LONELINESS AMONG ELDERLY IN NURSING HOMES

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ABSTRACT

Elderly is very vulnerable to loneliness and it is a barrier to achieve successful ageing. Prevalence of loneliness among the elderly is increasing as well as other associated factors that make it worse. in addition, loneliness has a negative impact on our quality of life, and mental and physical health. Moreover, the assessment and identification of loneliness among the elderly are slightly ignored by the health care providers. There is no specific tool to measure the level of loneliness among elderly in Malaysia health care settings. Moreover, by measuring the loneliness level for elderly will help them and health care providers to demonstrate the positive impact of their work on the way people feel about their relationships and connections. The aim of this study was to explore the level of loneliness among elderly in nursing homes using UCLA loneliness scale.A quantitative cross-sectional design conducted in nine nursing homes chosen by a stratified random sampling method in Kuantan, Pahang, Malaysia.Eighty elderly was involved and self-modified questionnaire for sociodemographic data and UCLA loneliness scale that was used to measure the level of loneliness with internal consistency (coefficient α ranging from 0.89 to 0.94) and test-retest reliability (r = 0.73).The descriptive analysis, such as frequency and percentage and Chi-Square test was analyzed using the (SPSS) version 20. 75% of elderly felt very high loneliness while 25% felt moderately loneliness. These participants were mostly came from age-group 71-80s, female, Chinese, not schooling, already loss spouse and don't have any jobs currently. About 58.8% suffered illnesses and 62.5% faced physical limitation. However, the overall result indicates that there was no association between socio-demographic factors and level of loneliness, but all elderly experienced loneliness either moderately or very high.Early detection and lonely screening are the first stage of primary prevention for elderly. It is very advisable to apply a simple tool, UCLA Loneliness Scale to measure the level of loneliness. For the health care providers, they can provide the best facilities and health services for elderly in helping to reach good quality of life as well as successful aging along their life journey.

Keywords: Elderly, Loneliness, UCLA Loneliness Scale, Nursing Homes

Introduction

In the year 2013, several reports wrote that Malaysia will reach the old country status in 2030 when the population aged 60 years and up to 15% of the population. And also, Malaysians would also be making fewer babies while elderly population will rise to 11.4% of the population or about 4.4 million people in the year 2040 (Lee, 2013). In future, the productive and healthy elderly is not guaranteed because elderly is susceptible and vulnerable to internal and external harm due to the ageing process. Getting sick either physically or mentally obstacle for them to achieve three components of successful ageing such as low probability of disease and disease-related disability, high cognitive and physical functional activity and active engagement with life (Bowling, 2005). Unfortunately, one of the barriers to achieve successful aging is loneliness which is currently attacking among elderly. Loneliness always refers as unpleasant and negative feeling (Tzouvara,et.al, 2015) and that feeling can alleviate or remain constant across the life course because the level of loneliness depends on personality, situation and condition of that individual. in Malaysia, the study about loneliness is limited. A study done by Teh, Tey and Ng, (2014), reported that the increasing numbers of age tend the person to feel very lonely. Another report by Zakaria, Alavi and Suhbi (2013), stated that elderly is very vulnerable to loneliness due to life changes after their retirement. In addition, Nikmat and Almashoor (2015), also reported that less social interaction and social support for elderly risk for loneliness. In addition, a research conducted by Mutafungwa (2009) also found that elderly living at the nursing homes have a risk for loneliness. Therefore, the objective of this study is to explore the level of loneliness among elderly.

Ageing refers to the increasing number of the age and it has been discussed that feeling of loneliness among people of different age is different and worldly agree that the elderly can be a subgroup into young, old (60-69), middle old (70-79) and very old (85+). However, many previous studies agreed that those aged 80 and over have higher loneliness compare to 65 to 79 ages (Neto, 2014). Therefore, advancing age is a factor in developingloneliness among elderly.

