ELDER LONELINESS, SOCIAL SUPPORT AND DEPRESSION©

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June 2005

A thesis submitted to
McGill University
in partial fulfillment
of the requirements of the degree of
Master of Social Work
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Canada
ABSTRACT

A rapidly growing senior population is facing loneliness, desolation and isolation in our ageist society. Age-linked detachment and a number of social interactors are closely related to general health, physical condition and depression.

Using standardized instruments, the UCLA Loneliness Scale (Russell et al., 1980), the Multidimensional Scale of Perceived Social Support (Zimet et al., 1988), and the Geriatric Depression Scale (Brink et al., 1982), this non-experimental-study investigated the level of perceived loneliness, social support and the causative relationship of these factors to the presence of depression among 50 independent, relatively healthy elders in a Montreal senior centre.

Findings suggest that loneliness is a major predictor of elder depression. Lack of perceived social support could contribute to sensed loneliness and that depression may be present in healthy, independent elderly.

Intergenerational workshops for seniors are suggested to improve life satisfaction through social interaction. Further goals are to modify myths, stereotypes and contradictory attitudes inherent to the cohort.
ABSTRAIT

Dans notre société faisant preuve d'âgisme, un nombre croissant de personnes âgées doivent faire face à la solitude, la désolation et l'isolement. L'indifférence à l'égard du vieillissement et un nombre de facteurs sociaux sont étroitement liés à la santé générale, à l'état physique et à la dépression.

Au moyen d'instruments standardisés, cette étude non-expérimentale a étudié le niveau perçu de solitude et de soutien social dans un groupe de personnes âgées indépendantes et relativement en santé, ainsi que le lien de causalité de ces facteurs à l'égard de la dépression.

Les résultats établissent que la solitude est un élément prédictif de la dépression chez les aînés. Le soutien social perçu peut contribuer au sentiment de solitude et la dépression peut se manifester chez des aînés indépendants et en santé. Des ateliers intergénérationnels pour aînés sont suggérés pour améliorer la satisfaction de vivre par l'entremise d'une interaction sociale. D'autres objectifs visent à modifier les mythes, les stéréotypes et les attitudes contradictoires inhérentes à la cohorte.
ACKNOWLEDGMENTS

I wish to express my sincere thanks to my supervisor, Dr. Sydney M. Duder. What I know today about the procedure of research, I learned from Dr. Duder.

My sincere thanks are due to Ms. Estelle Katz, Assistant Executive Director of the Cummings Jewish Centre for Seniors, for making it possible to conduct my research in this institution. I would especially like to thank to Ms. Karen Wertheimer for the help extended to me during the commencement of my work with the seniors, and to Ms. Carole Klein, for providing me with her constant support during the interviewing process.

I would like to take the opportunity to thank the seniors at the Cummings Centre. This project would not have been possible without their willing and supportive participation.

I can assure you I will never forget the time and companionship spent with many supportive friends and fellow research scholars. In particular, I am thankful to Gina Lennox-Shapiro and Brahms E. Silver for their help, support and encouragement.

Lastly, but most importantly, I am grateful to my wife Kathy for inspiring and supporting me through out the long journey of writing my thesis. I will be forever grateful for her willingness and ability to share technical and organizational aspect of my research. Without her dedication, understanding and profound belief in my ability to carry out this work, I would surely not be feeling the same sense of accomplishment that I feel today. I would like to thank my three children, Daniel, Esther and Suzy, who also rendered enormous support during the entire tenure of my research.
Finally, I would like to thank all whose direct and indirect support helped me completing my thesis in time.
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Alone, alone, all, all alone,
Alone on a wide wide sea!

S. T. Coleridge, The Rhyme of the Ancient Mariner
CHAPTER 1
INTRODUCTION

Aging is a gradual procedure that marks the passage of years. “Old Age” generally refers to people over 65 years of age. The elderly represent a wide diversity of social issues and needs, therefore it is helpful to subdivide into periods for example, “young-old” are those between ages of 55 and 64; “old” are between 65 to 74; “old-old” are persons between ages of 75 and 84 and the “very old” are over 85 years of age (National Association of Social Workers [NASW], 1995).

When demographic balance shifts, one cohort becomes over-represented. Our society is aging by reason of baby boomers who will reach their sixties in ten years. Statistics Canada (2004) reported that the elderly are the fastest growing age group in our society. It is predicted that by 2030, the elderly will comprise 21.2% of the population. These changing demographics have already begun to provide new challenges in social work practice. “The demand for social services in the field of aging will increase through the year 2020.” (Klein, 1998, p. 220). In order to understand the challenge for social work, social work students and clinicians must acquire profound gerontological knowledge and an understanding of the biopsychosocial issues of aging (Peterson & Wendt, 1990). We must also demand respect for a growing senior population promoting Quality of Life (QLF) as a determinant of health (Raphael et al., 1995). Table 1 gives a brief outlook about the expected dramatic shift in the Canadian population.
Table 1. Facts About Growing Old in Canada

<table>
<thead>
<tr>
<th>Year of 2026</th>
<th>Both sexes (thousands)</th>
<th>Female (thousands)</th>
<th>Male (thousands)</th>
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<tbody>
<tr>
<td>All ages</td>
<td>36,190.60</td>
<td>18,250.90</td>
<td>17,939.60</td>
</tr>
<tr>
<td>65+ population</td>
<td>7,753.00</td>
<td>4,237.50</td>
<td>3,515.50</td>
</tr>
</tbody>
</table>

All figures are in thousands.

*Note:* Figures represent the medium-growth projection and are based on 2000 population estimates.

A rapidly growing part of the population is experiencing physical, cognitive, social and economic losses. It is an immense challenge for the older person to live in a youth oriented society. Different losses and depletions mark the aging process. Primary losses are those of biological nature, for example stiff joints, decline in sensations and visual acuity, and reduced short-term memory. Negative changes in physiological conditions, weakening immune system, memory loss, decreased cognitive ability also belong to this category. Secondary, social and economic depletions follow the course of biological aging and are related to the environment of the individual. Elderly are more intensively hit by social isolation, unfavorable financial status and the loss of significant others (Harrigan & Farmer, 2000).

Social Detachment and Isolation of the Elderly

As a society, enamoured with the glamour of youth, we all too often harbour a blanket view of the elderly as non-productive human beings (Riley et al., 1972). We unintentionally characterize them as potential victims of
mental and physical deterioration who have become obsolete and expendable. This reflects a prejudicial and oppressive view of a population who, by virtue of their having survived all through the years to be classified as elderly, deserve much more positive recognition than they sometimes get. What is often left unacknowledged is how much we unwittingly relegate elderly folk to the margins of our lives, particularly when they have so much more to give (Rose & Peterson, 1965). Society is burdened with ageism, namely, with negative biological, psychological and social myths towards older people. Health institutions are based on age-segregation, legal structures that often degrade old people to the status of second class citizens, while mandatory retirement laws and business organizations prefer young employees with vivid spirit (Harrigan & Farmer, 2000).

The society's mentality is reflected in the views of Cumming and Henry (1961) when they stated that both social involvement and activity decrease during aging. It is the individual's obligation to withdraw. They also believed that the disengagement process is advantageous for the society as well as the elderly. There is little indication, however, for the support of benefit. Nevertheless, both theory and society seem to ignore that social isolation and inactivity have depressive effects on individuals.

The Secretary General stated in his report to the U. N. General Assembly (as cited in Bennett, 1980) that “loneliness, desolation and isolation characterize the social lives of many of the aged, particularly in many developed countries” (p. 2).

The focus in this paper is primarily brought about through personal experience and observation of how the seniors personally feel in a society that has integrated a system of planned obsolescence for the older person.
Social Isolation and Depression in the Literature

The literature reviewed was selected to present a different perspective on social loneliness among the elderly. Despite the fact that aging should be perceived as a time in which individuals are enjoying the rewards of past accomplishment, and that surveys have shown that most senior individuals in Canada (75 and over) continue to feel good about themselves, many elderly people find difficulty negotiating a society that has come to define old age as the end of the useful part of life. The division of themes under review is as follows:

- **Social isolation and loneliness** which shows a significant difference throughout the research, when measured as psychosocial component of the aging process,
- **Social support deficit** that warrant understanding, and is often the impetus behind reasons for sensed loneliness,
- **Loneliness and Depression** as relational interdependence.

