited. Moreover, although the task force behind the Positive Aging Strategy held a number of public meetings to seek input on the Strategy, socially-isolated senior women likely would not have participated in these meetings. Without knowing the barriers to social participation experienced by socially-isolated women, it is difficult to develop strategies that aim to reduce isolation. Obtaining seniors' input on initiatives that affect them is in line with recommendations from the research literature (Cattan, White, Bond, & Learmouth, 2005; Findlay, 2003).

1.2   Interventions to Address Social Isolation

Given the number of negative consequences associated with social isolation, health promotion researchers and practitioners have developed and studied the effects of interventions to reduce isolation in seniors. Building on a review of social isolation interventions (Findlay, 2003) that found very limited evidence of their effectiveness, Cattan et al. (2005) reviewed 30 health promotion interventions targeting social isolation and loneliness in seniors. They found that of the 10 most effective interventions, nine were group interventions with an educational or social activity component. One-to-one interventions were likely to be ineffective. Community development interventions or those aimed at providing services, such as transportation, were either partially effective in reducing isolation or conclusions could not be drawn because of limitations in the methods used, such as self-selection to the intervention group. Of the interventions Cattan et al. (2005) examined, most used a form of behavioural theory to guide the intervention. However, it is known that one's immediate environment and broader policies play an important role in influencing behaviour (Schneifer & Stokols, 2009). Cattan and colleagues acknowledged that in their review they did not find any studies that evaluated the effects of policy change or the built environment on seniors' social isolation.

In their study on the effects of social isolation and loneliness on the health of older women, Hall and Havens (1999) identified several community and policy interventions that could help reduce social isolation, such as increased availability of programs and services for seniors and increased housing options. Their recommendations emphasize the role of the broader environment in addressing social isolation in seniors, and are in line with the social ecological framework of behaviour change (Schneider & Stokols, 2009).

1.3   Statement of the Problem

This study aimed to provide a better understanding of: 1) the barriers to social participation experienced by socially-isolated senior women; 2) an understanding of not only what socially-isolated senior women lack, but also what they experience; and 3) an understanding of the environmental factors that contribute to social isolation. A more complete understanding of the experiences of socially-isolated senior women is an essential step in developing health promotion programs and policies that reduce social isolation and promote social engagement. The study focused on answering two main research questions:

1) What does it mean to be a socially-isolated senior woman in the Halifax Regional Municipality and what factors contribute to this experience?

2) Based on senior women's understandings and experiences of, and meanings attributed to social isolation, what recommendations can be made to address the environmental factors that contribute to social isolation?

1.4   Overview of the Research Design

The methodology that fits best with the main research question is interpretive, or Heideggerian, phenomenology (Heidegger, 1962; Smith, Flowers, & Larkin, 2009). This methodology has several assumptions. One is being-in-the-world, which states that people's realities are influenced by the world in which they live, and that they can't separate themselves from their world (Lopez & Willis, 2004; Mackey, 2005). Another assumption is that individuals have situated freedom; that is, they are free to make choices within the constraints of their daily reality (Lopez & Willis, 2004; Mackey, 2005). Using this methodology allowed for a reflection of the situational factors that

contribute to social isolation in senior women and the barriers to social participation that individuals may experience.

To answer the research questions, I recruited a purposeful sample of six senior women and three service provider participants through local senior-serving organizations. Individual, semi-structured, open-ended interviews were conducted with service providers and seniors identified as isolated through screening measures assessing objective isolation and perceived loneliness (De Jong Gierveld & Van Tilberg, 2006; Shankar, McMunn, Banks, & Steptoe, 2011). Data from the service provider interviews were analyzed using thematic analysis (Braun & Clarke, 2006). Data obtained from the seniors' interviews were analyzed using the interpretive phenomenological analysis process described by Smith and Osborn (2008). This approach focuses on interpreting the meanings that participants attribute to events, experiences, and states. It involves a double hermeneutic approach of the participant making sense of her world and the researcher making sense of the participant's interpretation of her world. In this analytic approach, the researcher has an active role in the research process and seeks to understand the participant's point of view as well as look for underlying meanings behind the participant's experiences.

As with any study, this study has its limitations. Challenges in recruitment limited the number of participants in the study. Although a small participant sample is common and acceptable in qualitative research, a larger number of participants would have been beneficial given the heterogeneity of the sample in terms of age and varying degrees of feelings of loneliness. Another limitation was that minority groups were not represented

in the study and the participants who were involved represented a small subsection of isolated senior women, limiting the transferability of the results to other populations.

1.5   Summary

To summarize, the study examined the lived experiences of socially isolated senior women in Halifax to understand the factors that contribute to this experience. The results of this study will be used to make program recommendations for the senior-serving organizations that assisted with participant recruitment. The following chapters describe the study in detail. Chapter 2 reviews the healthy aging and social isolation literature. Chapter 3 describes the methodology and methods used to answer the research questions. Chapter 4 presents the results, and Chapter 5 discusses the results in relation to the research literature and presents policy and practice recommendations.

CHAPTER 2   LITERATURE REVIEW

In order to develop effective health promotion interventions that reduce social isolation and encourage social engagement in senior women it is important to understand that social isolation occurs in the context of a number of other influences, both positive and negative, on senior women's health. This chapter will begin by defining social engagement, including associated concepts, and social isolation. Following this, health promotion and social determinants of health are described. The remainder of the chapter will focus more closely on examining social isolation using a social ecological model of health promotion to identify research gaps that the thesis study will work toward addressing.

2.1   Social Engagement

Before examining social isolation, it is beneficial to understand its opposite: social engagement. Social engagement is defined as participation in activities with others for productive or leisure reasons (Andrew, 2010; Glass, Mendes de Leon, Bassuk, & Berkman, 2006; Krueger, 2009; Mendes de Leon, Glass, & Berkman, 2003). Some researchers used the term social connectedness in place of social engagement, and include the objective presence of social ties as well as a more subjective psychological component in its definition (Ashida & Heaney, 2008). In keeping with the prevalent term used in the literature, social engagement will be used here unless connectedness was used in a specific study. While social engagement includes activities involving leisure or productive aspects, companionship focuses on interactions between people done purely for enjoyment, such as having a conversation (Flatt & Hughes, 2013; Rook & Ituarte,

1999). Social activities often include both social engagement and companionship (Flatt & Hughes, 2013).

Social interactions with others encompass different components. Social networks include structural characteristics (e.g., number of members, density) and functional characteristics (e.g., social connectedness, social support) (Ashida & Heaney, 2008). Social networks enhance well-being by providing emotional (having a close friend to confide in), instrumental (help with an activity), appraisal (help with decision making), and informational (provision of information or advice) support (Andrew, 2010). Social support can have a direct effect on well-being, or it can buffer the adverse effects of stressful life events (Ashida & Heaney, 2008).

Although social support and social connectedness are related, one can feel disconnected even if surrounded by others. In a study involving 126 community-dwelling seniors, Ashida and Heaney (2008) found that social connectedness was positively associated with health, but social support was not. Other researchers have found similar protective effects of social engagement. In a study of resilience in older widows, Fry and Debats (2010a) found that 70% of widows who scored high on a measure of social engagement survived 6.5 years after baseline compared to 38% of widows who scored low on this measure.

There is evidence that senior men and women differ in their social networks. Women seniors tend to have more frequent contact with their network members, be more satisfied with their friends, and have larger and more diverse social networks than men (Antonucci, 1985, 1990 as cited in Fiori, Antonucci, & Cortina, 2006). Furthermore, the health implications of different types of social networks vary. Fiori et al. (2006)

examined five different types of networks that varied based on the characteristics of its members in terms of marital status, number of children, frequency of contact with children, religious service attendance, contact with friends, and frequency of attendance at meetings. The most prevalent network, labelled the diverse network, was distinguished by above-average values on all variables except number of children, and by especially high values on frequency of attendance at meetings and religious services. Women outnumbered men in all of the networks except one network, labelled the nonfriend network, which was characterized by low scores on frequency of contact with friends, attendance at meetings, and attendance at religious services. Participants in this type of network had the lowest functional health scores compared to the other networks, and after controlling for demographic variables including gender, this network was associated with members who reported having more depressive symptoms than members in other types of networks. These results show that the characteristics of senior women's social networks may protect them from adverse health effects more so than characteristics of social networks associated with a larger proportion of senior men (Fiori et al., 2006).

To increase isolated seniors' access to social support networks, and the benefits that come from these networks, it is important to understand the complex and multiple individual, interpersonal and environmental influences on social isolation. Prior to examining the factors that make people both at risk for and protect against social isolation, social isolation will be more fully described.

2.2   Social Isolation

Social isolation has been defined a number of ways in the literature, reflecting its span across different levels of the environment. It has been described as an objective state

of having minimal contact with people (Wenger, Davies, Shahtahmasebi, & Scott, 1996), as being separated from the community or disconnected from the collective (Ferrara, 2009), and as encompassing physical, mental and social dimensions at the individual, community, and societal levels (Hall, 2004). Victor, Scambler, Bond, and Bowling (2000) identified four ways of experiencing social isolation: 1) by comparing one's social network to those of one's peer group, 2) comparisons with younger people, 3) comparisons with when one was younger, and 4) comparisons with older people from past generations.

Some researchers focus solely on the objective aspects of small social network size and limited frequency with social contacts when defining social isolation (e.g., Steptoe et al., 2012). In contrast, others include more subjective aspects in the conceptualization of social isolation. Based on the various definitions of social isolation found in the literature, Nicholson (2009) defined it as "a state in which the individual lacks a sense of belonging socially, lacks engagement with others, has a minimal number of social contacts and they are deficient in fulfilling and quality relationships" (p.1346). This definition also encompasses aspects of loneliness, which is a related construct that can result from being socially isolated. Wenger et al. (1996) define loneliness as a subjective state of negative feelings as a result of being socially isolated, and having lower levels of contact than desired. Van Baarsen, Snijders, Smit, and van Duijn (2001) differentiate between emotional and social loneliness. They define emotional loneliness as the absence of a specific attachment figure, and social loneliness as a lack of meaningful social relationships and social integration. These different conceptualizations

of social isolation and its relationships with loneliness illustrate the complexity of this phenomenon.

2.3   Health Promotion and Mental Health Promotion

According to the Ottawa Charter of Health Promotion, "health promotion is the process of enabling people to increase control over, and to improve, their health" (World Health Organization [WHO], 1986, p. 5). This process is achieved through five strategies: building healthy public policy, creating supportive environments, strengthening community action, developing personal skills, and reorienting health services towards health promotion (WHO, 1986). Creating supportive environments that reduce social isolation and promote social engagement is therefore a focus for health promotion policies and practices.

Reducing social isolation is not only a health promotion priority, but it is also more specifically relevant for mental health promotion. Mental health promotion and health promotion share similar aspects, such as targeting a specific population and including various strategies such as education and policy development, but mental health promotion also has unique components (Centre for Addiction and Mental Health [CAMH], 2010). It focuses on increasing people's sense of power and resilience in order to enhance their mental health. The goals of mental health promotion are to increase resilience and protective factors, decrease risk factors, and reduce inequities (CAMH, 2010). Social isolation is a risk factor for mental health problems; thus, decreasing social isolation can be thought of as an important aim of mental health promotion (CAMH, 2010). Health promotion strategies often focus on addressing the social determinants of health; these determinants are discussed next.

2.4   Social Determinants of Health and Risks for Social Isolation in Seniors

According to the Public Health Agency of Canada (PHAC, 2011), "at every stage of life, health is determined by complex interactions between social and economic factors, the physical environment and individual behaviour". These factors are known as the social determinants of health. The PHAC (2003) has identified twelve determinants of health: income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, access to and quality of health services, gender, and culture. Of these, social support networks, social environments, and gender are of particular importance to understanding social isolation and loneliness in senior women.

The PHAC (2003) emphasizes the protective effects of people's friends, families, and communities on health. These social support networks and positive social environments help people deal with adversity and give people a sense of control over their lives. Individuals who are isolated or lonely, by definition, have limited or no access to this health-protective resource.

2.4.1   Gender as a key social determinant of health. As noted previously, gender has been identified as a key determinant of risk for social isolation. Although gender differences in the experiences of social isolation exist, the specific influences of gender are not yet clearly established. While a number of factors place women at greater risk for becoming socially isolated than men (Hall & Havens, 1999) some research shows that the loss of a spouse, which is more likely to be experienced by women, leads to an immediate increase in some types of social participation, including relationships with

family and friends, and participation in religious organizations (Ferraro, 1984). Other research indicates that men are more likely to be isolated (World Health Organization, 2007). However, women are more likely to outlive men, lose a spouse, and live alone, which are all risk factors for isolation (Hall, 2004). Women are also more likely to be concerned with their personal safety than men, increasing their chances of being isolated (Hall & Havens, 1999), particularly if they perceive their neighbourhood as being unsafe.

Other researchers have also found gender differences in social isolation. Keefe, Andrew, Fancey, and Hall (2006) examined levels of social vulnerability in seniors, which they defined as vulnerability for becoming isolated based on five risk factors: support for instrumental activities of daily living, emotional support, engagement in leisure physical activity, mastery and sense of life control, and home living situation. They found that there were more women than men at the higher levels of vulnerability. However, they also found that gender was not a significant predictor of vulnerability in the context of the other risk factors. Even so, they found that women were less likely to report engagement in leisure physical activity, had higher instrumental activities of daily living vulnerability, and had worse living arrangement scores than men.

Hall and Havens (1999) examined gender differences in social isolation and loneliness. They found that on a 15-item scale measuring isolation women scored higher than men on 12 of the items. Women were also more likely to be extremely isolated on a scale measuring overt social interaction. On a scale measuring loneliness, women and men were about equally likely to report some degree of loneliness, but 50% of women compared to 39% of men reported being very lonely. Hall and Havens also found that social isolation and loneliness predicted home care use one year later.

To increase isolated seniors' access to social support networks, it is important to examine the nature of social isolation and the factors that influence it at different individual, interpersonal and environmental levels. A social ecological model allows for examination of the multiple influences on social isolation and engagement in later life.

2.5 The Social Ecological Model of Health Promotion

Bronfenbrenner (1977) originally developed the social ecological model to address the lack of attention paid to environmental factors that influence human development. He described the influence of various levels of the environment on human development. This social ecological model, that originally stemmed from research on human development, has been tailored to other fields including health promotion. McLeroy, Bibeau, Steckler, and Glanz (1988) developed the social ecological model of health promotion based on Bronfenbrenner's (1977) work. In this model, there are five levels of influence on a person's health behaviour. At the innermost level are intrapersonal factors, which are characteristics of the individual such as knowledge and developmental history. Interpersonal factors and primary groups include formal and informal social networks such as friends and colleagues. Institutional factors include organizational characteristics and operating rules of social institutions, such as workplaces. Community factors are composed of relationships among organizations and informal networks within defined boundaries. At the outermost level, public policy factors include municipal, provincial, and national laws and policies.

Health promotion interventions can be applied at each of these five levels (McLeroy et al., 1988). Interventions at the intrapersonal level can include strategies such as education and support groups, but the focus is on changing the knowledge, attitudes,

skills, or intentions of individuals. Interventions at the interpersonal level target the social

norms that influence behaviour. At the organizational or institutional level, organizational

changes support long-term behaviour change in individuals, create a culture supportive of

health, and support the adoption, implementation, and institutionalization of health

promotion programs. At the community level, health promotion programs can use

structures within a community, such as churches and voluntary associations to influence

health behaviour change by changing norms, values, and beliefs. At this level, health

promotion strategies can also work on increasing coordination among community

agencies. Finally, at the policy level, health promotion professionals can engage in policy

development, advocacy, and analysis to create policies that support healthy behaviour

and discourage unhealthy behaviour. McLeroy et al. (1988) assert that "an essential

component of ecological strategies…is active involvement of the target population in

problem definition, the selection of targets of change and appropriate interventions,

implementation, and evaluation." (p. 369). This stance emphasizes the value of

understanding the problem of social isolation in senior women and involving senior

women in interventions designed to enhance social engagement.

2.6   Social Isolation at the Five Levels

Examining social isolation at the different levels within the social ecological

model allows researchers and professionals in the healthcare and health promotion fields

to understand the complexity of the problem and develop interventions to alleviate it.

Researchers have identified a number of individual (e.g., living alone, poor physical and

mental health), environmental (e.g., lack of a sense of community, lack of access to

transportation), and societal (e.g., cost of living, negative perceptions of aging) risk

factors for social isolation (Ferrara, 2009; Hall, 2004). Consequences of social isolation also occur at these same levels. For example, at the individual level the consequences of social isolation can include loneliness, decreased mental and physical health, and reduced quality of life. Consequences of social isolation at the environmental level include neighbourhood deterioration and lack of social cohesion, and ageism is the most prevalent consequence at the societal level (Ferrara, 2009; Hall, 2004). The relationships between risk factors and consequences are complex and recursive, since a consequence of social isolation can further increase isolation.

Social isolation is essentially a lack of social engagement, which encompasses the second level of McLeroy et al.'s (1988) model. Interventions aimed at reducing social isolation can focus on policy, community, institutional, interpersonal or intrapersonal factors to reduce levels of isolation. Interventions at each of these levels can change seniors' levels of isolation or engagement.