A concept of loneliness is various same goes to the measurement of loneliness that helps on assessment and identification of loneliness among elder. However, this instrument slightly ignored by a health care provider and the Ministry of Health since they do not view loneliness as a great threat to the elderly, even they have the knowledge about the risk factors and aetiology of loneliness. The reasons are the workers are unfamiliar with that instrument and it is not a routine assessment in Malaysia health setting. In addition, research on loneliness among elderly in Malaysia is limited and less acknowledged by people. Hence, the benefit of this research is to develop interests among the health care providers to use loneliness instruments like UCLA Loneliness Scale, besides it provides new findings in gerontology course regarding the current mental health and psychological well-being of elderly.

MATERIALS AND METHODS

A quantitative cross-sectional design and 80 elderlies from Nursing Homes in Kuantan, Pahang were conducted and selected by using a stratified random sampling method. The material used in this research is a questionnaire that consists two parts, Part A (Socio-demographic data) and Part B (UCLA Loneliness Scale). Part A related with socio-demographic data, including 9 questions. The questions consist of age categories, gender, race, educational level, marital status, employment status, having an illness, functional status and frequency of being visited by family members. For functional status, they were asked to select the activity that they cannot perform by themselves. The activities are self-feeding, bathing, getting dressed, going to the toilet, exercising, and daily housework; attend to religious gathering and grocery shopping. Part B is regarded with the level of loneliness by using UCLA Loneliness Scale. This scale developed by Daniel W. Russell on 1980 21. The scale consisted of 20 statements or items related to the elder socialization activity. The validity and reliability of this scale are very strong and highly reliable where is $\alpha = 0.89 – 0.94$ and $r = 0.73$. The participants will rate each item as either "Never", "Rarely", "Sometimes" or "Often". Each item has its own score, Never = 1, Rarely = 2, Sometime = 3 and Often = 4. After that, the score was calculated to get a total score. The evaluation for the level of loneliness depends on the range of the total scores, which are, 20-34 = low degree of loneliness, 53-49 = moderate degree of loneliness and 50-80 = moderately high degree of loneliness.

Statistical analysis was performed by using IBM Statistical Social Science (SPSS) version 20.0. Two variables such as, the level of loneliness among elderly and socio-demographic factors were investigated using descriptive analysis and the result portrayed in visual like such as histogram and a pie chart that depict the percentage and the frequency the distribution of sociodemographic of respondents and their level of loneliness while the association both variables were analysed using Chi-Square test. Ethical clearance was obtained from Kulliyyah of Nursing Post Graduate Research Committee (KNPGRC), International Islamic University Malaysia Ethics Committee (IREC), each Director of Nursing Homes in Kuantan, Pahang and each participant.

RESULTS

Total respondents in this research were 80. (N = 80). The result indicates all elderly experience loneliness at nursing homes. While only 25% (N=20) feel loneliness moderately and 75% (N=60) feel very lonely. The details were shown in table 1.

Regarding the disturbing of the socio-demographic data of the elderly were shown in table 2.

Concerning the relationship between age and level of loneliness among elderly in a nursing home was not significant, X^2 (3, N = 80) = 1.692[a], p ≤ 0. 657.The details showed in table 3.

The relationship between gender and level of loneliness was not significant, X^2 (1, N = 80) = 1.358[a], p ≤ 0.305. The details showed in table 4.

The relationship between race and level of loneliness was not significant, X^2 (2, N = 80) = 0.754[a], p ≤ 0.854. The details showed in table 5.

The relationship between education level and level of loneliness was not significant, X^2 (3, N = 80) = 3.882[a], p ≤ 0.301. It is very interesting that those who finish their study in university or college face loneliness often compared to another level of education such as no schooling, primary school and secondary school. The details showed in table 6.

The relationship between marital status and level of loneliness was not significant, X^2 (3, N = 80) = 0.296[a], p ≤ 1.00. The details showed in table 7.

Employment status cannot be related to the level ofloneliness in this research because all respondents were retired and none of them has any job right now.

The relationship between having the illness and level of loneliness were not significant, X^2 (2, N = 80) = 0.559[a], p ≤ 0.753. The details showed in table 8.

The relationship between functional status and level of loneliness was significant, X^2 (2, N = 80) = 12.121[a], p ≤ 0.002. The details showed in table 9.

The relationship between a frequency of being visited by family members and level of loneliness was not significant, X^2 (3, N = 80) = 1.769[a], p ≤ 0.660. The details showed in table 10.