*Social isolation and loneliness*

Deprivation of meaningful social contact may result in isolation. Social isolation is “The absence of specific role relationships which are generally activated and sustained through direct personal face-to-face interaction” (Bennett, 1980, p. 15). The lack of satisfying relationships may result in separation from one’s environment, hence the individual becomes socially isolated (Delisle, 1988). An isolated person is not necessarily lonely, as solitude can be a personal choice.

Social loneliness, however, is a subjective emotional term, a psychological stage, as one may not be satisfied with the quality of the
relationships or with the number of contacts (Bennett, 1980; Hall & Havens, 2002). The number of expected personal contacts and the desired quality level of existing relationships therefore, can characterize loneliness (de Jong-Gierveld & van Tilburg, 1999). Loneliness is not only a physical experience but also a feeling, an emotional term (Gibson, 2000). It is “the unpleasant experience that occurs when a person's network of social relations is deficient in some important way, either quantitatively or qualitatively” (Perlman & Peplau, 1981, p. 31). The feeling of loneliness is inherent to the existing discrepancy between the desired and the factual (Dykstra & de Jong-Gierveld, 1994). Ryan (1998) also confirmed the link between social isolation and loneliness.

Previous research and theories on social isolation and loneliness have primarily investigated the causes of loneliness and its certain associations to other behavioral and emotional problems such as depression, self-esteem, and suicide. Many studies, however, were undertaken as part of psychological or medical research (Perlman, 1989). Human life is marked by social relationships. For social work, therefore, it is essential to recognize the need to draw attention to social aspects of life.

Until recently research has mainly focused on instances where individuals feel subjectively “crowded”, or when “too many people” are present at the same time (Freedman, 1975; Stokols, 1972). The subjective phenomenon of loneliness, when social relationships are “too few”, has not been in the focus of past research. Researching loneliness holds a twofold significance: it offers not only better understanding of the basic aspects of social relations but also contemplates the fact that many individuals suffer from this adversity. Bradburn (1969) stated in his survey, that 26% of American individuals indicated loneliness or detachment during the few weeks before the study.

Age-linked isolation and the number of social interactors are closely related to general health and physical condition (Lowenthal, 1964). Tijhuis,
de Jong-Gierveld, Feskens and Kromhout (1999) assumed that age has an increasing effect on loneliness, however, no longitudinal study has established a strong link between the two factors. Other studies have reported that loneliness is a common experience among the elder population (Dugan & Kivett, 1994; Forbes, 1996; Harris et al., 1975; Holmen et al., 1992).

Perception of personal relationships effects not only self-reported health status but also actual physical health (Holmen et al., 1992; Mullins et al., 1996). Elderly who perceive themselves as not lonely may rate their own health status as better (Auslander & Litwin, 1991).

Several studies have shown that gender differences play an insignificant role in loneliness, however, males feel less lonely than females. Russell (1996), using the UCLA Loneliness Scale, also found no statistically significant differences in loneliness related to gender. Borys and Perlman (1985) drew the same conclusion in their literature review.

Social support deficit

Durkheim (1897/1951) in his milestone work “Suicide” emphasized the importance of social supports and socialization as key elements in the origin of depression. Personal and societal changes in old age may induce decline in both the quality and quantity of social support. Consequently, the elderly tend to perceive less social support (Prezza & Pacilli, 2002). Social isolation, therefore, has a distinguishable role in the 65+ cohort (Chaisson-Stewart, 1985). Many researchers have supported this idea. Without confiding relationships one can face increased risk for depression (Brown & Harris, 1978; Costello, 1982). Loneliness is negatively associated with measures of social support (Russell, 1996). Presence of loneliness indicates deficit in social relations and in the available interpersonal resources (Peplau, 1985).
Blazer (2002) suggested that social environment contributes to the individual as meaningful and protective social support that empowers him or her to handle different stressors. Others emphasized the moderator role of social support between daily stress and depressive symptoms; the buffering hypothesis (Cohen & McKay, 1984; Gore, 1981; House, 1981). Any change in this support influences the capability of one's interaction with the social environment. Perceived level of social support is meaningful in later life when environmental stressors have more powerful effects on a vulnerable person (Blazer, 2002). Disruption in social support may contribute to depression as the elderly individual is facing difficulties in negotiating social stressors (Kessler & McLeod, 1985; Landerman et al., 1989).

Prince et al. (1997) in their community survey found strong evidence that lack of social support is directly associated with depression. They suggested that, besides loneliness, social support deficit is the biggest risk factor. Interestingly, living alone has much less effect in the genesis of depression.

Clara et al. (2003) investigated the associations between depression and perceived social support with three distinct sources: family members, friends and significant other. Lack of support provided by these subgroups, however, is strongly associated with depressive symptoms. People fulfilling the role of support within the sub-groups are interchangeable for the senior; therefore there is no significant difference in the pattern of perceived social support. Higher level of support seems to increase both physical and psychological health (Stanley, Beck & Zebb, 1998).

Burnette and Mui (1994) found that lack of social participation is one of the predictors of depression. Social support deficit and its components, reassurance of worth and reliable alliance, have direct impacts on depression level (Russell & Cutrona, 1991). This is confirmed by Zimet et al. (1988) who stated that low depression level has a strong correlation with high level of social support.
Gender differences have no significant effect on perceived social support (Russell & Cutrona, 1991). Females, however, reported a slightly higher level of perceived global social support than males. Stanley, Beck and Zebb (1998) reached similar conclusions in their study of a normal elderly control group. Nevertheless, social factors play a notable role in the 65+ population (Murphy, 1982).

Loneliness and depression

Loneliness can be the source of many individual and social issue, that is, alcoholism (Nerviano & Gross, 1976), adolescent delinquency (Brennan & Auslander, 1979), suicide (Jacobs, 1971; Wenz, 1977), depression, physical illness and over utilization of the health care system (Lynch, 1976). There is an evident correlation between healthy relationships, physical well being and longer life span. Moreover, individuals in loving and secure family and community environments cope much better with psychological stressors than others without such social bonds (Lynch, 1976). The sense of abandonment is a traumatic experience and may result in different levels of mental disturbance (Gibson, 2000).

Lowenthal (1964), in her study on social isolation and mental illness in old age, linked late-developing isolation with mental disorder, at an equally important level as any other psychogenic or organic disorders. Mor-Barak and Miller (1991) suggested a stronger link between old-age loneliness and the increase of depression. Williams and Jako (1958) stated that deprivation in social interaction contributes to old age mental problems.

Russell (1996) concluded in his study that loneliness is strongly associated with well being, life satisfaction and depression. He also found significant relationship between loneliness and perceived health status, as well as with chronic illnesses among the elder population. A study conducted

by the National Institute of Aging (1990) suggested that loneliness has a disabling effect on the elderly individual similar to any other chronic medical condition. People who feel lonely may also say that they feel depressed (Perlman, Gerson & Spinner, 1978; Russell, Peplau & Ferguson, 1978).

Depression is one's psychobiological response to life stressors associated with real and perceived losses that produce both somatic and psychological symptoms. The 65+ population is often facing multiple losses, therefore their risk for depression is increased (Chaisson-Stewart, 1985).

Geriatric depression is usually measured by the presence of somatic symptoms, such as somatic anxiety, appetite decrease and sleep disturbances. However, these signs cannot necessarily be easily detected in milder forms of the disease. Yesavage et al. (1983), therefore, developed an instrument that screens the psychological symptoms, that is, dissatisfaction, depressed mode, emptiness and personal devaluation, and so forth. In their study they found that these symptoms indicated the highest correlation with depression. These results correspond to the findings of another investigation conducted by Steuer et al. (1980).

Others have also related elder depression to such negative life events as social dissatisfaction and loss of social support (Blazer, 1983; Cassileth et al., 1984; Goldberg et al., 1985; Gotham et al., 1986; Hale, 1982; Murphy, 1985). Social-psychiatric research has found evidence that isolation-induced helplessness, uselessness and meaningless of life are hints for the presence of elderly depression (Butler & Lewis, 1973). The Gospel Oak Project VI, a community survey on the elderly in London, UK, reported that loneliness “was one of the strongest cross-sectional associations with pervasive depression” (Prince et al., 1997, p. 326).