In their review of health promotion programs targeting social isolation and loneliness in seniors, Cattan, White, Bond, and Learmouth (2005) found that of the various types of interventions, educational and social activity group interventions were the most effective in reducing isolation and loneliness. However, it is known that one's immediate environment and the broader policies in place play an important role in influencing behaviour (Schneider & Stokols, 2009). The relationships between the risk and protective factors for and consequences of social isolation and social engagement at the five levels are illustrated in Figure 1. Risk and protective factors influencing social isolation at the intrapersonal, institutional, community, and policy levels are described

below. The interpersonal level overlaps with these other levels; thus, it is not discussed separately.

2.7   Social Isolation at the Intrapersonal Level

There are a number of intrapersonal risk and protective factors for social isolation. Some of these, such as demographic variables, are uncontrollable, whereas others, such

Figure 1. Influences on social isolation and social engagement. The levels interact to influence experiences of social isolation or social engagement.


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                        ┌──────────────────┐
                        │      Policy       │
                        │  (e.g., Healthy   │
                        │  Aging Strategy)  │
                        └──────────────────┘
                    ┌──────────────────────────┐
                    │        Community          │
                    │ (e.g., age-friendly cities,│
                    │  intergenerational contact)│
                    └──────────────────────────┘
                      ┌──────────────────┐
                      │   Institutional   │
                      │  (e.g., hospitals, │
                      │ physician's offices)│
                      └──────────────────┘
                      ┌──────────────────┐
                      │   Interpersonal   │
                      │  Social isolation │
                      │ Social engagement │
                      └──────────────────┘
                      ┌──────────────────┐
                      │   Intrapersonal   │
                      │ (e.g., gender, age,│
                      │     mental and     │
                      │  physical health)  │
                      └──────────────────┘
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Decline in mental and physical health

Improved mental and physical health
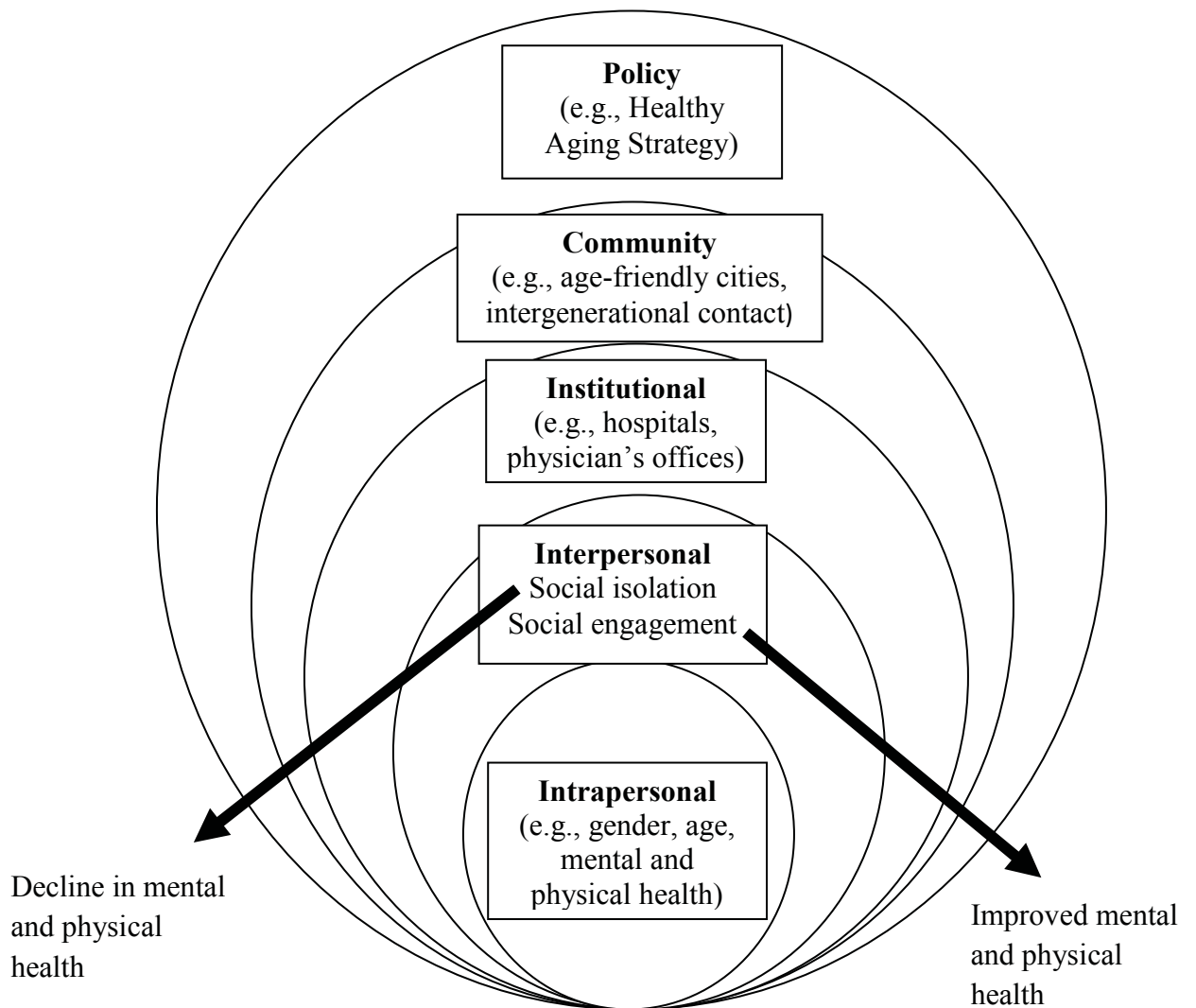
as coping skills, are controllable to varying degrees. Adequate coping skills, good mental and physical health, and demographic variables such as higher income and social status reduce the likelihood of an older adult experiencing social isolation (Elder & Retrum, 2012; Wilson, Harris, Hollis, & Mohankumar, 2010). Conversely, the absence of these factors, and the presence of other risk factors, increase an older adult's likelihood of experiencing social isolation.

Intrapersonal risk factors for social isolation include demographic factors, such as older age, lower socioeconomic status, widowhood, and living alone (Hall & Havens, 1999; Keefe et al., 2006; Wenger et al., 1996; Wilson et al., 2010). Mental and physical health problems are also associated with social isolation (Elder & Retrum, 2012; Keefe et al., 2006; Nicholson, 2012). Depression has been associated with social isolation as both a risk factor and a consequence of isolation (British Columbia Ministry of Health, 2004; Cloutier-Fisher, Kobayashi, & Roth, 2006; Hall, 2004). Nicholson (2012) states that although there is close relationship between social isolation and depression, "there is no consensus in the research that is available regarding the relationship between depression and isolation" (p. 143). It is most likely a circular relationship where isolation increases the likelihood of depression, and depression further increases isolation (British Columbia Ministry of Health, 2004). Although mental and physical health conditions are typically included in the intrapersonal or individual level, the effects of these conditions can go beyond this level to the interpersonal and community levels, as access to health services and stigma toward those with certain conditions can affect one's experience of his or her health problem. The role of personality in relation to social isolation has received little empirical attention.

Individual characteristics can be targeted to reduce social isolation in seniors. For example, Caring Neighborhood is a program centered around volunteers who reach out to isolated people in the community (Sparrow, 2006). Fifty percent of the program's participants are the frail elderly. According to Sparrow (2006), this type of program increases people's confidence, skill, and self-efficacy to start forming their own, natural relationships. Other research shows that one-on-one interventions are less effective in reducing isolation than group interventions (Clifton, 2011).

2.8   Social Isolation at the Institutional Level

Although seniors do not typically interact with some formal institutions such as workplace and schools, they do interact with healthcare institutions such as hospitals and physician's offices. Even though there has been limited attention in the health promotion literature to the potential role of health promotion practitioners in reducing social isolation, nurses have been identified as a contact point to identify potentially isolated seniors and refer them to the appropriate services (Nicholson, 2012; Wilson et al., 2010). Nurses can also educate community groups about the services needed to increase social engagement in seniors, and, in order to reduce ageism, nurses can work with schools to increase awareness around the benefits of intergenerational contact (Wilson et al., 2010). These education initiatives require cooperation from community groups to produce the desired changes in seniors' levels of social engagement.

2.9   Social Isolation at the Community Level

Groups or organizations in the community can help foster social engagement in older women. The Red Hat Society® is one such group. It is an international organization with local chapters that promote fun and relationship-building among women above 50.

Membership in the Society promotes socio-emotional and psychological health by creating happy moments through fun activities, assisting women with responding to transitions and negative life events, and enhancing women's perceptions of themselves (Son, Kerstetter, Yarnal & Baker, 2007). Participation in the Red Hat Society® also helps older women cope with stress caused by normative life transitions (e.g., retirement) and daily hassles by providing social support, reducing stress and enhancing positive emotions, sustaining coping efforts, and providing opportunities for re-appraisal or personal renewal (Hutchinson, Yarnal, Staffordson & Kerstetter, 2008). Hutchinson et al. (2008) note that the positive benefits of social support gained through participation in the Society were particularly important to older women who live alone. Son et al. (2007) suggest that health professionals could recommend participation in the Society as an option for older women who are socially isolated.

In their study on the effects of social isolation and loneliness on the health of older women, Hall and Havens (1999) identified several community-level interventions that could help reduce social isolation, such as increased availability of programs and services for seniors, increased intergenerational activities, and the involvement of seniors in all levels of planning. On a global scale, the age-friendly cities initiative incorporates aspects of social ecology to enable seniors to age healthily. Organized by the World Health Organization (WHO), the age-friendly cities initiative aims to optimize "opportunities for health, participation and security in order to enhance quality of life as people age" (2007, p. 1). The WHO (2007) notes that to increase social participation in seniors, a wide range of activities should be available close to where seniors live, seniors

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should feel safe in their communities, and intergenerational activities should be supported.

Locally, Halifax, Nova Scotia is a participant in the age-friendly cities initiative. Seniors were consulted about age-friendly features and barriers in this city; however, socially-isolated seniors did not participate in these consultations (Keefe & Hattie, 2007). Age-friendly features that were identified include parks, seniors' clubs, and volunteer opportunities, whereas age-friendly barriers include inadequate sidewalk maintenance, lack of parking, and inaccessible buildings in the city's core (Keefe & Hattie, 2007). The barriers represent opportunities for health promotion initiatives to increase social engagement, but the barriers to social engagement that socially isolated seniors experience are also important to know.

2.10   Social Isolation at the Policy Level

Both national and provincial initiatives have been implemented to promote healthy aging and reduce social isolation. Although not policies per se, these initiatives contain guidelines to assist in the development of policies that promote healthy aging. On a national level, the Public Health Agency of Canada (PHAC, 2006) published a vision for healthy aging, defined as "a lifelong process of optimizing opportunities for improving and preserving health and physical, social and mental wellness, independence, quality of life and enhancing successful life-course transitions" (Health Canada, 2002b, p. 1). The vision consists of "a society that values and supports the contributions of older people; celebrates diversity, refutes ageism and reduces inequities; and provides age-friendly environments and opportunities for healthy choices that enhance independence and quality of life" (PHAC, 2006, p. 9). This report identified five key focus areas for

seniors' health: social connectedness, physical activity, healthy eating, falls prevention, and tobacco control. Of particular importance to this thesis is the focus on social connectedness. The PHAC emphasizes that seniors who are engaged in life and connected to others are happier and healthier than seniors who are isolated. To encourage seniors to connect with others, supportive environments need to be created that remove barriers to participation and promote participative activities such as volunteering and recreation (PHAC, 2006).

Provincially, Nova Scotia's Positive Aging Strategy identifies several goals for governments, communities, and organizations to aim toward to promote positive aging (Seniors' Secretariat of Nova Scotia, 2005). Positive aging emphasizes that positive attitudes toward aging can encourage the ongoing participation of seniors in society. It promotes individual responsibility for positive aging, while addressing the role of environmental factors in providing support for seniors to age positively. One of the goals identified in the strategy is celebrating seniors, which includes eliminating ageism and recognizing seniors' contributions to society. This goal encompasses the need to reduce social isolation and encourage seniors' participation in the community, which can be accomplished by examining the interactions between seniors and their environment that either promote or discourage participation.

Hall and Havens (1999) identified several policy interventions that could help reduce social isolation, including increased housing options, involving seniors in all levels of planning, and increased cooperation across different levels of government to improve service delivery. MacCourt (2004) developed the Seniors Mental Health Policy Lens to provide policy developers and program planners with an analytical tool that

predicts or identifies unintended negative consequences of policies, programs, and services on the mental health of older adults. Social support networks, social participation, and social isolation are among the many considerations MacCourt (2004) identifies. These examples of healthy aging initiatives show that the social ecological model is useful for both identifying factors that influence the health of seniors and implementing health promotion interventions that enhance seniors' health.

2.11   Conclusion

To summarize, social isolation in seniors has a number of negative effects on mental and physical health. In Atlantic Canada about 8% of seniors indicated that they had no close friends, defined as friends they felt at ease with, could talk with openly, or call for help (Turcotte & Schellenber, 2006), making these seniors more likely to experience health problems. The costs of social isolation in seniors include economic costs as well as health care costs, which are currently greater for senior women (Health Canada, 2001). Furthermore, seniors contribute the greatest number of volunteer hours of any age group (Statistics Canada, 2006), and the need for volunteers will increase as the population rises (Seniors' Secretariat of Nova Scotia, 2005). Isolated seniors are less likely to volunteer, representing a lost opportunity in terms of their contribution to society and the positive individual benefits of volunteering.

The literature on social isolation in seniors provides a broad overview of the determinants and consequences of isolation, but the numerous definitions and the mixed effectiveness of health promotion interventions targeting social isolation implies that a better understanding is needed of what it means to be a socially-isolated senior woman. Current definitions emphasize what socially isolated seniors lack, but a better

understanding is needed of how seniors spend their time if they are not connecting with others, and how that use of time affects their health. Before effective health promotion interventions can be developed, researchers should have a clear understanding of the factors that contribute to social isolation in senior women so that those factors can be addressed. This study aimed to work toward addressing some of the gaps in the literature and used the information obtained to make recommendations for hypothetical health promotion programs and policies.

CHAPTER 3   RESEARCH DESIGN AND RESEARCH METHODS

This chapter describes the methodology and method that were used to explore the research questions outlined in the previous chapter.

3.1   Methodology

The methodology that fits best with both the research question and guiding paradigm is interpretive, or Heideggerian, phenomenology (Heidegger, 1962; Smith, Flowers, Larkin, 2009). This methodology has several assumptions. One assumption is that individuals have situated freedom; that is, they are free to make choices within the constraints of their daily reality (Lopez & Willis, 2004; Mackey, 2005). Another is being-in-the-world, which states that people's realities are influenced by the world in which they live, and that they can't separate themselves from their world (Lopez & Willis, 2004; Mackey, 2005). Using this methodology was in line with asking participants to discuss the situational factors that contribute to their experiences of isolation and the barriers they experience to social engagement.

Interpretive phenomenology also has some assumptions related to the interpretation of data. It recognizes the existence of fore-structures: the knowledge that a researcher has in advance of interpretation of data (Lopez & Willis, 2004). This knowledge can come from previous experience or knowledge gained from a literature review, and it actively shapes the interpretations a researcher makes from data.

It is important to explain how my pre-conceptions of social isolation may have influenced what participants focused on and how I interpreted what they told me. I chose to focus my research on the senior population because I was interested in gaining a more realistic view of seniors' experiences in contrast to the popular, albeit changing, focus on

the negative experiences of aging. I chose to focus specifically on social isolation in seniors because and it is consistently identified as a risk factor for a number of negative health outcomes, and, on a personal level, my grandfather would be identified as being socially isolated, yet generally manages to maintain his well-being despite this risk factor. I was interested in learning about how social isolation fits in with the other risk and protective factors in a person's life. Based on this recognition of the existence of fore-structures which shape interpretations researchers make, I kept a field journal to remain aware of how past research on social isolation influenced my understanding of what the participants said. This process will be discussed in more detail below. Data interpretation is hermeneutic in interpretive phenomenology, meaning that it goes beyond description of key concepts to the meanings people attribute to their experiences (Lopez & Willis, 2004; Smith, Flowers, & Larkin, 2009). I went back to the data several times to look for meanings that were not always apparent to participants, and included fore-structures in data analysis (Lopez & Willis, 2004). Throughout the data analysis process, I remained reflexive by acknowledging that I was an active participant in the construction of meaning.

3.2   Method

3.2.1   Participants.

To answer the research questions, criterion sampling was used to recruit six socially-isolated women 65 years of age or older. The tools used to assess the inclusion and exclusion criteria are described further below. The main inclusion criterion, in addition to gender and age, was social isolation. Participants had to be objectively identified as being isolated so that the phenomenon of isolation could be studied. Participants who showed signs of severe depression or anxiety were excluded

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from the study in part to maintain greater homogeneity in the sample, in line with interpretive phenomenological analysis. Moreover, depression and anxiety are treatable and reversible states that affect the self-perceptions of those with these conditions, so the experiences of social isolation in older women with these conditions would likely be qualitatively different from women experiencing isolation for other reasons. Senior women who had severe dementia and might have had difficulty answering the interview questions were also excluded.