DISCUSSION

Age

Initially, elderly was sub-grouped into young old (60-69), middle old (70-79) and very old (85 and above). Nevertheless, most of them do not see the number in their age as the measurement of health, but they more concern how to spend their lives before dying. To them, having a psychological illness like loneliness, depression and severe anxiety before dying to make their life is less satisfying, a risk of reducing of their life span and finally facing death miserably. Loneliness arenegatively affected Quality of Life (QOL) in old age, in other words, Quality of Life decrease along increased feelings of loneliness (Singh and Misra, 2009).

Gender

Gender can be categorized as the identity of the individual. Even though, the previous study said the prevalence of loneliness is higher among elderly female than elderly male (Dahlberg and McKee, 2014) (Savikko, 2008) and the reasons are Malaysian women have longer life expectancy compared to men. Malaysian men exposed to unhealthy lifestyles such as smoking and the male tend to get married after loss an intimate relationship. These causes can be modified by applying healthy diet and lifestyle that can long the life expectancy and finding a new mate to recover broken relationship. Therefore, loneliness is not associated with gender. It once defines as an unpleasant feeling exhibit by individuals due to lack of friends or companions. So, the number of friends either male or female gives high impact toward individual's feeling.

Race

Research on race related to loneliness is very limited and the obvious finding is the indigenous group, Malays and Chinese prone feel loneliness due to several reasons (Savikko 2008). One of the reasons is Malay personality to have high expectation on social contact and social size (Savikko 2008). For instance, those live in a rural area might have small social contact and small social size compared those living in an urban area such as main city (Savikko 2008). Then, loneliness was more prevalent among rural resident than the urban. However, the result showed the race does not significantly associate with the level of loneliness because of race just a title and do not influence feeling of that person. Such as, in Malaysia, Malay, Chinese, Indian and indigenous group also do not affect the level of loneliness among elderly, but if it is associated with other factors like a physical limitation or marital status the result may be positive (Savikko2008) (Howled, et.al 2014) (Adu-Bediako, 2013). Besides that, the distribution of race in the nursing home does not equally and most nursing home residents are Chinese.

Education level and marital status

Those obtaining a better education have high chances of being employed and less worried about financial income, and it reduces their tendency on getting lonely background (Savikko 2008 and Slettebo 2008). In contrast, low levels of education unconsciously lead to low level of income, this is because those have higher education like having the main ticket to make more social contact which can increase the social network and the number of contact than a person who had just a basic or no educational level (Treacy, et.al 2006). However, high or low education or never getting a formal education is not the main issue for those born between the years 1920 until 1940 in Malay Land, because education is very hard to get due to prohibitionattending any school during that colonial era and to saving money is the main way to survive at that time. Therefore, all elderly in nursing homes have similar backgrounds. The issue about discrimination, social isolation or alienation between resident does not occur and it reduces the exposure toward loneliness. Same goes to build a new family, during that time not many of them get married and gradually loses their partner along the life course.

Having illness and functional status

Suffered from chronic illness and other handicap does not initiate a feeling of loneliness. It is reversed feeling of loneliness can lead to the development of chronic illness such as low which increases the risk of infection, depression, which is increased for mental disorientation and dementia immunology (Holt-Lunstad, et.al 2015). Therefore, most of the nursing homes were established by nurse managers and assisted by certified nurse to prevent the elderly from getting lonely and sick.

Unfortunately, it is different for those having limitations in their functioning. For example, having arthritis,body paralyzed totally and getting limb amputation automatically reducing their functional status and directly reduces their capacity to perform normal activities. Hence, feeling of lonely may develop inside them.

Frequency of being visited by family members

Lastly, feeling of detachment from family gradually suffered by the elderly nowadays in the world, however, there are several ways which are offered to reduce the loneliness like contacting by cell phone, social network and other media that can suppress long distance relationship between parents and children. Besides that, nursing homes also provide their contact information to guardian like office phone numbers and home addresses.