Interestingly, there is a difference in depression level between genders. Females seem to be less depressed than males. Prince, et al. (1997) mentioned the gender differences in their study of a non-clinical elderly group. They found that unmarried or widowed females, presumably living
alone, were at lower level of risk for depression than males in the same situation. However, many other researchers have agreed that the 65+ cohort has the highest rate of depressive symptoms (Gurland, 1976).

**Objective of This Study**

Environmental changes affect individual development in unique ways. Inability to cope with the changed environment profoundly affects the well being of an elderly person. The result may be a decline in social interaction, isolation and finally depression. Those who live alone may experience not only physical aloneness but also the emotional feeling of loneliness. The cause of loneliness may vary by age, therefore different age groups may experience loneliness at different degrees of intensity (Gibson, 2000).

The objective of this study is to investigate the level of perceived loneliness and social support in independent, relatively healthy seniors, and the causative relationship of these factors to the presence of depression.

Considering the biopsychosocial gender differences, most researchers have investigated the possibility of gender differences (Crawford, Prince, Menezes & Mann, 1998; Prezza & Pacilli, 2002; Russell, 1996; Russell et al., 1980, Stanley, Beck & Zebb, 1998). The present study, therefore, examined the difference between male and female samples.

*Theory diagram*

The reviewed literature suggests a research model (Figure 1), which displays the causal order of the factors, that is perceived loneliness and social support may have an effect on depression. The object will be to examine if obtained data fit this theoretical model.
Figure 1. Predictors of Depression: Theory Diagram
Research hypotheses

Considering the problem of social isolation and inactivity that may have depressive effects on elderly individuals, the hypotheses to be tested are as follows:

**Hypothesis One:** Loneliness is one of the predictors of depression.
A higher level of loneliness will be associated with a higher level of depression.

**Hypothesis Two:** Social support is a predictor of loneliness, and thus has an indirect effect on depression.
A higher level of social support will be associated with a lower level of loneliness.

**Hypothesis Three:** Self-reported health status may influence the level of perceived social support as well as depression.
Good health will be associated with a higher level of social support and a lower level of depression.

**Hypothesis Four:** Status of living arrangement has considerable impact on the level of perceived social support.
A higher level of social support will be associated with not living alone.
CHAPTER 2
METHOD

Design

In order to test the hypotheses, a cross-sectional, non-experimental, correlational design was used with a single sample.

Sample

Interviews were administered at the Cummings Jewish Centre for Seniors (CJCS), Montreal, in August, 2004. The agency is a non-profit, volunteer association that offers programs and support services to over 6,000 individuals 50 years of age and over. It provides a full range of programs and services for both active and frail senior adults.

The small, not-representative, convenience sample of voluntary participants was recruited from the independent and mobile daily visitors by random interception in the Cafeteria during lunchtime on Tuesdays and Wednesdays. Candidates received a thorough explanation of the purpose and nature of the study, and were offered ample time to think about participation. Exclusion criteria excluded those under the age of 65. The final sample consisted of 50 individuals.
Questionnaire

A four-page questionnaire was designed as a tool to conduct the interviews (Appendix C). The instrument included four parts:

- Demographic information,
- UCLA Loneliness Scale (Version 3),
- Multidimensional Scale of Perceived Social Support (MSPSS),
- Geriatric Depression Scale (GDS).

These instruments need only a short time to complete to lessen the burden on the participant, may be both respondent and interviewer administered, are widely used and reported in the literature and are the most reliable and validated measures available. These are tested and standardized tools, therefore, no development and testing of new tools were necessary.

Demographics information

Six direct observable variables, that is Age (computed from “Year of Birth”), Gender, Marital Status, Number of Children, Living Arrangement and Health Status.

UCLA Loneliness Scale (Version 3)

The UCLA Loneliness Scale (Version 3), (Russell et al., 1980), is a 20-item scale designed for empirical research on loneliness. The instrument is “psychometrically adequate” and widely used (Russell, 1982, p. 90). It is reliable and valid in assessing loneliness (coefficient alpha ranging from .89 to .94) and
can be used with different populations and data-collection methods (Russell, 1996).

Version 3 of the UCLA Loneliness Scale consists of 20 questions about loneliness, with response options on a 4-point scale: 1 (never); 2 (rarely); 3 (sometimes) and 4 (always). In order to avoid systematic biases, 10 of the questions are positively worded and 10 negatively. There are no sub-scores in the scale.

Content validity is achieved by items reflecting different aspects of loneliness. Also, feelings usually connected with loneliness, for example dissatisfaction, shyness, anxiety and depression, were related more strongly to the loneliness scores than feelings that are not associated with loneliness (Russell et al., 1978).

Following Russell’s (1996) instructions, the coding of the positively worded items was reversed, then item responses were summed (Appendix D). The possible scores ranged from 20 (lowest) to 80 (highest); the higher the score, the greater the loneliness level.

*Multidimensional Scale of Perceived Social Support (MSPSS)*

The MSPSS measures the level of social support one perceives from Family, Friends and Significant Other. The instrument comprises 12 questions, with response options on a Likert scale from 1 (very strongly agree) to 7 (very strongly disagree). Questions are divided into three sub-groups, consisting of four items each, that relate to the source of the social support, that is Family, Friends or Significant Other (Appendix D). Mean scores on the sub-scales, as well as on the total scale, demonstrate the level of satisfaction (Zimet et al., 1988).

In a different approach, however, the responses to items on each sub-scale are summed, giving scores from 4 to 28. The sum of the three sub-scales gives a
global satisfaction with perceived support scores from 12 to 84 (Clara et al., 2003). Higher scores mean higher levels of satisfaction, both on the global and the sub-scales.

Both the global and the sub-scales have strong internal reliability (Zimet et al., 1988). Cronbach's alpha values are:

- Global scale: .85
- Family sub-scale: .87
- Friends sub-scale: .85
- Significant Other sub-scale: .91

A negative correlation has been reported between the global perceived support score and depression and anxiety measures (Eker & Arkar, 1995; Zimet et al., 1988). The instrument can be employed with different age groups; however, it shows strong internal consistency with older adults (Oxman et al., 1994).

One question about social worker's contact was added to the MSPSS questionnaire.

**Geriatric Depression Scale (GDS)**

The Geriatric Depression Scale (GDS), (Brink et al., 1982) is a widely used instrument to assess and rate depression among the elderly. The scale includes 30 yes / no items designed to measure a common latent variable, depression. The presence of depression is indicated by “yes” answer to 20 of the items, and “no” answers to 10 other items, giving a range of scores from 0 – 30, a higher score indicating a higher level of depression. Depression level categories were computed according to the authors' suggestions (Appendix D).

“The computed value of the alpha coefficient was .94, suggesting a high
degree of internal consistency for the GDS.” (Yesavage et al., 1983, p. 43).

Pre-test of questionnaire

The original questionnaire was pre-tested on five independent, healthy elderly individuals who volunteered to verify for clarity and measure the time necessary to complete the survey. As a result the question regarding the role of the social worker was modified to “My social worker keeps regular contact with me”. Other items remained unchanged. All volunteers completed the survey within 20 minutes.

Procedure

Ethical approval

This study received ethical approval from McGill University Research Ethics Board –II (Appendix A) as well as from the Cummings Jewish Centre for Seniors. The risks of the study were minimal and may have included frustration or fatigue in completing the scales. The design of the study adhered to the Professional Code of Ethics of Social Workers (Gouvernement du Québec, 1995); that is, the study did not pose any risks and breach confidentiality in any form. No name appeared on the questionnaire, answers remained confidential and no deception was involved. Participation was voluntary and respondents were included in the study after having understood the potential risks and signed consent form (Appendix B).
Data collection

The study was planned to comprise 50 completed interviews. A signed consent form was a necessary prerequisite to start the interview. Signed consent forms and completed questionnaires were kept separated. A unique ID number was assigned to every questionnaire. Original data were collected through face-to-face interviews. No secondary data were gathered. In four cases, when the interviewees refused or did not respond, the interview was stopped and the uncompleted questionnaire was excluded. Recruitment continued until sample size was filled. The interview took approximately 20-30 minutes per individual. CJCS is continuously using several measuring instruments to identify and evaluate service outcomes; therefore, participants of the study were supportive and willing to answer the questions. In a few cases, however, special effort was needed to keep the length of the interview in the planned timeframe. During the interviews some of the respondents opened-up and took the opportunity to recount their own life-narratives.