Initially, 10 to 12 participants were sought because of the anticipated variability in terms of loneliness and age. Though some experts suggest that a sample of three to six participants is sufficient to answer a particular research question (Smith & Osborn, 2008), this is recommended for a largely homogeneous group. Despite various recruitment efforts (described below), there were challenges in finding participants who met the isolation criteria.

In total, 16 potential participants participated in the screening interview, seven were screened in, and six participated in the qualitative interview. One older woman declined to participate in the qualitative interview because she did not want to go into detail about her life. Eight older women did not meet the isolation criteria because they had relatively frequent contact with their family and/or friends, or because they were actively involved in volunteer or church activities, or for both reasons, and one older woman had a severe brain injury that caused short-term memory loss and would have been unable to participate in the qualitative interview. No potential participants were screened out due to current severe depression or anxiety.

In addition to interviewing socially-isolated senior women, I interviewed three

service providers who helped to identify potential participants and who worked or

volunteered for organizations that have programs aimed at reducing social isolation in

seniors. The recruitment of these service providers was added to the original study design

in part to compensate for the lower number of senior participants recruited, and in part to

expand the breadth of experiences obtained. These interviews were used to supplement

the interviews with the isolated older women so that the experiences and perceptions

between the groups could be compared.

3.2.2 **Recruitment.** Recruitment took place through several senior-serving

organizations: Spencer House, a drop-in community centre for older adults; the

Northwood Telecare program, which places volunteer calls to at-risk seniors living alone;

the Victorian Order of Nurses (VON), which provides home care, personal support, and

community services to older adults; and Northwood residences. Other organizations were

also contacted but were unable to assist with recruitment due to time constraints and

organizational policies. Contact people within these agencies were provided with a list of

inclusion and exclusion criteria so that they could identify potential participants (see

Appendix A). The Northwood contact passed this information on to the Wellness

Coordinator at Northwood Towers and Northwood Manor. The criteria included potential

participants' contact with others, their ability to live independently, and general questions

assessing their mental health. The purpose of this list was to initially exclude individuals

who showed signs of severe dementia or severe depression or anxiety. They were also

given a recruitment postcard to give to potential participants (see Appendix A). The staff

and volunteers were asked to either pass along the recruitment postcard to them, or seek

their permission for me to call them. All Northwood residents received the postcard because it was too time-consuming for the Wellness Coordinator to go through the recruitment criteria for each resident. To expand the recruitment strategy, posters were also displayed in doctor's offices, pharmacies, public libraries, senior residences, and grocery stores, and Spencer House members were given postcards or posters to pass along to potential participants.

3.2.3   Screening Procedure and Measures. When potential participants contacted me, or I contacted them through a referral from a service provider, I introduced myself and gave them a brief description of the study. All potential participants were still interested in meeting at this point, so I set up an in-person meeting with them to give them more information about the study and conduct the screening measures. This meeting took place at either the potential participant's home or a meeting room at a public library, depending on the individual's preference. At this meeting I introduced myself to the potential participant and gave another description of the research study. Oral consent was sought for the screening interview to reduce the burden to potential participants. Before oral consent was sought, participants were told the following:

"Thank you for meeting with me today. As I mentioned earlier, I'm a master's student at Dalhousie University studying health promotion, and I'm looking to learn more about the experiences of senior women who spend much of their time alone.

During this meeting, I'm hoping to gain an understanding of how much time you spend with others and how you feel about the time you spend with others. I'll also be asking you some questions about your well-being. You may skip any questions that you are not comfortable answering, and you can decide to stop at any time. This meeting

should take about 20 to 30 minutes. You will receive a $5 gift card to Tim Horton's as a token of appreciation, even if you decide to stop early or skip any questions I ask.

Do you have any questions?" (if yes, I answered their questions). "Is it ok if I go ahead and start asking you the questions I described?"

The screening questions were then asked. I asked participants introductory questions to assess their cognitive status and the likelihood that they were depressed or had anxiety (see Appendix B), including the date, the hardest part about living on their own, their sleeping patterns, their perceptions of the future, and whether they were diagnosed with depression or similar problems in the past. If they did not know the date (within one day), or if they described their future as bleak and hopeless and indicated difficulties falling or staying asleep on a regular basis, they were not eligible to participate in the study. Sleep disturbances are indicators of depression as people with depression tend to have difficulty falling asleep, experience frequent awakenings at night, and early morning awakenings (Riemann, Berger, & Voderholzer, 2001). Livingston, Blizard, and Mann (1993) found that in seniors with current depression the best predictors of future depression were current depression and sleep disturbance. Thus, asking potential participants about their sleep patterns provides information about their likelihood of being depressed. Because participants may have been hesitant to respond honestly to the question about being diagnosed with depression in order to appear socially desirable, asking about sleep disturbances provided another source of information about their likelihood of experiencing depression or anxiety.

Potential participants were also asked to describe how they saw their future to assess their levels of hope. Lack of hope is also an indicator of depression (Beck, 1963)

and it has been studied in the elderly population (Chimich & Nekolaichuk, 2004), where researchers found that hope, integrity, and depression are highly interrelated in the elderly population. Thus, seniors who see their future as bleak and hopeless are more likely to be experiencing depression. Lastly, potential participants were asked about the hardest part about living on their own to assess whether they had problems with activities of daily living or memory impairment.

Participants were then asked screening questions from a five-item social isolation index (Shankar, McMunn, Banks, & Steptoe, 2011). This measure assesses social network characteristics such as contact with friends and family. It focuses on the objective aspects of social isolation. It has a mean of 1.6 and a standard deviation of 1.4. Higher scores indicate higher levels of isolation. As I asked these questions, I wrote down individuals' answers and scored their answers as either 0s or 1s. After asking all five questions, I summed the scores. Potential participants who scored either 3 or higher (if they had children) or 2 or higher (if they did not have children) on the scale were considered isolated and were eligible for participation in the study. The cut score of 3 was chosen as it is one standard deviation above the mean; however, because the index is skewed toward women with children, a lower cut score is set for women without children. The scoring key is included with the measure in Appendix B.

After I met with seven potential participants and only one was screened in, I met with my thesis supervisor to discuss the screening criteria. We discussed the frequency and type of contact the potential participants were having, and decided to change the scoring so that participants received a point toward the social isolation index if they had contact with their friends or family on a less than bi-weekly basis, compared to on a less

than monthly basis as per the original index scoring. We also gave participants an extra point if all of their contact was either by phone or email. We agreed that having contact less than once every two weeks was still infrequent enough to be considered isolating. The updated scoring key is also included in Appendix B. Potential participants who were still eligible at this point were asked questions from a six-item loneliness measure, which assessed their subjective evaluation of their isolation (De Jong Gierveld & Van Tilberg, 2006).

Those who were ineligible for the study were thanked for their contributions and time, and were given a $5 gift card to Tim Horton's. They were also offered a copy of the Department of Seniors Positive Aging Directory. Eligible potential participants were given more detailed information about the interviews. I went over the informed consent form with the potential participants and asked them if they preferred to have the form read aloud to them. I asked the potential participants if they had any questions and answered any questions they did have. They were informed that if at any point they had questions they could contact me, and that they could ask for a break or withdraw from the study at any time. If potential participants decided to take part in the study, they were asked to sign the form and were given a copy of it for their records. The same process was followed for service providers. Both consent forms are included in Appendix C.

  3.2.4 Data collection. Using the assumptions of interpretive phenomenology as a guide, I conducted individual, semi-structured, open-ended interviews with the participants (Appendix D). Interviews were audio recorded with participants' consent. A semi-structured interview allows the researcher to modify initial questions according to the participant's response and probe interesting comments that may help to answer the

research questions (Smith & Osborne, 2008). During the individual interviews, participants were asked to answer questions about how they spend their time and their experiences of any interactions they had with others. By asking probing questions I was able to find out more details about their experiences in order to co-construct a narrative of their experiences with them, which is in line with interpretive phenomenology's assumptions of being-in-the-world and the co-constitution of meaning. The interviews took between approximately 35 and 90 minutes, and participants were reminded that they could take a break at any time and skip any questions they preferred not to answer.

An observation guide (see Appendix E) was also used to record signs of agitation or nervousness as well as features in the environment that may have contributed to participants' experiences of isolation. If participants provided consent, their scores from the loneliness and social isolation measures were also reported.

After participants completed the interview, they were thanked for their time, given $10, and offered a copy of the Positive Aging Directory. If they had concerns or required more information, I helped them find appropriate resources in the directory. At this time I also asked for permission to contact them again to set up either an in-person or telephone meeting to review the initial themes. All participants consented to this follow-up member checking meeting. They were also asked if they wanted a copy of the preliminary themes and a brief description of each one to be mailed or emailed to them before the member checking meeting.

This follow-up meeting involved a discussion of the preliminary themes in relation to representative quotes from the participant's interview. During this interview, participants had an opportunity to elaborate on the findings. More specifically, I spent a

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few minutes summarizing what I had heard in the interview and how I interpreted what the participant had said. Then, I asked participants for their thoughts on the initial themes, probing for agreement or disagreement. These meetings took between approximately 6 to 40 minutes. One participant was not contacted for the follow-up meeting because her phone number was incorrect. A summary of the recruitment and data collection procedures is outlined in Table 1.

Table 1

Recruitment and Study Stages

Recruitment stages	Study stages
1. Service providers contact potential participants	4. Participants sign informed consent form
2. Researcher contacts potential participants	5. Qualitative interviews
3. Researcher meets with potential participants to conduct screening measures	6. Phone or in-person follow-up

In addition to interviewing socially-isolated senior women, I conducted individual, semi-structured, open-ended interviews with three service providers who work or volunteer for organizations that have programs aimed at reducing social isolation in seniors. These interviews lasted between approximately 15 and 35 minutes. Service providers were asked about their views of social isolation in senior women, how their organization identifies socially-isolated seniors, and how they address social isolation through the services they provide. They were also asked for permission to be contacted for a review of the initial themes. One participant was going on leave so she was not re-

contacted. The follow-up meetings for the remaining two service providers took about 5 minutes each. Service provider participants were offered $10 for their participation. The interview guide is contained in Appendix G.

3.3 **Data Management and Analysis**

All interviews were transcribed verbatim. Interview files used unique identifiers instead of participant names, and pseudonyms for participants were created to use in the results and discussion. All electronic files were stored in password-protected files on a password-protected computer, and consent forms and paper copies of screening questionnaires were stored in a locked cabinet. The questionnaire and interview data will be retained for 5 years. On advice from the Dalhousie Research Ethics Board, after this period I will keep de-identified copies of the interview transcripts and observation guides for possible future research. Paper copies will be shredded and audio files will be securely erased to RCMP standards using Eraser.

The data were analyzed using the interpretive phenomenological analysis process described by Smith and Osborn (2008). This approach focuses on interpreting the meanings that participants attribute to events, experiences, and states. It involves a double hermeneutic approach of the participant making sense of his/her world and the researcher making sense of the participant's interpretation of his/her world. In this analytic approach, I had an active role in the research process and sought to understand the participant's point of view as well as look for underlying meanings behind the participant's experiences.

To analyze the data, I followed Smith and Osborn's (2008) suggested steps for interpretive phenomenological analysis. I used both handwritten notes on transcripts and

NVivo version 10 to analyze the data. First, I read through the first transcript and made summary notes, connected ideas, and made preliminary interpretations. Then I gave emerging themes titles and linked them to what the participant actually said. Next, I connected the themes based on similarities among them. I named these superordinate themes and linked them to quotes in the transcript. After discussing these initial themes with my supervisor, some of them were reorganized and renamed. At this point, I had a member checking interview with the first participant to summarize the themes from her interview and probe for agreement or disagreement. She agreed with the summary and elaborated on what she brought up in the first interview. I then used the list of themes to continue the analysis for subsequent interview transcripts. After each interview, I coded the transcripts using the existing list of themes, expanding and revising it as necessary. Throughout these steps, I used the data from the observation guide to look for similarities and differences between it and the screening and interview data. The observational data supported what participants spoke about in the screening and in-depth interviews.

At each member checking interview, I provided participants with a summary of the superordinate and sub-themes that were derived from their interview, asked them for their feedback, and asked one or two follow-up questions from the first interview. All participants agreed with the summaries that were provided to them, and the information obtained during these member checking interviews did not change the thematic structure of their individual summaries. After completing all of the interviews, I created a final list of superordinate and sub-themes, and translated these themes into a narrative account that provided an answer to the research question.

Data obtained from the service provider interviews were analyzed using thematic analysis to identify main themes. I familiarized myself with the data, generated initial codes, searched for themes based on similarities among codes, reviewed and refined the themes, defined and named them, and produced a narrative report of the results (Braun & Clarke, 2006). Because the main research question focused on the phenomenon of social isolation in senior women, and service provider participants were not isolated older women, interpretive phenomenological analysis would have been less appropriate for this group. Thematic analysis was thus used as its flexibility allows it to be applied to a broad range of qualitative data (Braun & Clarke, 2006).

When analyzing the data, I aimed to address the trustworthiness criteria of credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1985). To establish credibility, I attempted to build trust with the participants by explaining the purpose and procedures of the study, and by remaining respectful during the interviews. I also conducted follow-up interviews to verify the accuracy of the applicable superordinate and sub-themes that were derived from each individual interview. Additionally, I used observational data to supplement the interview data by examining similarities and differences between what I saw and what I heard. To establish transferability I used thick descriptions so that those who read my study can determine whether it applies to other research problems or populations.

To establish dependability, I documented in detail the decisions I made throughout the study to leave an audit trail. After each interview, I made field notes to summarize how the interview went, note any questions that weren't working well, and to summarize the main themes that came out of the interview. After each major iteration of

a coding structure, I wrote notes on what changes were made and why. I also made sure

that the themes and subthemes were related to the research question and were reflective

of the raw data. The raw data, field notes, methodological process, and results were all

parts of the audit trail. Finally, to establish confirmability I ensured that the

interpretations I made were grounded in the data and I used my field notes to examine

how my biases and fore-structures could have shaped my interpretations.

3.4   Ethical Considerations

Due to the sensitive nature of this study, there were ethical considerations that had

to be addressed in addition to common considerations such as informed consent and

proper storage of data. I asked participants to discuss issues that had the potential to put

them in a negative mood. To minimize the likelihood of this happening, I asked

participants to discuss factors in their environment that facilitated social interaction in

addition to those that hindered it. I also encouraged them to discuss how to overcome

barriers they identified. I created a decision tree outlining a series of steps to follow if

participants became distressed (see Appendix F).

A second ethical consideration specific to this study, and related to the first

consideration, is what happens to the participants after the interviews. They may leave

the interviews with a better understanding of why they feel isolated or lonely, but they

may also leave with problems that they hadn't thought about before and to which they

may not have a solution. To mitigate the negative effects of this possibility, I provided

participants with a copy of the Department of Seniors' Positive Aging Directory, which

contains information on the programs and services available to seniors in the province,

and offered to help find the services they were looking for.

CHAPTER 4   RESULTS

To answer the research question of what it means to be a socially-isolated senior woman in the Halifax Regional Municipality and what factors contribute to this experience, the data from participant interviews are presented in three superordinate themes that were derived from the interviews and supplemented with observations: 1) differences between current and desired levels of social activity and support, where desired levels reflect their social needs; 2) self-perceptions of social isolation and loneliness; and 3) constraints to and facilitators of social activity. The difference between current and desired social activity was influenced by the constraints and facilitators to social activity that participants perceived and experienced. The smaller the difference, the more participants' social needs were met. Participants' self-perceptions of isolation and loneliness also influenced, and were influenced by, their social needs. Figure 2 illustrates the relationships among the superordinate themes.

The results are presented in three main sections. First, the characteristics of the participants are outlined. Next, the three superordinate themes are described along with an outline of two participants who exemplify the connections among the themes. Lastly, the themes obtained from the service provider interviews are described.

4.1   Participants

Six older women participated in the study. Table 2 below displays descriptive information about the participants. Participants' social isolation scores ranged from 2 to 5 on a 5-point scale, with a mean of 3.2 and a standard deviation of 1.2. Participants' loneliness scores ranged from 0 to 2 on a 6-point scale, with a mean of 1.3 and a standard deviation of 1.0.