Conclusion

The research finding indicates socio-demographic factors do not affect the level of loneliness among elderly. However, the results from UCLA Loneliness Scale does not be ignored. The scale may be not a diagnostic test, but it acts a screening test for loneliness level. This research is quantitative cross-sectional research design. It uses numerical to interpret the level of loneliness. However, loneliness is the subjective feeling that has different meaning for each individual. Therefore, the quantitative is not enough to grade elderly loneliness. Another type of research, for example qualitative study is needed to support this research and make it more precise. In conclusion, the early detection and address of loneliness are very important for individual, family, health care provider as well as the government for a future and strategies to reduce the prevalence of loneliness among elderly.

ACKNOWLEDGEMENT(S)

We highly appreciate and thank to the elderly who are staying in nursing homes for giving their time and effort to collect the data for this study.

Appreciation also goes to my friends for all supports, advises and technical assistance provided by them from the start until the end of this research process.

Finally, our special thanks to all members in our faculty for giving full support throughout the study.

Conflicts of interest: Nil

Table 1: Level of Loneliness

Variables	F N	%
Low degree of loneliness	0	0
Moderate degree of loneliness	20	25
Moderately high degree of loneliness	60	75

Table.2: Distribution of Socio-Demographic Data

Variables	F N	%
Age (year)		
61-70	19	23.8
71-80	34	42.5
81-90	20	25.0
91-100	7	8.8
Gender		
Male	37	46.3
Female	43	53.8
Race		
Malay	22	27.5
Chinese	50	62.5
Indian	8	10.0
Others	0	0
Education level		
No schooling	33	41.3
Primary school	31	38.8
Secondary school	10	12.5
College/University	6	7.5
Marital Status		
Single	15	18.8
Married	10	12.5
Divorced	10	12.5
Loss spouse	45	56.3
Employment status		
Working	0	0
Retired	80	100
Having illness		
None	10	12.5
1 illness	23	28.8
2+ illness	47	58.8
Functional status: Physical Limitations		
None	11	13.8
1-2 limitations	19	23.8
3+ limitations	50	62.5
Frequency of being visited by family members	25	31.3
Once daily	49	50.0
Once a week	6	7.5
Once a year	9	11.3
Never		

Table 3: Age and Loneliness

Variables	N (%)	X^2	df	*p*-value
Age (year)				
61-70	23.8	1.692[a]	3	0.657

71-80	42.5			
81-90	25.0			
91-100	8.8			

* *p* value > 0.05
a- Continuity correction

Table 4: Gender and Loneliness

Variables	N (%)	X^2	df	*p*-value
Gender				
Male	46.3	1.358[a]	1	0.305
Female	53.8			

* *p* value > 0.05
a- Continuity correction

Table 5: Race and Loneliness

Variables	N (%)	X^2	df	*p*-value
Race				
Malay	27.5	0.754[a]	2	0.854
Chinese	62.5			
Indian	10.0			
Others	0			

* *p* value > 0.05
a- Continuity correction

Table 6: Education Level and Loneliness

Variables	N (%)	X^2	df	*p*-value
Education level				
No schooling	41.3	3.882[a]	3	0.301
Primary school	38.8			
Secondary school	12.5			
College/University	7.5			

* *p* value > 0.05
a- Continuity correction

Table 7: Marital Status and Loneliness

Variables	N (%)	X^2	df	*p*-value
Marital Status				
Single	18.8	0. 296[a]	3	1.00
Married	12.5			
Divorced	12.5			
Loss spouse	56.3			

* *p* value > 0.05
a- Continuity correction

Table 8: Having Illness and Loneliness

Variables	N (%)	X^2	df	*p*-value
Having illness				
None	12.5	0.559[a]	2	0.753
1 illness	28.8			
2+ illness	58.8			

* *p* value > 0.05
a- Continuity correction

Table 9: Functional Status and Loneliness

Variables	N (%)	X^2	df	*p*-value
Functional status: Physical Limitations				
None	13.8	12.121[a]	2	0.002

1-2 limitations	23.8			
3+ limitations	62.5			

* *p* value > 0.05
a- Continuity correction

Table 10: Frequency of Being Visited by Family Members and Loneliness

Variables	N (%)	X^2	df	*p*-value
Frequency of being visited by family members				
Once daily	31.3	1.769[a]	3	0.660
Once a week	50.0			
Once a year	7.5			
Never	11.3			

* *p* value > 0.05
a- Continuity correction

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