Data transformation

For use in the analysis, the following data transformations were performed. Age (years) was calculated from Year of Birth. Age was also re-coded into three categories: 65 – 74, 75 – 84 and 85+ in order to be consistent with the literature.

Living Arrangement was re-coded into two categories: living alone and living with others.

Scores for various scales were calculated as suggested by the authors, with coding for negatively worded questions reversed where necessary.
In order to compare the scores of the present study to those published in literature, two versions of scores were calculated for the MSPSS scale:

- Sum of item responses,
- Mean of item responses.

**Analysis**

Data were analyzed using SPSS Version 10.0 for Windows. The present study included nominal variables: Gender, Marital Status, Living Arrangement; ordinal variables: Health Status, items of scales; and ratio variables: Age, Number of Children.

Re-coded variables were Age Categories (ordinal) and the dichotomous Living Arrangement.

The following composite variables were computed: Loneliness Score; Global Social Support Score with Family, Friends and Significant Other Sub-Scores, Professional Support Score (Social worker) and Depression Score.

Frequency distributions were calculated for the demographic variables (Table 2), and means and standard deviations for Age and all scores.

Cross-tabulations (with chi-square) were performed to find statistically significant relationships between Gender and the other demographic variables: Age Categories, Marital Status, Number of Children, Living Arrangement (collapsed) and Health Status.

One-sample t-tests were used to compare sample means with means for studies reported in the literature.

Independent samples t-tests were performed to identify any significant differences in ages or scores between male and female groups.

SPSS reliability procedure was performed to examine the inter-item reliability of the standard scales.
The relationships between pairs of scaled variables were analyzed through bivariate correlation, using two-tailed test of significance.

Multiple regression analyses were employed to test the theoretical model.

Finally, a path diagram was created to show a graphic presentation of the above associations (Figure 8).
CHAPTER 3
FINDINGS

Description of Sample

Table 2 shows the description of the sample. Mean age of the total sample was 76.9 years ($SD = 7.32$), with the genders almost equal: male $M = 76.9$ years ($SD = 6.25$) and females $M = 77.0$ ($SD = 8.12$).

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Male (N = 21)</th>
<th>Female (N = 29)</th>
<th>Total (N = 50)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>65-74</td>
<td>8</td>
<td>38.1</td>
<td>11</td>
</tr>
<tr>
<td>75-84</td>
<td>10</td>
<td>47.6</td>
<td>12</td>
</tr>
<tr>
<td>85+</td>
<td>3</td>
<td>14.3</td>
<td>6</td>
</tr>
<tr>
<td>Marital Status a</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unmarried</td>
<td>4</td>
<td>19.0</td>
<td>1</td>
</tr>
<tr>
<td>Married</td>
<td>9</td>
<td>42.9</td>
<td>6</td>
</tr>
<tr>
<td>Divorced</td>
<td>2</td>
<td>9.5</td>
<td>7</td>
</tr>
<tr>
<td>Widowed</td>
<td>6</td>
<td>28.6</td>
<td>15</td>
</tr>
<tr>
<td>Number of Children</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>3</td>
<td>14.3</td>
<td>2</td>
</tr>
<tr>
<td>One</td>
<td>3</td>
<td>14.3</td>
<td>9</td>
</tr>
<tr>
<td>Two</td>
<td>8</td>
<td>38.1</td>
<td>13</td>
</tr>
<tr>
<td>Three or more</td>
<td>7</td>
<td>33.3</td>
<td>5</td>
</tr>
<tr>
<td>Living Arrangement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alone</td>
<td>9</td>
<td>42.9</td>
<td>22</td>
</tr>
<tr>
<td>With Somebody</td>
<td>12</td>
<td>57.1</td>
<td>7</td>
</tr>
<tr>
<td>Self-reported Health Status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not so Good</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>Fair</td>
<td>8</td>
<td>38.1</td>
<td>6</td>
</tr>
<tr>
<td>Good</td>
<td>7</td>
<td>33.3</td>
<td>12</td>
</tr>
<tr>
<td>Very Good</td>
<td>6</td>
<td>28.6</td>
<td>9</td>
</tr>
</tbody>
</table>

Note: a $\chi^2 (3, N = 50) = 7.96, p < .05$. Phi = .399. b $\chi^2 (1, N = 50) = 5.63, p < .05$. Phi = -.336.
Statistically significant gender differences are illustrated in Figures 2 and 3. As might be expected, many more senior women were widowed than men. Men of this age group were much more likely to live in relationship; senior women tended to live alone, while men resided with partners.

Figure 2. Living Arrangement by Gender

![Figure 2: Living Arrangement by Gender](image)

Figure 3. Marital Status by Gender

![Figure 3: Marital Status by Gender](image)
A frequency distribution of loneliness scores is shown in Figure 4, which was considered sufficiently close to normal to permit the use of parametric statistics. Very few (8.5%) of the respondents scored high (i.e., above 60) on the scale.

Figure 4. Loneliness Scores with Normal Distribution Curve

\begin{figure}
\centering
\includegraphics[width=\textwidth]{figure4.png}
\caption{Loneliness Scores with Normal Distribution Curve}
\end{figure}

- Std. Dev = 11.95
- Mean = 40.3
- N = 47.00
Social support

Figure 5 shows frequency distributions of the Global Social Support scores. The curve is skewed to higher scores, reaching a maximum value of 84, hence a high level of perceived support.

Figure 5. Global Social Support Scores with Normal Distribution Curve
A frequency distribution of Professional Support (social worker) scores is presented in Figure 6. The curve is skewed to lower scores, at a minimum value of 1.; hence a lower level of perceived support.

Figure 6. Professional Support Scores with Normal Distribution Curve

![Histogram and Normal Distribution Curve]

- Std. Dev = 2.10
- Mean = 3.9
- N = 45.00
Depression

A frequency distribution of Depression scores is shown in Figure 7, which was considered to be sufficiently close to normal to permit the use of parametric statistics. The majority of the respondents (70.2%) scored normal (non-depressed) on the scale, 27.7% of the participants were mildly depressed and only 2.1% were severely depressed (for depression level categories refer to Appendix D).

Figure 7. Depression Scores with Normal Distribution Curve.
Reliability of Measures

Reliability analysis was performed by computing Cronbach's alpha coefficients for each scale. Results by instruments are presented in Tables 3, 4 and 5. Inter-item reliability was excellent to good for all scales, and corresponded well to values reported for other studies.

Comparisons with Earlier Studies

The nature of the samples of earlier studies is compared to the present sample in Chapter 4.

Loneliness

The mean loneliness scores from the current study and from Russell's study (1996) on a non-clinical elderly group ($N = 284$) were significantly different, $t(46) = 5.07$, $p < .001$ (two-tailed). Table 3 shows the means of the two samples. The lower mean loneliness score indicates that elderly in the earlier study were less lonely than were the participants in the present research.

Table 3. Loneliness Scores: Comparison with Earlier Study

<table>
<thead>
<tr>
<th>Statistics</th>
<th>Russell (1996)</th>
<th>Present Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>$N$</td>
<td>284</td>
<td>47</td>
</tr>
<tr>
<td>$M$</td>
<td>31.51</td>
<td>40.34</td>
</tr>
<tr>
<td>$SD$</td>
<td>6.92</td>
<td>11.95</td>
</tr>
<tr>
<td>Cronbach's alpha</td>
<td>.89</td>
<td>.89</td>
</tr>
</tbody>
</table>
Social support

The mean (sum) scores from this study and from the Clara et al. (2003) study of a psychiatric outpatient adult group \((N = 156)\) were significantly different for global social support, \(t(48) = 6.58, p < .001\), and all sub-scores: family support, \(t(48) = 5.83, p < .001\), friends support, \(t(49) = 3.77, p < .001\), and significant other support, \(t(48) = 6.21, p < .001\) (two-tailed in every test).