Figure 2. Relationships between superordinate themes

barriers and facilitators to social engagement

self-perceptions of social isolation and loneliness

Social needs:
Desired levels of social
activity and social support

Current levels of
social activity
(engagement and
companionship) and
social support
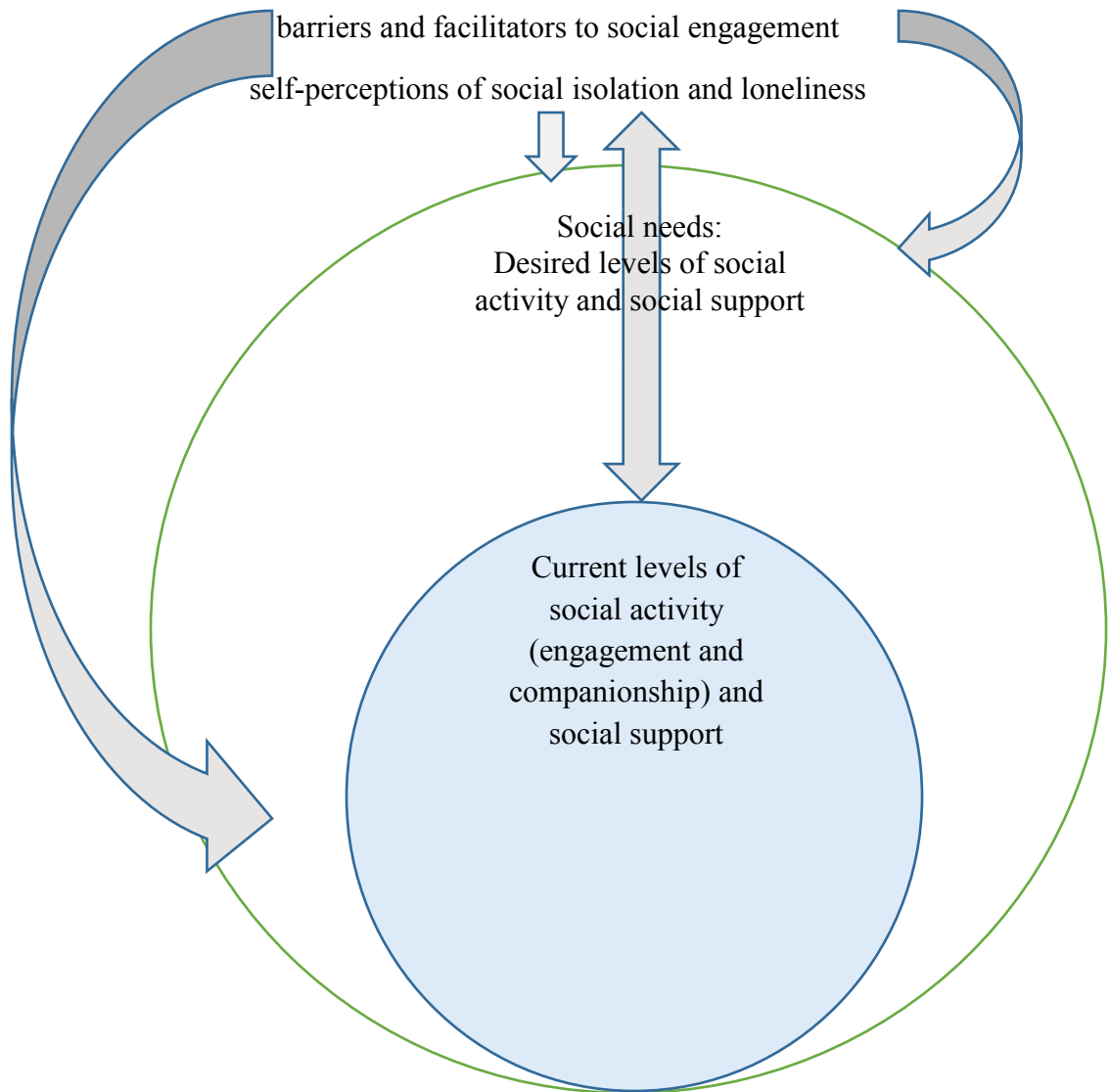
Based on the information from participant interviews, I came up with descriptions of their personalities and preferences for social engagement. I read through the transcripts and made notes on these characteristics based on how they described themselves and their behaviour. Jasmine was thoughtful, optimistic, sometimes hesitant in reaching out to others, and generally unsatisfied with the amount of contact she had with others. Nadia was independent, physically active, and easy going. Felicity was introspective, physically

active, focused on living in the present, and lacked close relationships with her family

members. Kate was focused on living in the present, spiritual, living with a terminal

Table 2

Participant demographic information

Participant	Type of dwelling	Marital status	Age range	Mental health	Physical health
Jasmine[1]	Apartment	Widowed	80 +	Good; saw psychologist in the past	Liver problem
Nadia	Apartment	Single	80 +	Starting to notice memory problems	Sporadic breathing problems; uses a walker
Felicity	Apartment	Divorced	65-69	Diagnosed with depression in the past	Good
Kate	Apartment	Widowed	65-69	Described as excellent	Stage 3 ovarian cancer
Christine	House	Single	65-69	Good; trouble staying asleep sometimes	Diabetes; high blood pressure
Tasha	Townhouse	Widowed	65-69	Good; trouble falling asleep sometimes	Wears hearing aid

illness, and focused on maximizing her comfort and quality of life. Christine was

independent, kept to herself, busy, lacked close relationships with her family members,

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[1] Pseudonyms are used unless otherwise indicated.

and uncertain about how she might handle health problems in the future. Lastly, Tasha was curious, social, occasionally hesitant in reaching out to others, and empathetic.

4.2   Differences between Current and Desired Levels of Social Activity and Support

Concepts from the social activity and social support literature were used to inform the analysis of the results. Social activity encompasses social engagement, which includes activities done for productive or leisure reasons, and companionship, which includes activities done solely for enjoyment (Flatt & Hughes, 2013). Social support encompasses the emotional, instrumental, appraisal, and informational support that comes from contact with others (Andrew, 2010). The data suggested that the difference between current and desired levels of social engagement, companionship, and social support indicates the extent to which participants' social needs were met. Participants' self-perceptions of isolation and loneliness also indicated the extent to which they thought their social needs were met.

4.2.1   Current levels of social activity. Social activity for participants included participating in cultural activities with others, learning from others, and spending time with others simply because they enjoyed their company. Nadia talked about occasionally going to lunch with a group of friends:

> *And so you know I've gotten to know them and we go out to lunch occasionally, you know they'll say let's go out to lunch and we'll go, a group of us.*

Tasha spoke about learning about different topics from an older friend:

> *There's another gentleman who was a former neighbour…if I don't call him, he'll call and say are you coming over for coffee, so I'll go over and spend a couple of*

hours with him…and I just love to listen to his stories and I'll ask some questions.

Last time we talked about radar and what it was like to be out in the middle of the

ocean and what if the radar failed and so, you know there's just so much to learn

from these people.

Christine spoke about spending time with her neighbour purely for the sake of enjoyment:

Well we sit out on the deck and you know you sit there and enjoy the weather and

that sort of thing.

Tasha described the time she spent with an older senior that she visited as part of a volunteer visiting program. She enjoyed spending time with this older senior because they could talk about common interests.

…but I used to take these coffee table books that somebody had given me,

beautiful portraits of movie stars, old movie stars, and she would remember them

all and we would talk about the movie stars, and then she's talk about, oh I

remember a film when I first went and you know, or she'd point out like a

particularly good looking man, oh he's sexy isn't he, you know, she hadn't lost

any of that. So that was enjoyable and she'd always be full of life…

To summarize, participants spoke about social engagement and companionship activities they took part in on a regular or occasional basis.

4.2.2   Current levels of social support. In addition to the companionship described above, Christine spoke about how her neighbour provided her with instrumental support:

My neighbour up the street I have contact with on a pretty regular basis…I might

not see her that often but I would talk to her on the phone if I didn't see her, you know that sort of thing…she's my main everything, if I need to go to the hospital or something and you know, she would take me, she wouldn't always take me but you know, or if I had to come down to the garage to pick up my car she'd be coming in town I'd just ask her if she could drop me…

Kate described her long-distance contact with a spiritual group. The phone calls with this group seemed to provide her with emotional and informational support for her spiritual development.

I'm in a spiritual group, but that's a long distance thing from California, those contacts, we have telecalls once a month, sometimes more frequently I'll have, like I had one last week, a two hour, I'll have another one next week so I maximize my spiritual development…

Jasmine spoke about the social support she received from her regular check-in calls from volunteers. She appreciated the feeling of being looked after that came from these daily phone calls:

That means everything to me because I can go to bed at night and think 'somebody will be checking on me in the morning' not that I sit and wait or anything for it. But it's a nice feeling to know that somebody is looking out for you when you're alone.

4.2.3 Desired levels of social activity. Desired levels of social activity varied among participants. Christine, who preferred to do things on her own rather than wait for others to do things with them, was satisfied with the amount of social contact that she had:

Sometimes you know you might say, you know, I'd like to have someone I can go

to the movies with or something like that but other than that I just don't like to

wait for people…just to be able to go when I wanna go and do you know, if I

wanna leave for the States at 5 o'clock in the morning or 4 o'clock in the morning,

I get up and go. You know, never had to wait for somebody else and that's what

you'd be doing is waiting. I'm just too independent. I just like to go.

Nadia's level of social activity seemed to be quite close to her desired level, as can be

seen from the following quote:

I don't have a lot of friends here but it doesn't seem to worry me you know.

Although Jasmine initially said that she was satisfied with the quality of contact she had,

she later indicated that she would like to have more contact with others, specifically that

she would like to have friends with whom she could take part in leisure activities:

Well, the point is, if I had more people, life would be different because you would

go to like Neptune or go so many more places or feel more comfortable in going

by yourself, like the Rebecca, or say something like that, you know, you can put it

in your own terminology, but you know. I think if you're young or old, I think most

people like to have somebody to go places with.

Only two participants spoke about wanting more companionship in their lives.

Kate spoke about her contact with her long-distance friends. She missed the enjoyment

that came from having close friends nearby who could drop in and spend time with her:

I always had phone contact but so ideally I would like to have some of my friends

closer. That would be the ideal idea. My friend in Italy, she came to Germany

when I was there last year for treatment, she came up for a week so that was quite

lovely so I would love to have that kind of contact with a close friend, who would

drop in and share dinner but coming here was a tradeoff.

Although Christine often preferred to do things on her own, she seemed to miss the companionship that came from having parties with her friends:

I had great, great parties, not that many years ago before my girlfriend went to

PEI we used to have parties all the time. Just even in the summer out on the deck

with some beer and stuff like that, you know just enjoy those things…socializing,

you know you have your friends there and you cook up steaks or hamburgers or

whatever you could afford that week and you had a case of beer and sit around

and chat and you know, I like that.

Even though Kate had regular phone contact with her long distance friends and Christine enjoyed spending time with her neighbour, they both indicated that they would prefer to have more contact with others that was for the sole purpose of socializing.

    4.2.4 Desired levels of social support. Some participants indicated that they would prefer to have more social support. Nadia emphasized the disadvantage of not having relatives close by. If she had relatives living nearby they could provide her with instrumental, and also likely emotional, support in helping to arrange plans in the event of her death. Nadia, speaking about making preparatory arrangements in the event of her death, said:

I think look I'm not gonna be here to do it, so as far as I know, the friends I have

all say, don't worry, we're, you know, but if you haven't got a relative, see that's

the difficulty. Nobody takes any notice of you if you're not a relative. I don't have

any relatives here at all.

Jasmine indicated her desire for more social support when she made a suggestion for a seniors help line:

Say if you had something worrying you or say you wanted to talk to somebody about, and you hadn't, you know you wanted to talk to a stranger, you don't want to, you want somebody to talk to, and it's called a helpline, 24 hour a day, and now if they had an older person for the older people that…I think it would be great. Like if I had something and it was bothering me, I couldn't solve it myself, they might lead me to somebody or suggest somebody to call.

Felicity spoke about recently starting to rely on the social support from members of her church group, indicating that she was working to fill her social needs:

Yes I do and I'm just kind of waking up to the awareness of that and I'm saying ok I could, I realize what an ally in my church could be if I allowed myself to be a more part of it. Like if they would know more of my situation…then they could be there for me and I could be there for them sort of thing and there are other single alone women in my church and in many churches and that is where, churches are full of single older women so I have improved somewhat in that…

In summary, all participants indicated that they wanted more social engagement, companionship, or support, albeit to varying degrees. This indicates that no participant had social needs that were completely fulfilled, though some were more fulfilled than others. Participants' feelings of isolation and loneliness also indicated the extent to which their social needs were met.

4.3 Self-perceptions of Social Isolation and Loneliness

Participants' scores on the screening measures provided one picture of their

isolation and loneliness levels. The information they shared during the qualitative interviews provided a more in-depth view of how their perceived themselves in relation to isolation and loneliness. They provided information on when and why they felt lonely or isolated, or why they did not.

4.3.1 Self-perceptions of isolation. Participants viewed themselves either as not isolated, isolated because of their own choosing, or feeling isolated in some situations. Some participants did not see themselves as isolated because they had cars and could go wherever they wanted. For example, Christine questioned:

Oh no, how can you be isolated when you have a car and you can go wherever you wanna go?

Other participants didn't see themselves as isolated, although they acknowledged that others might think of them as so. In Nadia's view, she wasn't isolated because it just wasn't her preference to go out of her way to reach out to others. Nadia's perception that others might view her as isolated was also related to comparisons to her more outgoing neighbours. Nadia stated:

Well I never think of myself as isolated no. But perhaps other people do. I mean the people down the hall here might think I am. I don't really talk to anybody down the hall. It's not because I don't like them or I'm snobbish, it's just to me, when that happens, I say good morning, good afternoon, how are you, and, but some people they go knocking on people's doors well that's nothing I would ever do so you know, I'm not likely to start now.

Kate didn't see herself as isolated because of the quality of the social connections she did have:

Not really. Because I have very deep contact with a number of close friends, not a huge number maybe about 3 that I have really deep contact with and about 6 others who phone regularly that I have good contact with, you know long-term friends, so I don't see myself as isolated…

Felicity spoke about how she saw herself as choosing to be isolated:

…the opportunities are here but I don't take part in them, so that's kind of a bubble that way. There's bingo, there's card games, there's little people get-togethers and stuff but I haven't done it. So yeah, so I'm self-isolated and in my church I realized there are little cliques of people that get together outside of church and so on, and little committees, I've never been a committee person so I'm kind of in my own little bubble at church which is why I volunteer to make a coffee. I'm in early in the morning all by myself and it's nice until people start arriving so I think I've somehow chosen to be isolated.

Though Felicity described herself as self-isolated, she doesn't seem to view this negatively as it is a choice that she makes based on her personal preferences.

For the remaining participants, situational factors affected whether or not they felt isolated. For example, being in situations where there were groups of people around amplified feelings of isolation, as Tasha explained:

Remember when I was talking about the seasons, and I think when I feel isolated is when I can see, when I look out my window and I see other people going about their daily lives. You can feel, anyone can feel isolated in the middle of a shopping mall if you stop. You know if you're sitting there with a coffee or I can feel

isolated let's say walking along the Halifax boardwalk during the busker's where

people are in groups, you know families together and you've gone on your own.

Participants' self-perceptions of isolation influenced their social needs and the

extent to which those needs were met. If, like Christine, they did not see themselves as

isolated, they likely had less of a need for social engagement and support than

participants who sometimes felt isolated. Similarly to their perceptions of isolation,

participants also reported varying degrees of loneliness.

4.3.2   Self-perceptions of loneliness. Participants' perceptions of their levels of

loneliness ranged from lonely, to lonely in some situations, to not lonely at all. Felicity,

for example, did not think of herself as lonely. She indicated that she viewed loneliness

as a trait that remained stable over time when she said "I'm not a lonely kind of person":

No. I'm not a lonely kind of person. Don't think I've ever been lonely. Alone but

not lonely.

Jasmine, on the other hand, indicated that she did feel lonely. She attempted to cope with

this by distracting herself with activities, but at the end of the day still felt alone:

Well I think everybody that's alone feels lonely, but you either sink or swim. If you

were to sit and cry or mope and whatever, somebody will have to come along and

put you back on your feet, so why get in that situation. So myself I read something

about psychology or beauty or I'll take my car and go and maybe buy a little treat

or I'll pop over to my sons or I'll take a different route maybe someday and go to

some end of the city I haven't gone to for a while and basically that's, but

basically I'm still alone and it's not nice.

Others felt lonely in certain places or around certain people. Kate seemed to feel as though her sister didn't acknowledge her because she was always on the go, which was different from Kate's preferred level of activity. She explained:

Sometimes when I visit one of my sisters, the one who actually she's a doer, she's always on the go, so we have a very different temperament, so sometimes with her because she doesn't, she's always busy, I can feel more lonely there than being on my own, if that makes sense.

Tasha described her feelings of loneliness when she ended up with a group of people in Paris, who didn't speak English. In this case, Tasha's loneliness stemmed from a lack of ability to communicate with the people around her:

So but that, that's a very, very good example of feeling very, very lonely in the middle of something that's happy and you know, stuff going on.

In summary, participants either did not see themselves as isolated, saw isolation as a choice, or felt isolated only in some situations where they noticed that they were alone. One participant described herself as being lonely; the others did not feel lonely or felt lonely only in certain contexts. Participants' views of loneliness thus reflected both a stable trait and a situational state and influenced the degree to which they felt that their social needs were met.

4.4   Constraints and Facilitators to Social Activity

Participants spoke about reasons for and against connecting with others largely at the intrapersonal, interpersonal, and community levels. At the intrapersonal level, participants spoke about whether they prioritized connecting with others, the norms they grew up with which shaped their personality and preferences throughout their lives, and

their perceptions of others' wishes. At the interpersonal level, participants spoke about difficulties meeting and getting to know new people. At the organizational level, participants spoke about the availability of transportation. Spanning the intrapersonal, interpersonal, and community levels, participants spoke about the attractiveness of available opportunities for social engagement. Participants also talked about the effects of the weather on their ability and desire to engage with others. In some cases, the factors influencing social activity acted as constraints for some participants and facilitators for others, and in others they were either constraints or facilitators for all participants.