Table 4 shows that every score was lower in the earlier study, showing a lower level of perceived social support for the patients of the psychiatric group than for subjects in the present study. In both samples the significant other scores were the highest. Patients of the Clara et al. (2003) study perceive family as the least important source of support in comparison to the participants of the present research, who rate friends support as the lowest.

Table 4. Social Support Scores: Comparison with Earlier Study (Sum-Scores)

<table>
<thead>
<tr>
<th>Support</th>
<th>Clara et al. (2003) ((N = 156))</th>
<th>Present Study</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(M) (\quad) (SD) (\alpha)</td>
<td>(N) (M) (\quad) (SD) (\alpha)</td>
</tr>
<tr>
<td>Family</td>
<td>16.21 (7.16) (.92)</td>
<td>49 (22.37) (7.39) (.89)</td>
</tr>
<tr>
<td>Friends</td>
<td>16.81 (6.93) (.94)</td>
<td>50 (20.68) (7.27) (.90)</td>
</tr>
<tr>
<td>Significant Other</td>
<td>18.74 (7.45) (.94)</td>
<td>49 (23.73) (5.63) (.81)</td>
</tr>
<tr>
<td>Global support</td>
<td>51.76 (17.61) (-)</td>
<td>49 (67.02) (16.24) (.90)</td>
</tr>
</tbody>
</table>

The mean (average) scores from this study and the Stanley et al. (1998) study on an elderly control group \((N = 94)\) were significantly different for global social support, \(t(48) = -4.22, p < .001\), and again for all sub-scores: friends support, \(t(49) = -4.79, p < .001\), family support, \(t(48) = -2.68, p = .01\), and significant other support, \(t(48) = -3.31, p < .01\) (two-tailed in every test).
Table 5 shows that every score was higher in the earlier study than in the present research. This result indicates a higher level of perceived social support among the individuals of the normal control (NC) group than among the participants in the present study. For both samples, scores for significant other support were the highest. Subjects in the Stanley et al. (1998) study perceived family as the least important source of support, in comparison to the participants of the present research who rate friends support as the lowest.

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(n = 94)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>Family</td>
<td>6.3</td>
<td>1.09</td>
</tr>
<tr>
<td>Friends</td>
<td>6.4</td>
<td>0.91</td>
</tr>
<tr>
<td>Significant Other</td>
<td>6.6</td>
<td>0.92</td>
</tr>
<tr>
<td>Global support</td>
<td>6.4</td>
<td>0.75</td>
</tr>
</tbody>
</table>

Depression

The mean depression scores from this study and the Yesavage et al. study (1983) of a normal elderly control group ($N = 40$) were significantly different, $t(46) = 2.81, p < .01$ (two-tailed). Participants in the present study scored higher on the scale than the subjects in the earlier study (Table 6), however the mean (8.9) was still below the cut-off point of 9 for normal-level (non-depressed) (Appendix D).
Table 6. Depression Scores: Comparison with Earlier Study

<table>
<thead>
<tr>
<th>Statistics</th>
<th>Yesavage et al. (1983)</th>
<th>Present Study</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>40</td>
<td>47</td>
</tr>
<tr>
<td>M</td>
<td>5.75</td>
<td>8.09</td>
</tr>
<tr>
<td>SD</td>
<td>4.34</td>
<td>5.69</td>
</tr>
<tr>
<td>Cronbach's alpha</td>
<td>.94</td>
<td>.85</td>
</tr>
</tbody>
</table>

Comparison between Gender Groups

Table 7 shows a comparison of mean scores for all scales for male and female samples. The only statistically significant difference between genders was found for support from significant other, \( t(47) = -2.04, p = .05 \) (two-tailed). The female sample had the higher score, indicating a higher level of support.

Table 7. Mean Scores by Gender

<table>
<thead>
<tr>
<th>Scores</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>M</td>
</tr>
<tr>
<td>Loneliness</td>
<td>21</td>
<td>40.81</td>
</tr>
<tr>
<td>MSPSS</td>
<td>Family support</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Friends support</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Significant other s.</td>
<td>21</td>
</tr>
<tr>
<td></td>
<td>Global support</td>
<td>21</td>
</tr>
<tr>
<td>Professional support</td>
<td>18</td>
<td>3.94</td>
</tr>
<tr>
<td>Depression</td>
<td>21</td>
<td>8.71</td>
</tr>
</tbody>
</table>
Regression Analyses

Table 8 shows correlations between all the variables in the study. A statistically highly significant relationship was found between loneliness and depression, as suggested in Hypothesis One. Furthermore, loneliness was strongly associated with social support, as suggested in Hypothesis Two. In accordance with Hypothesis Three, there were significant relationships between self-reported health status and perceived social support and depression. Finally, a high level of correlation was found between living arrangement and perceived social support, as suggested in Hypothesis Four.

Multiple regression

Figure 8 is a path diagram giving a graphic presentation of the relationships found. Three regression models are presented in reverse order, built up from left to right:

1. Table 9 shows the predictors of social support. The regression model was highly significant, $F(4, 44) = 4.31, p = .005$, and explained 28% of the variation in social support ($R^2 = .28$). Two variables, Health and Living Arrangement, were individually significant. High levels of global social support were associated with better self-reported health and not living alone.

<table>
<thead>
<tr>
<th>Variable</th>
<th>B</th>
<th>SE B</th>
<th>β</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>5.37</td>
<td>4.44</td>
<td>.17</td>
</tr>
<tr>
<td>Health</td>
<td>6.69</td>
<td>2.39</td>
<td>.36*</td>
</tr>
<tr>
<td>Age</td>
<td>.45</td>
<td>.31</td>
<td>.20</td>
</tr>
<tr>
<td>Living Arrangement (collapsed)</td>
<td>12.86</td>
<td>4.72</td>
<td>.39*</td>
</tr>
</tbody>
</table>

*p < .01
Table 8. Pearson's Product - Moment Correlation Matrix

<table>
<thead>
<tr>
<th></th>
<th>1.</th>
<th>2.</th>
<th>3.</th>
<th>4.</th>
<th>5.</th>
<th>6.</th>
<th>7.</th>
<th>8.</th>
<th>9.</th>
<th>10.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
<td>.04</td>
<td>.01</td>
<td>-.04</td>
<td>-.10</td>
<td>.05</td>
<td>.28*</td>
<td>.04</td>
<td>-.18</td>
<td>-.34*</td>
</tr>
<tr>
<td>Health</td>
<td>-.08</td>
<td>-.29</td>
<td>-.46**</td>
<td>.39**</td>
<td>.25</td>
<td>.33*</td>
<td>.34*</td>
<td>.10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>.09</td>
<td>.11</td>
<td>.05</td>
<td>-.01</td>
<td>.20</td>
<td>-.14</td>
<td>-.30*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Loneliness</td>
<td></td>
<td></td>
<td>.64**</td>
<td>-.70**</td>
<td>-.55**</td>
<td>-.59**</td>
<td>-.55**</td>
<td>-.40**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>-.48**</td>
<td>-.39**</td>
<td>-.38**</td>
<td>-.39**</td>
<td>-.24</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSPSS Global Support</td>
<td></td>
<td></td>
<td>.77**</td>
<td>.87**</td>
<td>.77**</td>
<td>.32*</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSPSS Significant Other Support</td>
<td></td>
<td>.60**</td>
<td>.33*</td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSPSS Family Support</td>
<td></td>
<td></td>
<td></td>
<td>.47**</td>
<td>.20</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSPSS Friends Support</td>
<td></td>
<td></td>
<td></td>
<td>.42**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living Arrangements (collapsed)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*p < .05,  **p < .01, (two-tailed)
Figure 8. Predictors of Depression: Path Diagram

Note: Only statistically significant relationships are shown.

*p < .05  **p < .01  ***p ≤ .001

N = 44
2. Table 10 shows the predictors of loneliness. This regression model was also highly significant, $F(5, 40) = 8.95, p < .001$, and explained 53% of the variation in loneliness ($R^2 = .53$). Only one variable, Global Social Support, was individually significant; a lower loneliness score was associated with more social support.

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>$SE$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>-2.57</td>
<td>2.84</td>
<td>-.11</td>
</tr>
<tr>
<td>Health</td>
<td>0.00</td>
<td>1.65</td>
<td>-.00</td>
</tr>
<tr>
<td>Age</td>
<td>0.00</td>
<td>.21</td>
<td>.01</td>
</tr>
<tr>
<td>Living Arrangement (collapsed)</td>
<td>-4.96</td>
<td>3.19</td>
<td>-.30</td>
</tr>
<tr>
<td>Global Social Support Score</td>
<td>-.46</td>
<td>.10</td>
<td>-.63**</td>
</tr>
</tbody>
</table>

$**p < .001.$

3. Table 11 shows the predictors of depression. This regression model was also highly significant $F(6, 37) = 6.19, p < .001$, and explained 50% of the variation in depression ($R^2 = .50$). Two variables, Health and Loneliness Score, were individually significant; high depression score was strongly associated with high level of perceived loneliness. Furthermore, a higher depression score was also associated with ill health.

<table>
<thead>
<tr>
<th>Variable</th>
<th>$B$</th>
<th>$SE$</th>
<th>$\beta$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td>0.00</td>
<td>1.44</td>
<td>.00</td>
</tr>
<tr>
<td>Health</td>
<td>-1.92</td>
<td>.83</td>
<td>-.30*</td>
</tr>
<tr>
<td>Age</td>
<td>0.00</td>
<td>.10</td>
<td>.06</td>
</tr>
<tr>
<td>Loneliness Score</td>
<td>0.30</td>
<td>.08</td>
<td>.62**</td>
</tr>
<tr>
<td>Living Arrangement (collapsed)</td>
<td>0.33</td>
<td>1.64</td>
<td>.03</td>
</tr>
<tr>
<td>Global Social Support Score</td>
<td>0.01</td>
<td>.06</td>
<td>.08</td>
</tr>
</tbody>
</table>

$*p < .05. **p = .001.$
CHAPTER 4
DISCUSSION

Summary of Key Findings

The regression analysis showed statistically significant relationships between:

- Self-reported health status and living arrangement and level of global support,
- Self-reported health status and depression level,
- Level of social support and perceived loneliness,
- Perceived loneliness and elder depression.

The findings confirm the first hypothesis that loneliness is one of the major predictors of elder depression. Lonely people over 65 years of age are more at risk of that disease.

There was a strong relationship between perceived social support and sensed loneliness, as suggested in the second hypothesis. Lack of social support makes elder individuals feel lonelier. Family, friends and significant other all play collective important and reasonably equal roles in how elder sense loneliness, as indicated in Table 8.

Depression could be present also in healthy, independent elderly; consequently a sensed poor health condition could induce depression. However, when one is content with his / her health status then it is believed that the perceived social support is satisfactory. Hence the third hypothesis is proven.
There is a general tendency that a high percentage of the 65+ cohort live alone. Women are over-represented in this group. Elderly, however, see social support as an important resource, as postulated in hypothesis four.

Results of the present study are relatively consistent with those reported in earlier studies. Nevertheless, there are some areas where present findings are different.

Social support level has strong influence on depression; however, due to its inter-correlation with loneliness it is not a direct predictor of depression in the present sample. Many researchers have mentioned that social support deficits and its components have direct impact on depression level (Burnette & Mui, 1994; Russell & Cutrona, 1991; Zimet et al., 1988). "The negative associations of perceived social support with depressed symptomatology suggest a potential buffering effect that can protect an individual from succumbing to adversity" (Clara et al., 2003, p. 268).

Interestingly, Prezza et al. (2002) have indicated that family plays the most important role in the support system, in comparison to the participants in the present study, who rated the significant other support as the highest.

Professional support (social worker) did not play a significant role in the life of the healthy seniors in this sample.

Gender and age were also associated with living arrangement at a significant level. In conformity with findings of earlier studies, age did not seem to influence depression significantly in this sample. Others have speculated that age may contribute to depression on the long-term; however, the evidence of strong association between the two factors is yet to be proved (Tijhuis, de Jong-Gierveld, Feskens & Kromhout, 1999).
Nature of the Different Samples

Analysis of data in Chapter 3 revealed that comparative samples in earlier studies were significantly different from the present sample. Though Russell (1996) conducted the research on a similar age group (i.e., individuals over the age of 65), the researchers collected “extensive medical information”, including initial screening of the participants “to ensure that they were in good health” (p. 25). The present study did not screen the respondents for medical history and used self-reported health statements. Furthermore, the method of recruitment was not detailed in Russell’s study and the size of his sample was considerably bigger, which could also contribute to the difference.

Clara et al. (2003) investigated an adult group of psychiatric outpatients. The patients “were referred for assessment at a mood disorder program... and had been diagnosed 1 year previously with ... major depressive disorder... The mean age of this sample was 41.5 years (SD = 10.75)” (p. 266). The sample of the present study was considerably smaller in size and included relatively healthy, much older individuals whose mental state was not assessed for this research. These factors might explain the statistically significant difference between the samples.

Stanley et al. (1998) “investigated ... two groups of well-diagnosed older adults, one with generalized anxiety disorder (GAD) and the other without any diagnosable psychopathology” (p. 187). Present study used the latter, the normal control (NC) group as a comparison. Individuals who were recruited for the NC group had been initially screened for being free from diagnosed psychiatric disorders. The minimum age was 55 years (M = 67.5, SD 6.77). Participants in the current study were recruited by random interception, thus the respondents’ actual medical history remained unknown. Furthermore, those who were younger than 65 years of age were excluded from the study. The dissimilar method of recruitment and the almost 10-year difference in
mean age might be important elements in the lower level of sensed social support in the present sample.

Yesavage et al. (1983) investigated two groups of seniors. The first consisted of patients under treatment for depression; the second included normal elderly persons as control group. The latter sample was used as a comparison to the current sample. The method of recruitment and the age distribution were not detailed in the earlier study; possible differences in these factors might have contributed to the statistically significant difference in depression scores.

Limitations

The findings in this study confirmed the hypotheses. However, there are some limitations to be considered:

- The present study has limited external validity as it was based on a non-random convenience sample; hence findings cannot be generalized.
- Reactivity is presumed, as the seniors were aware that they were part of a study.
- There is an element of social desirability in which seniors may have given a socially acceptable answer, rather than truthful one, during the interview.
- Survey methods have limited internal validity. No data were collected on family structure, medical history or pan-normative events.
• Because on the non-normal distribution of social support scores, there might be some questions about the exact statistical significance found in the first regression model.

Future Implications

*Implications for practice*

Earlier literature findings are in line with the present study that loneliness and diminished social contacts contribute dramatically to persons with an inclination to depression. Research has shown that lack of social ties and isolation are risk factors for health at all ages. At the same time protective social support in late age empowers the vulnerable individual to negotiate environmental stressors.

It is essential to maintain and improve social contacts and connections for the benefit of seniors, their family members and all age groups of society. Community involvement lessens feelings of loneliness and improves life satisfaction. It is important to encourage and maintain social involvement through stimulating, enjoyable activities and interpersonal attachments to alleviate fears from segregation and isolation (Fry, 1986).

Past research has shown that between 20 and 50% of the youth population also suffer social isolation and loneliness (Brennan, 1982). Stressors in teenage life increase their likelihood of engaging in risky behaviours. Besides the elderly, the adolescent is the most needy cohort in way of social support and appreciation. A possible solution to this might be to sensitize each group to the other, thus making it possible for teenagers as well as seniors, to positively discover each other sharing their social support network.
Intergenerational (IG) programs, as part of the social support system, are excellent tools that could encourage connection and social interaction for the elderly with younger cohorts. IG activities increase cooperation, communication and/or exchange between generations. Like the elderly, adolescents have difficulty handling social risks as a result of poor communication and social skills which often is depicted by loneliness (Brennan, 1982).

The present study was conducted in parallel with a study of lack of social support and loneliness among adolescents (Lennox-Shapiro, 2005). Both studies have suggested a need to pursue a planned IG workshop project, which would offer a unique opportunity to enable and support the two generations.

Social workers, educators and teachers can work with both populations under one roof, sharing thoughts and ideas. Improved communication would allow each cohort to openly express fears and apprehensions that cause dissention and oppression within both populations. The workshops would endeavor to facilitate and address issues, biases, and misunderstandings associated to both age groups.