4.4.1 Prioritizing social activity

A major factor in how much social activity participants had, and to what extent their social needs were met, was how much they prioritized maintaining friendships and seeking opportunities to socialize. Participants' social needs were more likely to be met if they prioritized socializing and experienced more other facilitators than constraints to social activity, or if they placed greater importance on goals other than socializing. Participants' social needs were less likely to be met if they prioritized socializing and experienced more constraints than facilitators to social activity.

Some participants spoke about maintaining high-quality friendships or their preference to simply be around people. Jasmine was highly motivated to connect with others. For her, connecting with others was more important than the nature of the activities that took place when she was connecting with others:

I guess I'm a person that I'll do anything just to be with people and I find you can

always learn from somebody too…I would go in if I didn't mind, even if I wasn't

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really interested in what was going on, I would make myself go just to be with the

people.

Kate, restricted by limited energy related to her illness, was motivated to maintain her closest friendships. Living with diminished energy forced Kate to evaluate her friendships and choose the ones that she wanted to invest time in:

...and maintaining, that's a huge priority, maintaining my friendships, that close

bond because some of them I noticed that I'm feeling less interest in as my energy

diminishes. You know long, one hour conversations are not, and I lot of people

email me and some I answer and some I don't cause I'm kind of prioritizing the

closest friends.

In contract, other participants valued other pursuits more than connecting with others. As described earlier in the sub-theme on desired levels of social activity, Christine expressed that sometimes she wished she had someone to share activities with, but her preference to be independent and do things on her own terms was more important to her than connecting with others. Felicity also expressed that she did not prioritize connecting with others:

Yeah it's my preference and I've learned to let go, I'm learning to let go of the

idea that I'm supposed to be out there sitting in the lobby talking to whoever

comes by or that there's something wrong with me if I'm not playing Bingo

Wednesday nights, that it's perfectly ok.

Participants' preferences toward and priorities for connecting with others were influenced in large part by the norms with which they grew up.

4.4.2 **Norms growing up.** The participants who did not prioritize socializing grew up with norms that didn't foster preferences for social engagement. Felicity described the lack of opportunities for social engagement during her childhood and adolescence:

> *Yeah there was just never any norm of making friends. There was no opportunity to start with, there wasn't an opportunity to make friends, grew up in isolation and for school, we'd just get on a school bus in the morning, then we'd bus to school and we'd be home in the afternoon, it's not like we'd get together with friends after school. I had no phone, my father, he wasn't into phones, so we couldn't call a friend and until I was, I don't know, sometime in my teens we got a phone and wouldn't have a friend over or anything like that.*

Nadia experienced different norms of socializing based on the culture she grew up in:

> *Well you're much more outgoing to each other, whereas in England we're very standoffish. I came from a very standoffish family so that was bred in me from a little girl. You didn't talk to this person and that person and you know you had to be very polite and bow and scrape. So it's a kind of different life altogether.*

If participants were raised in environments that discouraged, or at least didn't foster, making and maintaining social connections, they were less likely to have the personality characteristics and preferences for social engagement, and these internal characteristics remained relatively stable throughout their lives.

Participants often spoke about the persistence of their preferences for contact with others. Felicity had a preference to be by herself that she attributed to the norms she grew up with:

I realized in hindsight that people can make friends at work, anybody will make

friends with anybody, but I was just kind of, wasn't interested. So I guess I was

just always a person who was self-absorbed or happy to be by myself so it started

out when we were kids, we never had friends.

Tasha spoke about how the hobbies she has had throughout her life tend to be solitary

ones:

I guess a lot, I like reading, a lot of my, the things that I do, and always have I

guess, have been things that you do by yourself. You read by yourself, right, and

you can do these things as a group but that kind of introspective type hobbies as

opposed to going out and singing in a choir or in a group.

Kate spoke about the consistency of her preference to have a small number of close

friends:

I've been like that. I've always just had a certain number of close friends, I always

had close friends and, but I'm not a party person, like the more the merrier that

sort of thing, at all. So I mean I'm fairly consistent with my previous lifestyle.

These participants tended to be less likely to see themselves as isolated or lonely because

they generally maintained the same level of social engagement throughout their lives. In

contrast, Jasmine, the one participant who described herself as lonely, had higher levels

of social engagement in the past:

I always had lots of friends and I always seemed to be the leader because I drove

and I seemed to be the one that was, that had more life than the others, but I

really enjoy, and I think they liked me because I was kind of the driver and drove.

Her levels of actual social engagement declined as she got older because she lost touch

with her friends or they passed away, but her desire to engage with others remained stable throughout her life.

4.4.3   Perceptions of others' wishes. Participants sometimes spoke about behaving in ways that met their perceived needs or wishes of their friends or family, which constrained how they connected with them. Jasmine spoke about the tension between wanting to move in with one of her sons and letting them have their own lives:

> *Well I'd like to see my sons more but I realize they have a family and their jobs, and they're into sports and their children so I kind of have gone through it myself even though I have two sons and I understand them all although I think I'd be much happier and I think any mother would if they were around them all the time. I mean like, not really right with them, but say you lived in part of their house, which I did have an opportunity to but I like them to have their own life.*

Tasha was sometimes hesitant to contact others if they were married or had families because she thought she might be bothering them. Below, she hypothesizes why her sister might choose to spend time with her:

> *…as I mentioned to you before I can feel that I'm bothering people. Maybe people who do have families or do have a spouse or something that I'm the person who's alone and, with my sister for instance, her husband's accepts that the two of us are close, that we're gonna talk, but and they, my sister could, I don't know if she kind of feels sorry for me because I'm on my own since my husband died. I don't know if she thinks that way.*

Christine thought that her daughter would see her as a bother, which limited the amount of contact she had with her:

Cause like I say my daughter lives in Halifax like where you know, you had to

come all this way, same thing for her, but she's only home in the evenings so I try

not to bother her too much, I feel like I'd be a nuisance. I shouldn't feel that way

about your children but I just don't like to bother people.

In the examples above, the participants thought that their family members would

perceive them as a bother or a nuisance if they made too much contact with them. This

potentially means that these women did not see themselves as valuable participants in

social interactions, and in one case this view extended beyond social interactions to one's

place in society. After a follow-up interview, Felicity stated that sometimes she and her

neighbours, as residents in a subsidized housing facility, felt powerless and felt that

others viewed them as less valued members of society. This perception would certainly

have an effect on how likely one is to reach out to others. Interestingly, only one

participant explicitly talked about the positive effects of social interaction on the other

person. Tasha explained her role as a volunteer visitor for isolated seniors:

Yeah I might go for a couple of hours, an hour and a half or so and this particular

lady does tend to repeat herself a lot, but I know that, but I know that she's

looking forward to my visit.

Even though Tasha knew the person she would be visiting would repeat herself a lot, she

made a point to visit with her regularly because she understood it was important to the

senior. Like other participants, she was proactive about doing the things she thought were

important to do.

4.4.4 Difficulties making and maintaining friendships. One of the constraints

to social engagement that some participants talked about was the difficulty in making and

maintaining friendships. Christine found it difficult to get close to people through the structured activities she attended at the library:

…in the evenings sometimes they have knitting and bring your cross stitch and all that stuff and sit around and gab and all that stuff, and like I say yoga and that stuff, but I never get close to people because I'm not there long enough. You're there an hour and then it's over you know.

The limited amount of time spent with others during these activities was a constraint in getting to know others better. Tasha hypothesized why it was difficult to make friends in older adulthood:

…it's harder to make friends when you're older. I don't know why, well I guess if I think about it, when you have, you make friends and keep friends, lifetime friends, you're making friends when you're going through sort of the formative years, you're all going through learning things together, having your first experiences of whatever at the same time.

Kate spoke about the difficulties of trying to meet people through her ovarian cancer support group:

…it would be nicer if I had more friends here and I have tried to meet people, it's difficult I've met, I went to an ovarian support group meeting and met a woman and we talk on the phone maybe every 2 weeks but she's just been told she's terminal so, you know they die, the ovarian people…

The nature of Kate's disease meant she was likely to meet people who would continue to live for only a short period of time.

4.4.5   Attractiveness of structured opportunities for social activity. Some participants spoke about the factors that influenced their decision to pursue structured opportunities for social engagement, such as activities available through seniors' drop-in centres or activities organized within their buildings. Their likelihood to pursue these activities depended on the fit between themselves, including their interests, abilities, and health status, and the activities. Sometimes participants weren't motivated to participate in structured activities because they didn't match their interests. Felicity stated:

> *One thing about being in a seniors' subsidized housing is that you can automatically have friends and I haven't chosen to do that. I'm friendly with my neighbours, I have very nice neighbours, I don't get involved, there's a big organization, tenant's organization, for a few bucks a year I could join and it's mostly about eating and they arrange to go out to restaurants or they have, they're having a brunch here the other week and there's always things going on. I don't eat any of the food that they eat…yeah it's just, if I wanted to eat out I'd go pick a restaurant I like and go eat where I want and when I want.*

Other times, participants compared the activities to which they had access to other, more attractive activities, as Jasmine did:

> *Over in the other building they have a movie every week, they have a library which we don't have, and they seem to make use of the room that's available for them. And they have a place where you can even make a coffee or a tea if you want to, but here, everybody just seems to have other things to do or whatever.*

Other times the available opportunities didn't match the ability or energy levels of participants. Referring to a day trip she recently took, Nadia stated:

I got extremely tired to a point because the next day I couldn't do anything at all

and so I sort of wonder whether it's good for me to bother to go but I did find that

one. I know they're gonna have another one in the new year and I probably will

go again…Well I may, I'll see how I feel.

The factors influencing participation in structured activities interacted with each other.
Even though the day trip Nadia described made her tired the next day, she still considered
going to something similar in the future because it matched her interests.

Features of the social and physical environment also influenced whether
participants would take part in structured activities. For example, Jasmine was more
likely to go to an event if she knew others would be going on their own:

Well they only have them, I don't know how many they have a year, but I went to a

barbeque they just had recently and was very happy, sat down beside a lady and

we talked all the time and now there's a meet and greet, and I'll go to that because

I figure everybody will be going on their own, and I'll go.

Kate spoke about the "sunshine room" within the cancer clinic she attended as being a
very comforting place, where patients could explore complementary therapies and talk
with volunteers and other patients:

I might have a treatment like therapeutic touch or healing touch or Reiki and just

talk to whoever, whatever patients are there. Believe it or not when you have

cancer it's, I find it quite comforting to talk to other cancer patients, hear their

stories and how they're feeling, how they're handling things. So that's a very

comforting place, the sunshine room. It's phenomenal.

In this scenario, the physical environment of the sunshine room encouraged Kate to make social connections with others that helped her to cope with her disease.

4.4.6 Transportation. For some participants transportation was not a factor in participation in social activities either because they had access to a car, had others drive them, or lived within close proximity to services. Felicity relied on walking or public transportation:

> *No I can walk to my church and I could probably get a drive if I had to, and I can walk to my yoga class, take the bus to my other yoga class, so no there's, I'm able to get around.*

Nadia relied on others to take her out, and acknowledged that not having access to transportation can be a barrier for her:

> *Well I had my own car 'til I came here and I wouldn't be able to drive now, they wouldn't allow me to I don't think but I think that's one of the reasons why one gives up lots of things is because you can't do it on your own, take yourself and bring yourself back. And that would be my reason so if somebody does ask me, I don't usually say no. I usually say yes.*

Participants who had a car spoke about how seniors who had to rely on public transportation would have a much more difficult time getting around. Jasmine stated:

> *Well, if I didn't have my car, I'd be totally lost. Because you can, I often think of some people, they're in their apartment and their only way to go to Bedford or whatever, or wherever, they have to get one or two buses where I can take my car and go anywhere.*

Christine, when asked about whether relying on public transportation would make her feel isolated, replied:

I'd die. Cause I like to drive and you know, so, yeah, I don't know how I'd get my groceries or how I'd get anywhere, cause you live so far out eh?

However, she did at one point have to rely on public transportation:

... I didn't have a car for a year, I was saving money to get a new one and I did, took the bus, I had to go to Halifax every day like you just did and I had to go to Scotia Square every day and I did it. I'd get on the bus and went.

Thus, although participants who had their own cars thought that not having a car and taking the bus would be much more difficult and inconvenient, their perceptions are possibly overly negative.

4.4.7   Weather. Some participants spoke about how they were more likely to stay indoors in certain weather conditions. Although they didn't explicitly talk about how the weather affected their social interactions, it likely impacted their ability to connect with others if they stayed at home. Christine explained:

Oh my mental health's pretty good except in the winter it drives me crazy…I don't think I feel down it's just, you can't get around in the yard and mow the grass and you can't, you know shovel the snow, that's the only bad in the wintertime is you can't get out. I mean I can get out and drive, but I can't get out, just get out.

In other parts of the interview Christine talked about spending time on her deck with her friends and her neighbour, so these interactions likely decreased in the winter. Felicity also spoke about how the weather affected her activities:

In the summertime I can't go out in the daytime it's the weather, it's extreme

weather for me, I can't tolerate the heat, so I'm up, then I am up at 6 in the

morning.

4.5   Summary of Themes from Senior Interviews

To summarize, participants spoke about a number of constraints and facilitators to

social activity at the intrapersonal, interpersonal, and community levels. These factors,

combined with participants' prioritized activities and their perceptions of their levels of

isolation and loneliness, interacted to determine their current and desired levels of social

activity and social support. The size of both the current levels and desired levels of social

activity and support, along with the difference between the two, varied among

participants.

Two exemplars can be used to illustrate the relationships among the superordinate

themes. Jasmine spoke about her current levels of social activity and support, which

involved contact with her sons, chance encounters when she went out, and socializing at

structured meet and greets at a community centre. There was a gap between her current

levels and her desired levels of social activity and support that was shown by her

dissatisfaction with the amount of time she spent alone and her suggestions for ways to

increase social involvement for seniors. Thus, her social needs were not met. Although

she prioritized socializing, and had continuity in her desire for social engagement, her

perceptions that her sons wanted to live their own lives and her view of some social

events as unwelcoming for single people led her to feel lonely and unfulfilled in terms of

her social needs.

Nadia's social needs were met to a greater extent than Jasmine's. Her current levels of social activity involved occasional day trips that combined socializing and learning, and her desired level of social activity and support indicated that most of her social needs were met when she stated that although she did not have a lot of friends, it did not worry her. Her social needs were not completely met though, as indicated by the lack of having family members nearby to provide instrumental support for planning arrangements in the event of her death. She prioritized managing uncertainty more so than socializing, and the norms she grew up with of being relatively withdrawn continued throughout her life, leaving her with a smaller need for social activity and support than Jasmine. Figure 2 illustrates the relationships among the themes. Prioritized activities, barriers and facilitators to social engagement, and self-perceptions of social isolation and loneliness affect both social needs and current social activity and support. Additionally, current levels of social activity and support influence one's views of isolation and loneliness.

4.6   Service Provider Views on Social Isolation

Three service providers who work or volunteer at senior-serving organizations were interviewed on their views of social isolation in seniors. Jack Jones[2] is the coordinator of the Northwood Telecare program, which offers daily phone calls to seniors who live alone. He makes calls to over 100 seniors each week, and oversees the other volunteers who also make the phone calls. Natasha Handspiker[2] is the acting manager of Northwood's reBoom program, which offers a number of recreational and educational programs for seniors and connects seniors with other community services. Diane is the volunteer coordinator of a not-for-profit organization that provides a number of services

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[2] Real names are used as requested by these participants.

to seniors, including a volunteer visiting program where volunteers on a weekly basis visit seniors who feel lonely.

Service providers were asked about their definitions of social isolation, differences between social isolation and loneliness, gender differences in isolation and loneliness, identifying socially isolated seniors, and essential components of initiatives that aim to reduce social isolation. These themes are summarized below.

4.6.1   Defining social isolation. Natasha Handspiker defined social isolation as a disconnect between a person's desired and current level of social engagement:

> *I think isolation is, to me, when there's not enough interaction and engagement based on their personal standard, so if they're not receiving engagement or activities or connecting with their family, or friends, or societies, and they want to be, then I feel that they're isolated.*

Jack Jones[2] saw isolation as an inability to interact with others that remained constant throughout a person's life:

> *In a quick and general way it's an inability to interact with other people but you know once again that wasn't true when they were 86, that was true when they were 36 too you know. I have a woman on the program, she's 96 now, she's going blind, she can't see anymore and every time I call her you know she's up and bubbly…and she's magnificent and when we lose her I'm gonna be really sad. I mean she's been a really great lady. She's never changed, she's been like that all her life you know.*

These two conceptualizations of isolation appear to be quite different at first glance. Natasha places the emphasis on a lack of interaction, which may be the result of a

number of factors, whereas Jack focuses on an inability to interact with others. Yet, there may be some overlap as one reason (among many) a person may have a disconnect between their current and desired level of social engagement is that they lack the ability to make and maintain friendships.[3]

4.6.2 Differences between social isolation and loneliness. All three service providers viewed isolation as different from loneliness. Natasha viewed loneliness as an unmet need based on a lack of shared interests:

> *...you can be lonely and still have a ton of people around you… it's really easy to be lonely in a group of people if you've got nothing of interest to talk about, or nothing of interest to do.*

Thus, in Natasha's view, simply being around others would not reduce loneliness. Diane stated that seniors who are identified as potentially being isolated may not feel lonely:

> *….and I mean some people like to be alone. They're perfectly fine with that. Like I said we'd call someone up and say…we've got this referral, would you like us to, and they say no I don't need that, I'm fine, so they might not be lonely so just cause they live alone doesn't mean they're lonely…*

Jack saw loneliness as stemming from the loss of a spouse:

> *It can be that, yeah that's mostly what it is and that would be quite different than isolation. Many of these women, and I've known them, I'm not speaking idly I've known them, they participate around here in various things but they're terribly lonely, having lost [their spouse].*

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[3] The third participant's defined isolation in terms of identifying isolated seniors, so her conceptualization is included under that theme.