With this in mind, IG workshops will target independent and healthy residents in a community center or in a retirement home setting. The justification in targeting this group is to attempt to dispel, through appearance and involvement, the idea that healthy and independent elderly are not always in need of social and emotional support. The workshops can be adjusted to fit all levels of care, but for purposes of addressing stereotypical attitudes it might be more effective to deal with a healthy target population.

It is argued that creating a series of workshops, which would address and bridge the gap between the gerontological and youth populations, would make a significant and necessary contribution to social work practice. IG programs can endorse community involvement, improve life satisfaction through social interaction and enhance self-esteem. Further goals are to
modify myths, stereotypes and contradictory attitudes inherent in both groups.

Implications for policy

An aging population affects all levels of social policy. Seniors have lost their defined, productive roles in society. Lack of replacement roles leaves many of the elderly without the option of meaningful participation, social interaction and support. As observed, perceived social support contributes to the sensed loneliness in all age groups, hence its deficiency negatively influences health status. Social and community belonging, as well as satisfaction in social relationships, have a positive effect on both physical and mental health. The present study suggests a need to investigate resources readily available to elderly.

Seniors have little input on IG programs (Disch, 1988; Nichols & Monard, 2001; Schwalbach, 2002). Current government policies endorse neo-conservative individualism that results in a weakened social safety net for all populations. As a result of this policy, fewer resources are available. Nevertheless, it is the 65+ cohort that is affected the most. Society has a moral obligation to explore, create and offer societal resources and services that can secure QOL for seniors.

"Governments also have a crucial role in maintaining and strengthening exchanges between generations: society should offer its older members an opportunity to play a true social role" (National Advisory Council on Aging, 2002, ¶ 3 & ¶6).

The IG program is a journey from the micro to the macro level. By joining elders and adolescents, the personal becomes political and hopefully will command the attention of government support through funding school and community programs to help perpetuate the effort.
Additional involvement of the elderly in the IG workshops can facilitate better communication and understanding between adolescents and the elderly. Older volunteers will not only alleviate some of the economic pressure confronting schools, but can serve as role models combating negative stereotypes. Federal and provincial social policies and programs should facilitate and encourage meaningful involvement and participation of seniors in recognizing their potential. Governments should also provide financial and technical support to embark on the resources which seniors represent.

Implications for research

Considering the environmental changes that particularly impact the 65+ population, the present study investigated the level of perceived loneliness and social support in the independent, relatively healthy elderly and the causative relationship of the said factors to the presence of depression. Also, gender dependence of the demographic data was examined.

Some interesting relationships were found on how loneliness plays a significant role in old-age depression. It became relevant that social support deficit could contribute to the feeling of loneliness. Interestingly, age and living arrangement seem to have little or no influence on the occurrence of depression.

As mentioned in the literature review, previous research focused on the causes of loneliness and certain related behavioral and emotional problems (i.e., self-esteem, depression and suicide). Research trends, as well as findings of the present study, indicate some areas worthy of future investigation.

More comparative data are needed on the levels and possible causes of loneliness in relation to other socio-demographic factors, for example
ethnicity, religion, education and income. Cross-cultural comparisons would also be important; to what extent do these findings relate to other populations?

As social support deficit is a main contributor to sensed loneliness, it is essential to learn more about which factors lead to the strong family and/or friendship and/or significant other connections that offer support to the vulnerable elderly. The role of professional support and its effect on perceived loneliness must be also thoroughly investigated.

No significant gender effect on depression was found in this study. However, the notable gender difference in living arrangement in the present study indicates that this factor should be included in future examination. Furthermore, barriers to social participation need to be identified, that is health concerns, transportation, security, acceptance, level of stress.

Evaluation of new intervention tools designed for intergenerational activities are needed to measure effectiveness in changing attitudes and enhancing the coping skills of seniors.
CHAPTER 5
CONCLUSIONS

The present research verified that there is a close link between loneliness, social isolation and perceived mental health status. As senior population is growing rapidly, it is essential for social work to distinguish the various facets of social support and its relationship to general health, physical condition and depression. Findings confirmed loneliness as one of the major predictors of depression. Isolated seniors may sense loneliness and perceive insufficient level of social support. As a result, depression may affect the otherwise healthy, independent elderly person.

In conclusion, it is encouraged that practice, policy and research approach the social support phenomenon as a whole process. It is, therefore, essential to investigate the structure, function and the quality of relationships of the social network. They are fundamental parts of the coping and adjustment mechanism of a senior individual. Thorough understanding of the social support process could advise social work professionals how members of the 65+ cohort perceive these factors, and how social support could offer an alternative response to individual losses and environmental changes.
APPENDIX A
ETHICS CERTIFICATE

Research Ethics Board Office
McGill University
845 Sherbrooke Street West
James Administration Bldg., rm 429
Montreal, QC H3A 2T5

Tel: (514) 398-6831
Fax: (514) 398-4853
Ethics website: www.mcgill.ca/research/ethicshuman

Research Ethics Board II
Certificate of Ethical Acceptability of Research Involving Humans

Project Title: Elder loneliness, social support and depression

Applicant’s Name: George Viragh

Department: Social Work

Status: Master’s student

Supervisor: Dr. S. Duder

Granting Agency & Grant Title (if applicable): N/A

This project was reviewed on June 15, 2004 by

Expeditied Review __________ Full Review √

Signature __________

Blaine Ditto, Ph.D.
Chair, REB II

07/07/2004

Date

Approval Period: July 2, 2004 to July 6, 2005

REB File #: 20-0604
APPENDIX B

PARTICIPANT CONSENT FORM

Purpose of the study

The present research study titled, “Elder Loneliness, Social Support and Depression”, is being conducted by George Viragh, graduate social work student from McGill University School of Social Work, under the supervision of Dr. Sydney M. Duder, faculty supervisor (Tel.: 514-398-7066; Fax: 514-398-4760).

The purpose of this study is to learn how you feel about your social relationships and contacts, and your level of well being. The results may help to improve services offered at the Cummings Jewish Centre for Seniors such as this.

What participation involves?

If you consent, you will participate in a survey containing a questionnaire. I will read you the questions and responses and ask you to choose the option that is closest to the way you feel. The questionnaire also includes 6 questions regarding your demographic situation. Participation is voluntary: if you decide not to participate, your services will not be affected in any way. If you agree to participate you are free to end the interview at any time. Your answers to the surveys will remain anonymous.

I leave this Consent Form with you to think about it. If you agree to participate in the study then next time you visit the Centre I will ask you to answer the questionnaire. Answering the questionnaire takes about 30 minutes altogether. Your cooperation can help us understand your situation.

Risks & benefits

We believe there is little risk in participating in this study. However, there is always the chance that a question may upset you. You are always free to refuse to answer any question, or to end the interview when you choose.

There is not likely to be any particular benefit to you, although some people appreciate the chance to express their views concerning the perceived health, quality of life, or to contribute to a research study.

Confidentiality

Your answers will remain confidential and anonymous. Only the researcher and the supervisor will have access to the data collected.

<table>
<thead>
<tr>
<th>Do you understand the study?</th>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you agree to participate in the study?</td>
<td>Y</td>
<td>N</td>
</tr>
</tbody>
</table>

__________________________  ________________________  ________________
Name (please print)  Signature  Date

/George Viragh, researcher/
APPENDIX C
QUESTIONNAIRE

Demographic Information

I would like to ask you a few questions about yourself. Your answers will give me information about your situation.

1. When were you born? 

2. Gender: 
   Male  Female
   1      2

3. What is your marital status? 
   Unmarried/ Never married Married or Living with Divorced or Widowed
   Married or Living with Separated
   Common Law
   1      2      3      4

4. How many children do you have? 
   None  One  Two  Three or more
   1      2      3      4

5. Whom do you live with? 
   Living Alone Living with Partner Only Living with Partner and Children or Other Relatives Living without Partner in Family
   1      2      3      4

6. What is your general state of health? 
   Poor  Not So Good  Fair  Good  Very Good
   1      2      3      4      5
**UCLA Loneliness scale**

The following statements describe how sometimes you may feel. I will read you questions and 4 possible responses such as NEVER, RARELY, SOMETIMES and ALWAYS. For each statement, please tell me how often you feel the way described. Here is an example:

How often do you feel happy? If you never felt happy, your response would be “never”; if you always feel happy, you would respond “always”.

<table>
<thead>
<tr>
<th>Never</th>
<th>Rarely</th>
<th>Sometimes</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

1. How often do you feel that you are “in tune” with the people around you? 1 2 3 4
2. How often do you feel that you lack companionship? 1 2 3 4
3. How often do you feel that there is no one to turn to? 1 2 3 4
4. How often do you feel alone? 1 2 3 4
5. How often do you feel part of a group of friends? 1 2 3 4
6. How often do you feel that you have a lot in common with people around you? 1 2 3 4
7. How often do you feel that you are no longer close to anyone? 1 2 3 4
8. How often do you feel that your interests and ideas are not shared by those around you? 1 2 3 4
9. How often do you feel outgoing and friendly? 1 2 3 4
10. How often do you feel close to people? 1 2 3 4
11. How often do you feel left out? 1 2 3 4
12. How often do you feel that your relationships with others are not meaningful? 1 2 3 4
13. How often do you feel no one really knows you well? 1 2 3 4
14. How often do you feel isolated from others? 1 2 3 4
15. How often do you feel you can find companionship when you want it? 1 2 3 4
16. How often do you feel that there are people who really understand you? 1 2 3 4
17. How often do you feel shy? 1 2 3 4
18. How often do you feel that people are around you but not with you? 1 2 3 4
19. How often do you feel that there are people you can talk to? 1 2 3 4
20. How often do you feel that there are people you can turn to? 1 2 3 4

---

MSPSS scale

I am interested in how you feel about the following statements. There are 7 possible responses regarding every statement.

“1” = Very Strongly Disagree
“2” = Strongly Disagree
“3” = Mildly Disagree
“4” = Neutral
“5” = Mildly Agree
“6” = Strongly Agree
“7” = Very Strongly Agree

Please choose the answer that is closest to the way you feel about each statement.

1. There is a special person who is around when I am in need. 1 2 3 4 5 6 7
2. There is a special person with whom I can share my joys and sorrows. 1 2 3 4 5 6 7
3. My family really tries to help me. 1 2 3 4 5 6 7
4. I get the emotional help and support I need from my family. 1 2 3 4 5 6 7
5. I have a special person who is a real source of comfort to me. 1 2 3 4 5 6 7
6. My friends really try to help me. 1 2 3 4 5 6 7
7. I can count on my friends when things go wrong. 1 2 3 4 5 6 7
8. I can talk about my problems with my family. 1 2 3 4 5 6 7
9. I have friends whom I can share my joys and sorrows. 1 2 3 4 5 6 7
10. There is a special person in my life who cares about my feelings. 1 2 3 4 5 6 7
11. My family is willing to help me make decisions. 1 2 3 4 5 6 7
12. I can talk about my problems with my friends. 1 2 3 4 5 6 7
13. My social worker keeps regular contact with me. 1 2 3 4 5 6 7

The following statements help describe your mood. Please choose YES or NO answer for how you felt over the past week.

1. Are you basically satisfied with your life? YES NO
2. Have you dropped Many of your activities and interests? YES NO
3. Do you feel that your life is empty? YES NO
4. Do you feel often get bored? YES NO
5. Are you hopeful about the future? YES NO
6. Are you bothered by thoughts you can’t get out of your head? YES NO
7. Are you in good spirits most of the time? YES NO
8. Are you afraid that something bad is going to happen to you? YES NO
9. Do you feel happy most of the time? YES NO
10. Do you often feel helpless? YES NO
11. Do you often get restless and fidgety? YES NO
12. Do you prefer to stay at home, rather than going out and doing new things? YES NO
13. Do you frequently worry about the future? YES NO
14. Do you feel you have more problems with memory than most? YES NO
15. Do you think it is wonderful to be alive now? YES NO
16. Do you often feel downhearted and blue? YES NO
17. Do you feel pretty worthless the way you are now? YES NO
18. Do you worry a lot about the past? YES NO
19. Do you find life very exciting? YES NO
20. Is it hard for you to get started on new projects? YES NO
21. Do you feel full of energy? YES NO
22. Do you feel that your situation is hopeless? YES NO
23. Do you think that most people are better off than you are? YES NO
24. Do you frequently get upset over little things? YES NO
25. Do you frequently like crying? YES NO
26. Do you have trouble concentrating? YES NO
27. Do you enjoy getting up in the morning? YES NO
28. Do you prefer to avoid social gatherings? YES NO
29. Is it easy for you to make decisions? YES NO
30. Is your mind as clear as it used to be? YES NO

---

3 Brink, Yesavage, Lum, Heersema, Adey and Rose: Geriatric Depression Scale (G.D. S.), 1982
Scoring of the UCLA Loneliness Scale (Version 3)

All scale items can be found on page two of the Questionnaire (Appendix C). According to the author's instructions (Russell, 1996), the following scoring process was applied:

- The positively worded items (# 1, 5, 6, 9, 10, 15, 16, 19 & 20) were re-coded as: 1 = 4, 2 = 3, 3 = 2, and 4 = 1.
- The scores were added together.

Range of scores expands from 20 as the lowest to 80 as the highest. The higher the score, the greater the loneliness level.

Sub-Groups of the MSPSS Scale

All scale items can be found on page three of the Questionnaire (Appendix C). According to the author's instructions (Zimet et al., 1988) the 12 items of the scale were divided into sub-groups relating to the source of the social support as follows:

- Family support: item numbers 3, 4, 8, 11,
- Friends support: item numbers 6, 7, 9, 12 and
- Significant Other support: item numbers 1, 2, 5, and 10.
Scoring of the Geriatric Depression Scale

All scale items can be found on page four of the Questionnaire (Appendix C). Instructions for scoring and defining the level of depression categories were retrieved from Dr. Yesavage’s web page on October 6, 2004, [http://www.stanford.edu/~yesavage/GDS.english.long.html](http://www.stanford.edu/~yesavage/GDS.english.long.html).

Each answer was assigned one point 0 or 1 out of the 30 questions. Value “1” was assigned to item numbers 1, 5, 7, 9, 15, 19, 21, 27, 29, 30 when answered negatively and to the remaining items when answered positively.

The scores for each item were summed together. The higher score indicated higher level of depression. Depression level categories were as follows:

- Normal (non-depressed): 0 - 9
- Mild depression: 10 – 19
- Severe depression: 20 - 30

Table D1. Key to Scoring of the GDS Scale

<table>
<thead>
<tr>
<th>Scale Item Number</th>
<th>Answer</th>
<th>Scale Item Number</th>
<th>Answer</th>
<th>Scale Item Number</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>NO</td>
<td>11.</td>
<td>YES</td>
<td>21.</td>
<td>NO</td>
</tr>
<tr>
<td>2.</td>
<td>YES</td>
<td>12.</td>
<td>YES</td>
<td>22.</td>
<td>YES</td>
</tr>
<tr>
<td>3.</td>
<td>YES</td>
<td>13.</td>
<td>YES</td>
<td>23.</td>
<td>YES</td>
</tr>
<tr>
<td>4.</td>
<td>YES</td>
<td>14.</td>
<td>YES</td>
<td>24.</td>
<td>YES</td>
</tr>
<tr>
<td>5.</td>
<td>NO</td>
<td>15.</td>
<td>NO</td>
<td>25.</td>
<td>YES</td>
</tr>
<tr>
<td>6.</td>
<td>YES</td>
<td>16.</td>
<td>YES</td>
<td>26.</td>
<td>YES</td>
</tr>
<tr>
<td>7.</td>
<td>NO</td>
<td>17.</td>
<td>YES</td>
<td>27.</td>
<td>NO</td>
</tr>
<tr>
<td>8.</td>
<td>YES</td>
<td>18.</td>
<td>YES</td>
<td>28.</td>
<td>YES</td>
</tr>
<tr>
<td>9.</td>
<td>NO</td>
<td>19.</td>
<td>NO</td>
<td>29.</td>
<td>NO</td>
</tr>
<tr>
<td>10.</td>
<td>YES</td>
<td>20.</td>
<td>YES</td>
<td>30.</td>
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</table>
REFERENCES