Jack emphasized that even though these widows participate in activities, they still experience much loneliness. In sum, while participants agreed that social isolation is different from loneliness, they differed on what exactly those differences were.

 4.6.3 Gender differences in social isolation. Service providers thought that women were less likely to be isolated than men; women were more likely to seek and accept help if they felt lonely. Natasha asserted:

> *I think men are typically more likely to be isolated especially if they're the living survivor of their family, so like if their wife has passed, I think that they're at a really high risk for becoming isolated, so, they don't engage with children and family and stuff like that at the same capacity I find that women do.*

Jack also thought that men were less likely to be socially engaged than women and again emphasized that this was a tendency that remained fairly consistent throughout the lifespan:

> *Women tend to cluster more than men. They tend to, all their life, I think it's been said that girls tend to, 18 year old girls tend to group together. These are generalizations of course but I believe it to be…the girls tend to cluster and maybe that's the way, it's part of the nurturing instinct…*

Diane noted that a large majority of the clients served through the volunteer visiting program at her organization were women and that women were more likely to accept help to reduce loneliness:

> *So we find that and I'm just thinking off the top of my head here, but women are more open to the idea of someone coming to visit them. Men not so much and women are far more likely to admit that they're lonely than men are so we have,*

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our client list is probably like 75% women and 25% men, it's probably even

greater than that actually it's probably like 85/15 when you break it down.

Women are just more likely to open up about feelings than men are especially

senior men.

Participants' views on the gendered nature of social isolation reflected the view that

women are inclined to be more engaged with others and more likely to admit and accept

help when they need it.

4.6.4   Identifying socially isolated seniors. The only program that explicitly

identified isolated seniors was the volunteer visiting program that Diane worked with.

She relied on a scale and professional opinion to identify socially isolated seniors:

Well we use the Lubben scale…we use that to as a measurement of how lonely

someone is. I mean it's not set in stone but it does give us an idea…how many

people did you see this week and do people call regularly, those kinds of questions

so we use that a little bit but you can just tell you know when we get a referral and

someone says you know this person's really lonely, well we believe that the

person's really lonely. It's not like we need to have proof that they're alone kind

of thing.

Natasha's program, ReBoom, focused on creating opportunities for people to become

socially engaged:

Well as far as identifying them, we're trying to provide options for people to

become engaged regardless of location and regardless of ability so that is our

focus and our goal for the next little bit actually, is one, get the word out about

ReBoom, two, if you have a computer and you live in an area that it's not easily

able to access other people, that you can engage online.

Jack spoke about the ways seniors found out about the Northwood Telecare program:

Sometimes they hear about it and they just call us, they've had a diabetic passout

or whatever and they're concerned about falling and so they call us and they

wanna be called. In other cases it's a son or a daughter, they've got 2 or 3

people, the daughters are in New Brunswick and their mother's here and they

would like her to be checked every day so it will be a son or daughter. Usually a

daughter will call. In other cases it's another relative. In other cases, I've made a

good contact with the hospital…when somebody's discharged that they're

concerned about, this one woman who calls me, she says we're discharging Sally

today and you know she said she's going home to nobody there and I'm very

concerned about it and I really appreciate that a lot because it's somebody taking

the extra step.

Thus the participants in the Telecare program are at risk for a variety of different reasons and may not be isolated, although Jack asserted that the program does attempt to reduce isolation in the seniors that are:

Well you know me I'm yappy and if I think that they're in turned, I try to draw

them out, talk about, this is why on the form we try to put down the things that

they're interested in, it could be bridge, it could be reading, and if they say that

all the time they are alone, they read, I might suggest a book, have you read this.

Therefore, although participants may not be explicitly identified as isolated, the program volunteers use their judgement and information on clients' personal interests to try to increase their social engagement.

     4.9.5   Components of initiatives that aim to increase engagement or reduce isolation. Service providers spoke about the importance for programs to meet seniors' needs in terms of matching their interests, being affordable, accessible, and occurring within a welcoming environment. Natasha stated:

> *The components of a program that aims to reduce isolation, well it has to be meet their needs. That's the biggest thing is in order to get people to come back and to further reduce their isolation is you have to meet their needs… easy to access, affordable, and I guess to me that falls under the needs category cause affordable is different for everybody.*

She also spoke about using existing resources in the community to work toward meeting seniors' needs:

> *...we're also looking at, and we've done it with one other building, is the housing buildings, the housing authority in Halifax, going in and talking to the people who live in those buildings cause they're typically older and finding out, do they want programs in their buildings? If they want programs in their buildings what type of programs that they want in their buildings cause not everyone will come.*

The most important aspects for Jack were contact and being aware of available opportunities:

> *Well contact, to put it in a very simple word, contact, if we heard, if you told me that your aunt Lucy was becoming more and more withdrawn and more and more*

in isolation we would call… but they need to be told about this and an awful lot

goes on in Nova Scotia that some of these people don't know about. There are all

kinds of programs and clubs and Jesus, you don't need to be alone.

Jack and Diane both talked about the importance of having the right volunteers

participating in programs aimed at reducing isolation. Diane emphasized:

…you need to have people who want to do it. You need to have caring volunteers

who are genuinely interested in meeting with seniors and listening to them and

talking to them and you know willing to put the time in.

Safety was also paramount to the programs in Diane's organization:

So for us, safety is the most important feature for us, absolutely client safety and

volunteer safety so that's part of the home assessment is that we make sure that

we are sending volunteers into a safe environment, so you things like, like I said,

cats, dogs, unsecured weapons, is it a safe area of the city…We also have to make

sure that the volunteers we send in are safe as well so for us we have to do a

background check on all of our volunteers and we do 2 reference checks on every

volunteer and they don't go into a home until that's done.

Safety is understandably important in situations where volunteers are visiting seniors, but

it could mean that socially isolated seniors who live in unsafe neighbourhoods have

access to fewer resources to reduce isolation.

4.7   Summary

In summary, social isolation is a complex phenomenon that needs to be

understood to reduce the health risks associated with it. Most study participants who were

identified as socially isolated did not view themselves as isolated or lonely, or felt this

way only in some situations. Isolation stemmed from growing up without opportunities to make friends, preferences to be alone much of the time, unattractive social environments, and difficulties making friends. Although the data show that participants' social needs were not completely met, all participants engaged in some form of social activity and received some form of social support. They also engaged in other meaningful activities, either on their own or with others, that enhanced their physical and mental health.

Some of the experiences of the older women confirmed or extended the views of the service providers', while others conflicted with their views. Both groups of participants indicated that social isolation and loneliness were two different phenomena. Service providers' views that programs aimed at encouraging social activity need to meet seniors' needs reflected the diverse needs and priorities of the older women. The older women's experiences of social isolation did not reflect the view that isolation is an inability to interact with others; their experiences reflected both preferences for spending time alone and interpersonal constraints to connecting with others. Older women who are thought to be isolated can provide service providers with information on what is important to them so that service providers can create opportunities that enable healthy aging through social activity and other ways.

CHAPTER 5   DISCUSSION

The objective of this study was to understand the lived experiences of socially-isolated senior women and the factors that contribute to their experiences, and based on this information, to make recommendations for developing programs and policies that aim to reduce isolation. A reflective summary of how interpretive phenomenology was used to answer the research questions is first outlined. This section then discusses participants' views of social isolation in relation to the conceptualization of social isolation in the literature, including its risk factors and its relationship to loneliness; social isolation in relation to continuity theory; and gender differences in social isolation. Next, program and policy implications for health promotion are described. Following, plans for dissemination of the results are outlined. Lastly, limitations of the study are outlined.

5.1   Using Interpretive Phenomenology

Interpretive phenomenology has assumptions about the nature of people's experiences, and these assumptions influenced the analysis of the data and the conclusions that could be drawn from the data. One of the central ideas in interpretive phenomenology is being-in-the-world, meaning that a person cannot be separated from his or her world (Mackey, 2005; Smith et al., 2009). Asking participants questions about their everyday experiences and interactions allowed for a better understanding of how these experiences influenced their perceptions of themselves, which in turn affected how future experiences were perceived. For example, Christine spoke about how she didn't like to "bother" her daughter because she didn't want to be a "nuisance", which affected her likelihood to ask others for help when she needed it.

Another central idea in interpretive phenomenology is that the researcher brings

prior knowledge and experience of the phenomenon in question during the data collection and analysis processes; these are known as fore-structures (Lopez & Willis, 2004; Mackey, 2005; Smith et al., 2009). The questions and probes that were asked during the interviews were based on prior research on social isolation and its antecedents, and the interpretations made were influenced by this research as well as by the experiences of previous participants. It was therefore important to ensure that each participant's experiences were accurately represented.

5.2   Social Isolation, Risk Factors, and Loneliness

As stated earlier, Nicholson (2009) defines social isolation in terms of four components: a lack of a sense of belonging socially, a lack of engagement with others, a minimal number of contacts, and a deficiency in fulfilling and quality relationships. He also states that it is too new of a concept to determine how many components and what levels of these components are necessary for them to form social isolation. All participants in this study demonstrated at least one of these components. When participants were around others but not engaging with them, they lacked a sense of belonging. For example, Tasha described feeling out of place when she was attending a tourist attraction with a group of people who she couldn't engage with because of a language barrier. When participants spoke about choosing to be isolated, being in situations where they were alone among groups of people, or hesitating to connect with others, they demonstrated that they, at least sometimes, lacked engagement with others. Participants also had to have infrequent contact with their family or friends to be eligible in the study, and some participants had only one or two friends that they interacted with infrequently. Finally, when participants spoke about wishing others would reach out to

them more, or when they spoke about their needs for more social support, they indicated that some of the relationships they did have were not fulfilling. For example, Jasmine suggested a helpline that seniors could call if they had a problem and didn't have anyone to talk to about it, indicating that she could benefit from more social support. Jasmine experienced all four of these components, which essentially reflects that she was both objectively isolated and subjectively lonely. Thus, the findings provide support for Nicholson's conceptualization of social isolation, but further research is necessary to determine which of these components are most detrimental to quality of life and health.

The level at which a low sense of belonging or low social engagement becomes problematic is unclear in Nicholson's (2009) definition. Part of the reason for this subjectivity may be that people vary in their social needs, and two people may experience the same level of social engagement differently. Indeed, in this study, Christine, who had the least amount of social contact was generally satisfied with her contact with others, whereas some other participants who had more contact were more dissatisfied. Christine was used to being on her own from childhood and her independence was more important to her than frequent social contact, so her social needs were smaller. In contrast, Irene had frequent contact with her sons, but this did not satisfy her need for contact with people with whom she could participate in various activities. This finding provides support for the individualistic nature of the experience of social isolation.

One of the reasons people experience social isolation differently can be attributed to the social comparisons people make or their norms growing up. As outlined earlier, people can compare their social network to their peers, to younger people, to past social networks, and to older people from past generations (Victor et al., 2000). The participants

in this study compared their current social network with the contacts they had when they were younger, and they also compared their situations to their peers' situations, but not necessarily in relation to their social networks. Irene, who was used to having more social engagement when she was younger, felt lonely when her engagement levels decreased because her friends had passed away or moved away. Tasha felt lonely when she was around others who were in groups, and Irene also felt lonely when she compared the opportunities for social engagement in her building to those in a neighbouring building. However Christine was used to being on her own and did not indicate that she felt lonely. These social comparisons and norms growing up affected how lonely or isolated participants felt.

The views of the older women and service providers indicated that social isolation and loneliness are different constructs. All the older women were identified as isolated with the screening measure, but this did not necessarily translate to feelings of loneliness as all participants had low scores on the loneliness screening measure. In the qualitative interviews, they indicated that they were either lonely, lonely in some situations, or not lonely. Additionally, participants' self-perceptions of whether they were isolated were not congruent with their scores on the index of social isolation, as they perceived themselves as either not isolated, isolated based on their own choosing, or isolated only in some situations.

In the research literature, social isolation and loneliness are sometimes differentiated from each other (Van Naarsen et al., 2001; Wenger et al., 1996) and other times definitions of isolation include the subjective aspects of loneliness (Nicholson, 2009). There is evidence that these are two separate constructs with different outcomes

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(Steptoe et al., 2013), and the data from this study supports this differentiation. From an applied perspective, the relationship between social isolation and loneliness is important to understand to develop strategies that aim to reduce one or the other.

Some constraints to social engagement that participants brought up were in line with risk factors identified in the research literature, whereas others were not. Risk factors for isolation identified in the research literature include age, loss of a spouse, living alone, physical or mental health problems, substance use, homosexuality, speaking a minority language, lacking adequate transportation, and being new to the area (Hall, 2004; Osage & McCall, 2012). The participants in the current study had some of these risk factors. Some participants were widowed or divorced, one participant reported experiencing past depression, and one participant was new to Halifax.[4] However, even though all participants were screened into the study because they were identified as socially isolated, there was variation in both the quantitative isolation and loneliness scores, and how lonely or isolated participants felt, and this variation was seemingly unrelated to the risk factors participants experienced. Nadia, who was the oldest study participant and was starting to notice memory problems, felt neither isolated nor lonely. This may be explained in part by her preference to do things on her own and in part by her environment. She had access to a variety of activities and convenient transportation, so she could choose when she wanted to participate. On the other hand, Jasmine's risk factors of being widowed and having physical health problems, coupled with her preference for high social engagement but limited opportunities to participate, seemed to interact to increase her feelings of loneliness.

Participants' constraints to social engagement went beyond the risk factors

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[4] They also all lived alone; however, this was an inclusion criterion.

identified in the literature. If participants grew up with norms that didn't encourage social engagement, they were likely to maintain a low level of social engagement throughout their lives. If they saw themselves as less valuable compared to their peers or as a bother, they were less likely to reach out to others. These norms and self-perceptions are shaped throughout an individual's life and are important because they influence future behaviour and outcomes (Bandura, 1978). These factors may not typically be identified as risk factors for isolation in part because they are not measured in studies that examine isolation; studies that examine predictors of social isolation tend to focus on demographic characteristics such as gender and age, health conditions, and social network characteristics (Havens et al., 2004; Howat et al., 2004; Wenger & Burholt, 2004).

5.3   Social Isolation and Continuity Theory

As stated above, some participants indicated that they had low levels of social engagement, and this was congruent with their past levels of engagement. Continuity theory may explain why continuous low social engagement may be adaptive for some individuals. According to continuity theory, people are motivated to maintain inner psychological continuity and external continuity such as social behaviour as they age (Atchley, 1989). If people are motivated to be in familiar environments, do familiar things, and interact with familiar people, then individuals who are used to occasionally interacting with a small number of people will continue to do so as they age, and individuals who are used to a higher level of social engagement will continue to seek that level.

Participants in this study indicated that, for the most part, they maintained the same level of social activity throughout their lives. Participants who tended to keep to

themselves and had a small number of friends continued to do so, and those who had a

preference for a higher level of social engagement continued to have that same preference

as they got older. In other words, participants demonstrated continuity in their preferences

for social engagement; however, this preference did not translate to actual behaviour for

all participants. When participants lost friends or were unable to make new friends

because they perceived that others were too busy, or because the environments in which

they could meet new people were not welcoming, their social needs were not met, and

they did not maintain external continuity. According to Atchley (1989), maintaining

friendships provides a sense of comfort and predictability, so individuals who lack this

social stability may experience tension that may be associated with negative feelings. For

instance, Jasmine's inability to maintain her friendships because of external

circumstances was associated with loneliness, whereas Kate, who prioritized maintaining

her closest friendships, experienced a sense of comfort that helped her handle the

uncertainty that came with having a terminal illness. These findings provide support for

the protective effects of social activity and the negative effects of social isolation.

5.4   Gender Differences in Social Isolation

All three service providers in this study agreed that men are more likely to be

socially isolated than women. As discussed earlier, the research on the gender differences

in social isolation is mixed, though some resources for service providers (e.g., Osage &

McCall, 2012) clearly state that men are more likely to be isolated. One reason that men

are perceived to be more isolated is that women may be more likely than men to admit

when they need help, as described by one service provider, and this is supported by

literature on traditional masculine roles and norms (Courtenay, 2000). There may also be

more men than women at higher levels of isolation, or service providers may see more women than men participating in social activities. The mixed results in the research literature on the gendered nature of social isolation could be due to different ways of conceptualizing and measuring isolation, including grouping it with loneliness, or a focus on different factors associated with one's gender. Women have more risk factors for isolation than men, such as living alone and losing a spouse; however, some research has found that when these factors are controlled for, men experience greater loneliness (Mullins et al., 1996)

Gender differences are important to understand because there are differences in the types of social activities men and women participate in and the barriers they experience to greater participation (Gilmour, 2012), which has implications for the types of strategies that are developed to foster social participation for those who wish to participate. For example, in one study, more women than men indicated that not wanting to go to activities alone and transportation problems were barriers to more social participation (Gilmour, 2012). Although gender differences in barriers to participation could not be explored in this thesis, some participants did indicate that they would be more likely to engage in social activities if they had a friend to go with. To make programs equally accessible to both men and women, organizations need to understand the barriers to participation so that they can be reduced or removed.

5.5   Implications

The data from the interviews has implications for community-based programming and policy development that supports the goal of health promotion of enabling people to take control of their health. Initiatives at the intrapersonal, organizational, community,

and policy levels can be used to support the health of seniors through social engagement. At the intrapersonal level, clinicians can play a role in screening for social isolation and loneliness, and making recommendations for increasing social engagement. At the organizational or institutional level, organizations can implement changes that create welcoming environments for seniors and support seniors to take on active roles within their communities. At the community level, networks between various structures in the community can be developed to support social engagement and healthy development. At the policy level, inclusive policies that incorporate the strengths perspective can be developed that include the diverse needs and abilities of seniors. Each of these implications is elaborated below.

At the intrapersonal level, the identification of socially-isolated seniors and those at risk for isolation can help to prevent isolation and increase social engagement, which is important for seniors who may not realize that social isolation is a risk for a number of negative health outcomes. Nicholson (2012) suggests that nurses can ask clients questions from brief measures of social isolation and refer those identified as isolated to the appropriate services. Other healthcare workers who have frequent contact with the elderly, such as occupational therapists and physiotherapists, can also play a role in the identification of socially-isolated seniors. The abbreviated Lubben Social Network Scale (LSNS-6) is a valid and reliable brief measure of social isolation that could be used for this purpose (Lubben & Gironda, 2003). Both social isolation and loneliness are associated with negative health outcomes (Cacioppo & Hawkley, 2009; Steptoe et al., 2013); thus, researchers recommended considering both simultaneously (Cornwell & Waite, 2009). The 3-item UCLA Loneliness Scale could be used to assess loneliness

briefly and accurately (Hughes, Waite, Hawkley, & Cacioppo, 2004). Before implementing this type of screening, consultation with various stakeholders would be necessary to ensure acceptance as some patients may not consider these types of questions appropriate in a medical setting if they are unaware that social isolation is a risk factor.

Once clinicians identify someone as isolated or lonely, or both, they could provide recommendations for action. The most important recommendation would be to increase social activity, as research has shown that the greater the number of frequent social activities a person participates in, the higher the odds of positive self-perceived health, and the lower the odds of loneliness and life dissatisfaction (Gilmour, 2012). It would be equally important to emphasize the quality of social contact, as research has shown that factors such as emotional support and enjoyment are influential on cognitive health (Flatt & Hughes, 2013; Holtzman, Rebok, Saczynski, Kouzis, Doyle, & Eaton, 2004)

Individuals identified as isolated but not lonely could be provided with information on the risks associated with social isolation, and simple steps they could take to increase their levels of social engagement. Because individuals in this category would likely be satisfied with the amount of social contact they have, it would be important to include a broad range of suggestions for increasing social engagement, so that individuals could focus on those that matched their interests. Individuals identified as lonely but not isolated could be given information on available opportunities for socializing near their neighbourhoods, and they could be encouraged to focus on developing high-quality relationships with their current social contacts. Individuals identified as both isolated and lonely could also be given information on available opportunities for socializing, and the

clinician could help the client develop a goal-based strategy for increasing levels of social engagement. During follow-up appointments, this strategy could be reviewed to support the client and offer revised recommendations if necessary.

At the organizational level, the barriers to and facilitators of social activity that participants discussed as well as the essential components of programs aimed to reduce isolation that service providers discussed can be incorporated into community programs for seniors. Community centres can increase the attractiveness of available activities by creating a welcoming environment that supports individuals who come on their own, offering a wide variety of activities that meet the different needs and interests of seniors, and having ongoing discussions with seniors to ensure that their needs are being met. Natasha described how Northwood's reBoom program aims to cater to seniors' different needs by offering social, learning, and physical activities. Hiring staff and recruiting volunteers who make seniors feel comfortable and help them find activities suitable to their interests and needs is also important in creating a welcoming environment.

Community centres should also ensure that individuals can easily access the centres. Providing information on bus schedules, facilitating carpools, or implementing a shuttle service can remove the some of the transportation barriers to social participation. A little creativity can help remove other barriers to participation. For example, if community centres typically experience less participation on rainy days, offering incentives such as reduced rates, coupled with safe and accessible transportation, can encourage seniors to go out on days when they would have typically stayed home. Such programs can work to both prevent social isolation as well as increase social activity in isolated seniors by removing barriers to social activity.

Community centres can also confidentially use existing information on their members to develop programs that meet seniors' needs. For example, when seniors sign up for Northwood's Telecare program, they indicate on the application what their interests are. Northwood may be able to use this information to develop programs or interest groups that provide seniors with an additional source of social activity with others who have similar interests. If members are satisfied with one service they are receiving, they are more likely to try other services offered by the same organization, which can work to further increase social activity.

The recommendations above for community centres apply to seniors who are in close proximity to them, or are considering joining a centre. For more isolated seniors, telephone interventions can be a source of social contact. These interventions would be beneficial in situations where weather or transportation limited seniors' ability to interact with others in person, or for seniors who are more hesitant in reaching out to others. Telephone interventions have been shown to increase older adults' self-confidence and help them to re-engage with their community (Cattan, Kime, & Bagnall, 2009). These interventions may not always meet seniors' needs, however. Jasmine spoke about how much she valued the phone calls she received from volunteers through the Northwood Telecare program; at the same time, she expressed that she would like to have a friend with whom she could participate in different activities. Accordingly, encouraging volunteers to offer seniors suggestions for in-person social activities may be beneficial for seniors with higher social needs.

A suggestion made by a participant, which was also echoed in the Age Friendly Cities report (Keefe & Hattie, 2007), was the availability of a telephone information line

for seniors. Early in 2013, the Nova Scotia government launched its 211 information line so residents can have access to information on various community and social services, including seniors' services and mental health support. This is a positive step in helping to ensure that seniors have access to services relevant to them. Regular evaluations of this information line would inform decision makers of what works well and what could be improved to help meet seniors', and other residents', needs.

Group interventions with an educational or support component have been found to be effective at reducing social isolation and/or loneliness (Cattan et al., 2005). Specifically, Cattan et al. (2005) found discussion groups, physical activity groups, tenant-organized social activities, and self-help groups for widows to be effective. Additionally, they found that peer-led groups were either as effective or more effective at reducing isolation and loneliness than groups led by professionals. To encourage seniors to initiate activities, senior-serving organizations can provide informational materials on practical tips that seniors can take to encourage other seniors to get involved in community activities. Adopting a strengths perspective (e.g., Saleebey, 1996) may be a useful way to address social isolation for both seniors who are satisfied and dissatisfied with their levels of social engagement and support. The strengths perspective emphasizes a focus on "common human needs and barriers to meeting needs rather than on problem definition and analysis" (Chapin, 1995, p. 509). This approach would empower seniors to take on meaningful roles and would help foster a more positive view of seniors as active members of society.

The program recommendations described above necessitate or would benefit from partnerships between organizations. These partnerships are consistent with the

conceptualization of the community level within the socioecological model as relationships and informal networks among organizations (McLeroy et al., 1988). They are also in line with current practices described by two of the services provider participants. Natasha described how Northwood is beginning to partner with the Metro Community Housing Association to deliver programs in their residences to increase program accessibility. Jack also spoke about referring Telecare clients to other services, either at Northwood if they were offered, otherwise outside of Northwood, that may help to meet his clients' needs. Such partnerships, both formal and informal, are beneficial for both the service user as they make it easier for his or her needs to be met, and for the service provider as they reduce redundancies between departments or organizations.

Barriers to social activity can also be addressed at the policy level. Participants spoke about transportation and poor weather as being barriers; these concerns echoed those found through public consultations that took place as part of the Age Friendly Cities initiative in Halifax (Keefe & Hattie, 2007), and they have implications for active and public transportation policies at the municipal level. The ability to walk safely is important to seniors who live close to essential shops and services and who do not have easy access to public or their own transportation. Currently, the Halifax Regional Municipality's service standards for clearing residential sidewalks in areas outside of Spryfield and the peninsula are 36 hours after the end of a snowfall, and in 2014 city employees will also clear sidewalks on the peninsula and in Spryfield (Halifax Regional Municipality, 2013). The city did not hold public consultations about this increase in service and residents', including seniors', opinions are polarized about the role of the city in clearing sidewalks (CBC News, 2013). An improved public consultation process

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would be beneficial in guiding city council's decision making to ensure safe and affordable sidewalk snow removal for residents. Consideration of an alternative snow removal plan, where most residents are responsible for clearing their sidewalks and those who are unable to can apply to have theirs cleared by city employees, may also be a worthwhile pursuit. Public consultations and advocacy for seniors can also be beneficial for public transportation programs, as exemplified by Halifax's program where seniors can take the bus for free on Tuesdays.

The data also have implications for policies and programs related to childhood development, because the environments that children grow up in affect the habits they form and are likely to maintain throughout their lives. If someone grows up in an environment where social contact is not fostered or even discouraged, he or she may develop a preference for spending time alone and handling problems independently. A preference to be alone may not be problematic in and of itself, but it may become problematic if it prevents a person from asking others for help when help is needed. Christine grew up in this type of situation, and indicated that she would not know what to do if her health deteriorated to the point of needing assistance because she was used to doing most things on her own. School policies that support the teaching of effective coping strategies, including the identification of potential sources of help, can foster effective coping skills that span the lifecourse.

Policies targeting education around social isolation in seniors can be beneficial for increasing awareness of the issue and removing barriers to social participation. Policies can focus on: 1) educating the general public on social isolation in seniors and suggesting steps that neighbours, family, and friends can take to reach out to isolated seniors; 2)

providing guidelines for event organizers to ensure that public events and events targeted toward seniors are accessible to seniors with various health needs; and 3) educating seniors themselves on the benefits of social participation. These strategies can help to address some of the concerns voiced by study participants about limited availability of activities that matched their energy levels, and concerns voiced by participants in the age-friendly communities focus groups about certain public events being inaccessible to seniors (Keefe & Hattie, 2007).

Crossing the various levels of the socioecological model is the way social isolation is conceptualized. Inherent in the concept of social isolation is a focus on what is lacking. However, the participants in this study spoke about a number of activities that they engaged in on a regular basis that promote health and well-being. The language that is used and the way an issue like social isolation is framed has implications for the types of strategies that are developed to address the issue. Isolation and loneliness may create an image of someone who is sad and passive, and while that may be accurate for some people some of the time, it does not paint a complete picture of the phenomenon. The participants in this study talked about ways in which they tried to connect with others, made suggestions for ways for seniors to connect, and explained why they preferred to do things on their own. Shifting the focus from decreasing isolation to increasing engagement may lead to a more positive perceptions of seniors and the aging process.

5.6   Dissemination

The results of this thesis will be disseminated through conferences, reports and/or presentations to senior-serving organizations, and recommendations through participation on an advisory committee for a social marketing initiative on healthy aging. The study

will be presented to a multidisciplinary audience at the Canadian Gerontological

Association conference in Halifax. Preliminary results have already been presented at the

Crossroads Interdisciplinary Health Research Conference at Dalhousie University. The

representatives of the organizations that assisted with participant recruitment will be

given a summary report of the results along with recommendations specific to their

programs, and I will offer to meet with them to go over the report and present the main

findings. As well, as a member of the Fountain of Health advisory committee, I have been

and will continue to provide input on messaging around five areas of healthy aging:

social activity, positive aging, physical activity, mental health, and continuous learning.

By participating in this committee, I aim to make recommendations that take into account

the experiences of the sample of socially-isolated senior women in this study.

5.7   Limitations

Recruiting enough participants for this study was challenging because isolated

participants were sought. Accessing highly isolated individuals may have been

challenging because recruitment was done through service providers and posters, so those

who were not seeking services, or going to community centres or public libraries did not

learn about the study. Socially isolated seniors may be easier to reach through larger

studies that include measures on isolation or through programs where seniors are trained

to recognize other seniors who may be isolated.

Although 16 older women participated in the screening interview, only six

participants met the screening criteria for isolation and participated in the study. Even

though a small number of participants is often sufficient for qualitative research, the

participants in this sample were heterogeneous in age and satisfaction with current social

activity, so a larger sample would have been beneficial to more fully understand the effects of these differences on experiences of isolation. Focusing on the various needs of isolated seniors would have allowed for an understanding of their specific priorities and barriers to social participation, which could be used in the development of programs that encourage social participation and healthy aging.

Related to the first limitation is the narrow subsection of socially-isolated senior women who participated in this research. Though one participant received the highest score possible on the social isolation index, most participants had at least some regular social contact. Thus, they were not representative of the more extreme cases of socially-isolated senior women. Therefore, the results cannot be extended to older women who experience higher levels of isolation. Again, research on the diverse groups of seniors is necessary to create programs and policies that create supportive environments that allow seniors to take control of their health.

Another limitation of this study was the lack of minority participants; all participants were white and heterosexual. Questions related to socioeconomic status, which is a risk factor for social isolation, were not asked in this study, so the effect of this variable on experiences of social isolation could not be assessed. Participants who grew up in different cultures, speak English as a second language, or experience exclusion because of their minority status may be more at risk for isolation than seniors part of the majority group. Seniors who are gay, lesbian, or bisexual are also at a greater risk than heterosexual seniors (Osage & McCall, 2012). Research that focuses on social isolation in minority groups is also necessary to understand the full spectrum of needs and interests of the large and diverse senior community.

Finally, participants with current mental illnesses were excluded from the study. Older adults with depression are more likely to experience social isolation (Cloutier-Fisher et al. 2006), and the barriers to social activity they experience are likely different from those experienced by older adults without mental health problems. Individuals experiencing depression are more likely to be diagnosed with depression during routine physician visits and provided with treatment options, whereas individuals experiencing social isolation in the absence of mental health disorders may have fewer resources to address this problem. Because depression and anxiety are treatable, reversible psychological states, barriers to social activity related to these states would likely be diminished upon treatment.

Although I did not plan to interview participants who identified themselves as having depression or anxiety, I was unable to objectively assess participants' physical or mental health status. Thus, the results may not fully reflect the factors contributing to social isolation. However, participants quite openly self-reported their physical and mental health during the screening and full interviews, and the observational data that I took did not indicate that participants had underlying health concerns that they were not disclosing. Nevertheless, the lack of clinical diagnosis precludes conclusions about the impact of mental health on social isolation.

5.8   Conclusion

The findings from this study suggest that isolated older women may be isolated out of their own choosing, because of external circumstances, or for both reasons. The reasons for isolation are important to understand in order to remove barriers to social participation for those who wish to participate, and to offer other opportunities for

healthy aging for those who have a preference for more limited social contact. When organizations understand the barriers to social activity, they can develop strategies and allocate resources to implement these strategies so that it is easier for seniors to engage with others. Municipal and provincial policies that focus on creating healthy spaces can encourage people to engage in health-promoting behaviour on their own terms. Understanding the priorities of isolated seniors can be useful in identifying leverage areas to increase the likelihood of good health as people age.

There are a number of areas in the social isolation knowledge base that could benefit from additional research. More research on the mechanisms through which social isolation affects health and well-being is necessary so that interventions can focus on influencing triggers. A refinement of the conceptualizations of social isolation and loneliness would be beneficial for cross-study comparisons. Research on individuals who manage to maintain good health despite experiencing isolation is important as not all isolated individuals will choose to increase their social activity. Finally, while the target population of social isolation studies is often those who live alone, social isolation in married couples is also important to understand as the presence of a spouse does not always equate to the presence a high-quality source of social support. Exploring these avenues will help to form a more comprehensive view of social isolation in seniors.

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APPENDIX A: Recruitment Materials

Hi, I'm Iwona Tatarkiewicz and I'm a Dalhousie student at the School of Health and Human Performance. I'm looking to interview **women 65 years** of age or older.

If you spend much of your time alone and would be willing to share your **experiences** with me, please call (902) xxx-xxxx or email me at iwona.tatarkiewicz@dal.ca.

Or, if you prefer, fill in your phone number here, (902) _ _ _-_ _ _ _ , place this postcard in the mail and I will get in touch with you shortly. Thanks!

Recruitment checklist

Thank you for agreeing to identify individuals who might potentially participate in a study on social isolation in senior women. The purpose of the study is to learn about the experiences of women aged 65 and older who spend much of their time alone.

We are looking for individuals who are:

- ✓ females 65 years of age or older
- ✓ living alone
- ✓ able to communicate verbally
- ✓ seem to have little or no contact with others (other than with you and/or the meal delivery drivers)
- ✓ seem to be able to manage okay living independently

We are looking for individuals who are NOT:

- Almost always in a blue mood
- Experiencing short-term memory loss to a degree that they are unable to answer questions about their present experiences related to connecting with others

If you identify someone who meets these criteria, please:

A. Pass along the recruitment postcard to them

OR

B. Phone them to explain the purpose of the study and either provide them with my contact information, or ask their permission for me to contact them.

Thank you again for helping me with my master's thesis!

If you have any questions, feel free to contact me (Iwona Tatarkiewicz) at xxx-xxxx or iwona.tatarkiewicz@dal.ca, or my supervisor, Dr. Susan Hutchinson, at 494-1163 or at susan.hutchinson@dal.ca.

APPENDIX B: Screening Measures

Introductory screening questions:

Do you have today's date? (to assess cognitive status)

How would you describe your sleep? (Probes: falling asleep and staying asleep)

When you think about the future, how does it look like to you?

Have there been times in the past when you've had to see a doctor for depression or other similar problems?

What is the toughest part about living on your own? (probes: memory, ADLs, IADLs)

Social Isolation Index (Shankar et al., 2011)

1. Are you married or cohabiting with a partner? (question will not be asked as all participants will be living alone)
2a. Do you have any children? (if yes, go to 2b, if no, skip to 3)
2b. How often do you contact (including face-to-face, telephone or written/e-mail contact) your children?
3. How often do you contact (including face-to-face, telephone or written/e-mail contact) any other members of your immediate family?
4. How often do you contact (including face-to-face, telephone or written/e-mail contact) your friends?
5. Do you participate in any organizations, religious groups, or committees?

Scoring key:
1. Yes = 0; no = 1
2b. Initial: less than monthly = 1
    Revised: less than bi-weekly = 1
3. Initial: less than monthly = 1
    Revised: less than bi-weekly = 1
4. Initial: less than monthly = 1
    Revised: less than bi-weekly = 1
5. no = 1
* Additional point was given if all contact was over phone or email

Loneliness Scale (De Jong Gierveld & Van Tilburg, 2006)

Please indicate for each of the statements, the extent to which they apply to your situation, the way you feel now.

1. I experience a general sense of emptiness.	Yes	more or less	no
2. I miss having people around.	Yes	more or less	no
3. I often feel rejected.	Yes	more or less	no
4. There are plenty of people I can rely on when I have problems.*			
	Yes	more or less	no
5. There are many people I can trust completely.*	Yes	more or less	no
6. There are enough people I feel close to.*	Yes	more or less	no

*Items 4-6 are reverse-scored.

Scoring key: Items 1, 2, 3: yes/more or less = 1; no = 0

Items 4, 5, 6: yes/more or less = 0; no = 1

Consent Form

Study Title: The Lived Experiences of Socially Isolated Senior Women

Student researcher: Iwona Tatarkiewicz, t: 902-xxx-xxxx, e: iwona.tatarkiewicz@dal.ca

Supervisor: Susan Hutchinson, PhD, Associate Professor, School of Health and Human Performance, Dalhousie University; t: (902) 494-1163; e: susan.hutchinson@dal.ca

Introduction

We invite you to take part in a research study being conducted by Iwona Tatarkiewicz who is a graduate student at Dalhousie University, as part of her master of arts degree in health promotion. Your participation in this study is voluntary and you may withdraw from the study at any time. The study is described below. This description tells you about the risks, inconvenience, or discomfort which you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Iwona Tatarkiewicz.

Purpose of the Study

The purpose of this research study is to understand the experiences of senior women who spend most of their time alone. The results of this study will be used to make recommendations for future research as well as recommendations for policies and programs that affect seniors.

Study Design

The researcher will interview about ten to twelve participants to learn about their experiences of being senior women who spend much of their time alone.

Who can Participate in the Study

You may participate in this study if you are a woman 65 years of age or older who lives alone. Additionally, your answers to the set of questions that the researcher asked you during your first meeting must have indicated that you spend much of your time alone.

Who will be Conducting the Research

This research will be conducted by Iwona Tatarkiewicz, a master's student in health promotion at Dalhousie university. This study is being overseen by her supervisor, Dr. Susan Hutchinson, who is a professor at the School of Health and Human Performance at Dalhousie University.

What you will be asked to do

If you choose to participate in this study, you will be asked to schedule a meeting with the researcher to take part in an interview. During the interview the researcher will ask you questions related to your experiences with others and your preferences related to time spent with others. This meeting can take place in either your home or in a quiet room at a nearby library. The interview will take about 90 minutes, and you can take a break at any time. You may also skip any questions you prefer not to answer.

After this interview, the researcher will ask for your permission to schedule a second meeting to go over the initial themes found in your interview. This meeting can take place in person or over the phone, and will last 30 to 40 minutes. You may choose to have a description of the initial themes mailed or emailed to you before this second meeting.

Possible Risks and Discomforts

Some of the questions the interviewer asks you may make you feel stressed or anxious. You may choose to decline to answer any of the questions the researcher asks you, and you may choose to withdraw from the study at any time.

Possible Benefits

While participation in this study may not benefit you directly, the results will be used to make recommendations for future research and policies and programs that serve seniors.

Compensation / Reimbursement

You will be given $10 for your participation in the interview. You will receive this compensation even if you choose not to answer any of the interview questions or if you choose to withdraw from the study.

Confidentiality & Anonymity

Anonymity: Due to the nature of collecting data through interviews, your anonymity cannot be reasonably guaranteed. However, your name will not be written on the interview transcript. Instead, a unique ID will be used. Any reports written as a result of this research will not contain any identifying information about you.

Confidentiality: The answers to the questions you provided during your initial meeting with the researcher will be stored in a locked cabinet at the School of Health and Human Performance at Dalhousie University. An electronic file that is password-protected will also be kept on the researcher's computer. The interview will be audio recorded for accuracy and interview transcripts will be stored in a password-protected file on the researcher's computer. A list of participants and their unique IDs will be kept in a separate password-protected file on the researcher's computer. The researcher and Dr. Hutchinson will have access to all the information provided by you. In accordance with the Dalhousie University Policy on Research Integrity, all study data will be kept for 5

years.

If the researcher suspects that a participant is in a situation of abuse or neglect, she is obligated to contact Adult Protection Services at the Department of Health and Wellness.

Questions

If you have any questions about this study, you may contact Iwona Tatarkiewicz at 902-xxx-xxxx. You will be provided with any new information which might affect your decision to participate in the study.

Problems or Concerns

If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Catherine Connors, Director, Research Ethics, Dalhousie University at (902) 494-1462, ethics@dal.ca

Consent Signature Page

Study title: The Lived Experiences of Socially Isolated Senior Women

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

I also consent to (please check the boxes):

☐The audio recording of interviews

☐The use of data from the isolation and loneliness questions asked during the initial meeting with the researcher. Data used from these measures will be reported only in group format, so your individual responses will not be reported.

Participant signature _____

Date _____

Participant printed name: _____

Researcher signature:_____

Date _____

Researcher name: _____

You will be given a copy of this form to keep.

If you wish to receive any of the documents indicated below (check the boxes), please provide your mailing or email address:

□Final study report
□Interview transcript
□A one-page summary of main themes

I prefer to have the documents above: mailed or   emailed

Name:_____

Street:_____

City:_____

Postal Code:_____

Email address:_____

Signature Page (Post-interview)

Study title: The Lived Experiences of Socially Isolated Senior Women

Having participated in the interview, I now consent to consent to (please check the boxes):

☐The researcher using non-identifying quotations from the interview in study reports

☐Being contacted for the final in-person or telephone meeting related to this study

☐The researcher sharing my name and phone number with other study participants who wish to make new social connections. I understand that all the information I have provided and any future information I provide for this study will continue to be kept confidential, with the exception of my name and phone number that will be shared with other participants.

NOTE: If you are not interested in other study participants contacting you, do not check this option.

Participant signature _____

Date _____

Participant printed name: _____

Researcher signature:_____

Date _____

Researcher name: _____

You will be given a copy of this form to keep.

<p style="text-align:center">Consent Form – Service Providers</p>

Study Title: The Lived Experiences of Socially Isolated Senior Women

Student researcher: Iwona Tatarkiewicz, t: 902-xxx-xxxx, e: iwona.tatarkiewicz@dal.ca

Supervisor: Susan Hutchinson, PhD, Associate Professor, School of Health and Human Performance, Dalhousie University; t: (902) 494-1163; e: susan.hutchinson@dal.ca

Introduction

    We invite you to take part in a research study being conducted by Iwona Tatarkiewicz who is a graduate student at Dalhousie University, as part of her master of arts degree in health promotion. Your participation in this study is voluntary and you may withdraw from the study at any time. The study is described below. This description tells you about the risks, inconvenience, or discomfort which you might experience. Participating in the study might not benefit you, but we might learn things that will benefit others. You should discuss any questions you have about this study with Iwona Tatarkiewicz.

Purpose of the Study

    The purpose of this research study is to understand the experiences of senior women who spend most of their time alone, and the views of service providers who work or volunteer for organizations that have programs aimed at reaching socially-isolated seniors. The results of this study will be used to make recommendations for future research as well as recommendations for policies and programs that affect seniors.

Study Design

    The researcher will interview about ten to twelve participants to learn about their experiences of being senior women who spend much of their time alone. She will also interview three employees or volunteers of senior-serving organizations.

Who can Participate in the Study

    You may participate in this study if you work or volunteer for a senior-serving organization that has programs aimed at reaching socially-isolated seniors.

Who will be Conducting the Research

    This research will be conducted by Iwona Tatarkiewicz, a master's student in health promotion at Dalhousie university. This study is being overseen by her supervisor, Dr. Susan Hutchinson, who is a professor at the School of Health and Human Performance at Dalhousie University.

What you will be asked to do

If you choose to participate in this study, you will be asked to schedule a meeting with the researcher to take part in an interview. During the interview the researcher will ask you questions related to your views of social isolation in older women and ways to reduce isolation in this population. This meeting can take place in either your workplace or in a quiet room at a nearby library. The interview will take about 30 minutes, and you can take a break at any time. You may also skip any questions you prefer not to answer.

After this interview, the researcher will ask for your permission to schedule a second meeting to go over the initial themes found in your interview. This meeting can take place in person or over the phone, and will last about 15 minutes. You may choose to have a description of the initial themes mailed or emailed to you before this second meeting.

Possible Risks and Discomforts

Some of the questions the interviewer asks you may make you feel stressed or anxious. You may choose to decline to answer any of the questions the researcher asks you, and you may choose to withdraw from the study at any time.

Possible Benefits

While participation in this study may not benefit you directly, the results will be used to make recommendations for future research and policies and programs that serve seniors.

Compensation / Reimbursement

You will be given $10 for your participation in the interview. You will receive this compensation even if you choose not to answer any of the interview questions or if you choose to withdraw from the study.

Confidentiality & Anonymity

Anonymity: Due to the nature of collecting data through interviews, your anonymity cannot be reasonably guaranteed. However, your name will not be written on the interview transcript. Instead, a unique ID will be used. Any reports written as a result of this research will not contain any identifying information about you.

Confidentiality: The answers to the questions you provided during your initial meeting with the researcher will be stored in a locked cabinet at the School of Health and Human Performance at Dalhousie University. An electronic file that is password-protected will also be kept on the researcher's computer. The interview will be audio recorded for accuracy and interview transcripts will be stored in a password-protected file on the researcher's computer. A list of participants and their unique IDs will be kept in a separate password-protected file on the researcher's computer. The researcher and Dr. Hutchinson will have access to all the information provided by you. In accordance with

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the Dalhousie University Policy on Research Integrity, all study data will be kept for 5 years.

Questions

If you have any questions about this study, you may contact Iwona Tatarkiewicz at 902-xxx-xxxx. You will be provided with any new information which might affect your decision to participate in the study.

Problems or Concerns

If you have any difficulties with, or wish to voice concern about, any aspect of your participation in this study, you may contact Catherine Connors, Director, Research Ethics, Dalhousie University at (902) 494-1462, ethics@dal.ca

Consent Signature Page

Study title: The Lived Experiences of Socially Isolated Senior Women

I have read the explanation about this study. I have been given the opportunity to discuss it and my questions have been answered to my satisfaction. I hereby consent to take part in this study. However I realize that my participation is voluntary and that I am free to withdraw from the study at any time.

I also consent to (please check the boxes):

□The audio recording of interviews
□ Instead of remaining anonymous, I would like my name to be used in any reports that come out of this research.

Participant signature _____

Date _____

Participant printed name: _____

Researcher signature:_____

Date _____

Researcher name: _____

You will be given a copy of this form to keep.

If you wish to receive any of the documents indicated below (check the boxes), please provide your mailing or email address:

        □Final study report
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Signature Page (Post-interview)

Study title: The Lived Experiences of Socially Isolated Senior Women

Having participated in the interview, I now consent to consent to (please check the boxes):

□The researcher using non-identifying quotations from the interview in study reports
□Being contacted for the final in-person or telephone meeting related to this study

Participant signature _____

Date _____

Participant printed name: _____

Researcher signature:_____

Date _____

Researcher name: _____

You will be given a copy of this form to keep.

APPENDIX D: Semi-structured interview guide

Introductory questions:

Please describe for me what your typical day looks like. (probes: weekly, monthly, occasional activities)

Experience of social interactions:

Who do you have contact with on a regular basis?

Please describe the contact you have on a regular basis. What do your interactions with others look like?

How would you describe your physical health? How much does this contribute to you spending much of your time alone?

How would you describe your mental health? Your mood? How long have you been feeling this way? How much does this contribute to you spending much of your time alone?

Experience of social isolation:

Are you satisfied with the amount of contact you have with others? Why or why not?

Do you think of yourself as isolated?

How do you spend your time when you're on your own?

Think about the places you spend your time in. Probes: home, building, neighbourhood. Which of those places make you feel the most isolated? Why? Which one of these would you rank as the number one factor that affects how much time you spend alone?

Barriers to social engagement:

Tell me about the type of contact you had with others when you were younger. Has it changed?

What life experiences have you had that make it harder for you to reach out to others?

How would you describe your coping style? Does this affect how you connect with others? (provide an example)

What are the roles you see yourself as having? Have these changes over the years? Do your roles affect how you connect with others? What are some things you've given up over the years?

What do you like about being in your home? Dislike?

What do you like about going out? What do you dislike?

Can you give me an example of a great social interaction that you had? A bad one?

What affects how you connect with others? (probes: self-confidence, relationship with family members, income, availability of transportation, health status, perceptions of safety)

Thinking about all of the factors we've talked about that influence how much time you spend alone, what are the top 3 factors that contribute to you being alone much of the time?

Decreasing isolation and increasing engagement:

What places are close to you that could encourage connecting with others?

How motivated are you to go to those places?

What would encourage you to go those places?

Final questions

Is there anything else you would like to add, or anything you wish I would have asked you?

May I also have your age range?

65-69
70-75
76-79
80 and above

APPENDIX E: Observation Protocol

Date and time:	
Participant ID:	
Descriptive Notes	**Reflective Notes**
Indicators of ability to live independently	
Dependency on others to:	
Get dressed:	
Get groomed:	
Move about:	
Phone others:	
Do housekeeping:	
Do laundry:	
Self-presentation indicators	
Agitation:	
Nervousness:	
Self-confidence:	
Environment: apartment (e.g., condition, clutter, photographs)	
Environment: building (e.g., condition, working elevator, space for recreation / socializing, bulletin board announcements)	
Environment: neighbourhood (e.g., appearance, sense of safety, proximity to shops and services)	

APPENDIX F: Qualitative Interview Decision Tree

Signs of distress

Signs of minor distress (e.g., teary eyes, short crying spell, signs of minor agitation)

Signs of high levels of distress (e.g., continuous crying, major agitation, lack of responses of interview questions)

Check in with participant
- Ask if she needs a break
- Pass her a tissue (if applicable)
- Show empathy and understanding
- Remind her that she does not need to answer any questions asked of her and can stop interview at any time

Stop the interview
- Explain concern for participant and stop the interview

- Remain with participant until she has calmed down, and do something unrelated to the study (e.g., make a pot of tea)
- Ask participant if she would like help (i.e., looking up the number, dialing the number) calling her doctor to make an appointment

Ask participant if she would like to schedule another meeting to finish the interview, or if she prefers to withdraw from the study

Withdrawal: Thank participant and provide her with $10 for her participation. Remove her data from the study.

Schedule another meeting. Inform participant of the time commitment for the remaining part of the interview. Remind participant that she can stop interview at any time and does not need to answer any question asked of her.

APPENDIX G: Service Provider Interview Guide

How would you define social isolation in senior women?

Do you consider it to be different from loneliness? How so?

How do you identify socially-isolated seniors? (probes: what other services do you rely on?)

How do you address social isolation through the services that your organization provides? (probes: individual visiting, group activities, structural changes, policies)

In your opinion, what are the essential components of a program or policy that aims to reduce social isolation in seniors?

Is there anything else you would like to add, or anything you wish I would have asked you?